

PostScript

LETTERS

“Will the SARS epidemic recur?” A retrospective analysis of the experts’ opinions

Shortly after the severe acute respiratory syndrome (SARS) epidemic subsided, nine experts were invited by this journal to predict whether the epidemic would recur.¹ A review of their opinions two years after the epidemic may prove insightful.

SARS has not recurred in epidemic proportions since it ended in July 2003. Since September 2003, several laboratory associated cases occurred: in Singapore, Taiwan, and Beijing, the latter involving two secondary and five tertiary cases.² In addition, three sporadic cases occurred in Guangzhou from December 2003 to January 2004.³ One patient, a restaurant waitress, was linked to wildlife (civets) while the source of infection of the other cases remained unclear. No more SARS cases were reported since 30 April 2004.⁴

Of the nine experts, three predicted the recurrence of the epidemic in autumn/winter. Three (including the author) correctly predicted that the epidemic was unlikely to recur. Two correctly predicted the return of SARS, but did not predict whether as an epidemic or smaller outbreaks, and one abstained from prediction. Most experts agreed on the importance of vigilance in public health and hospital measures. None mentioned the possibility of laboratory outbreaks. The analogy of the epidemiology of SARS to the periodicity of influenza epidemics made by some experts was misplaced—SARS peaked in April–May 2003, the end of the respiratory virus season. The assumption that SARS might be more efficiently transmitted in winter has been queried. More evidence that civets are animal reservoirs is found. Antibodies to SARS-CoV among civets in Guangdong farms were found.⁵ Clinically inapparent infections were detected among animal market traders (highest in civet traders) in Guangzhou but a healthy human SARS carrier (either patients who recovered, or asymptomatic seropositive people) does not exist. These findings put the focus on wild animals and the laboratory as the most probable sources of future outbreaks. That sporadic cases continued to surface (both in the laboratory and in the community) is an ominous signal. Further research of the role of wild animal species that have close contact with humans is needed. While civets might be responsible for one case in Guangzhou,⁴ the unknown source of infection of the other community acquired cases shows the shortcomings of

contact tracing and disease investigation procedures, and also suggests the possibility of yet unidentified sources in the environment.

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- 3 World Health Organisation. New case of laboratory-confirmed SARS in Guangdong, China—update 5. http://www.who.int/csr/don/2004_01_31/en/index.html.
- 4 World Health Organisation. Update 4: review of probable and laboratory-confirmed SARS cases in southern China. http://www.who.int/csr/don/2004_01_27/en/index.html.
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Health and happiness in a materially deprived, ethnically mixed locality

We congratulate the journal and editors in highlighting the importance of “happiness” in terms of understanding conceptions of health (that is, what it means to be healthy) and the importance of the link between unhappiness and social exclusion for the pervading and widening inequalities in health.^{1,2}

These themes fit almost exactly with findings from a qualitative study we completed in 2003, which centred on understanding the health care needs of residents in a materially deprived, ethnically mixed locality in northern England. The study involved undertaking five focus groups with Pakistani and white residents (total of 28 Pakistani and 19 white residents). The focus groups with Pakistani residents were undertaken with the aid of an interpreter. All focus groups were transcribed and independently analysed by both authors using interpretive analysis.³

Two of the important themes to emerge from the focus groups were the holistic definition of health and the importance of “happiness” in maintaining and improving health. Many participants talked about a symbiotic relation between health and happiness, whereby happiness was a pre-requisite

for good health and vice versa. Both health and happiness were conceptualised in holistic terms, and were not seen as the sole provenance of public health or primary care services. Participants often spoke vociferously about a long history of dis-investment in services in their locality and “broken promises” from government agencies and also about general feelings of distrust of statutory sector institutions and exclusion from mainstream society. This had led to general feelings of unhappiness and therefore reduced levels of health. Therefore, to be healthy, respondents talked about the need for a cleaner physical environment (for example, clean streets, parks, and other public spaces), reduced traffic noise and pollution, reduced industrial pollution, more jobs, and better local services (for example, schools and advice centres in addition to healthcare services).

While none of these findings will come as a great shock to many people working within a social model of health, what they do is reinforce the importance of structural forces in shaping feelings of happiness (*qua* health) and suggest a heightened and widened advocacy role for public health practitioners within and across a number of statutory sector agencies, in terms of representing the “voice” of excluded and marginalised groups.

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- 1 Subramanian SV, Kim D, Kawachi I. Covariation in the socioeconomic determinants of self rated health and happiness: a multivariate multilevel analysis of individuals and communities in the USA. *J Epidemiol Community Health* 2005;**59**:664–9.
- 2 Ross N. Health, happiness, and higher levels of social organisation. *J Epidemiol Community Health* 2005;**59**:614.
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Addendum

We thank the authors of the letter for sharing their qualitative case study findings that highlighted the need to conceptualise health and happiness in holistic terms. Indeed, our analysis was motivated by the need to consider health and happiness as distinct, and yet intrinsically interrelated, components of wellbeing. It is encouraging that our quantitative approach and findings are grounded in “real” case experiences.

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