

COVID-19 and SARS – Learnings from Two Health Systems: Australia and Canada

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As a chief nurse in Ontario during the severe acute respiratory syndrome (SARS) outbreak in 2003, I never thought I would experience anything even remotely similar, let alone exponentially worse, in my lifetime. Seventeen years and almost 17,000 km later, the COVID-19 crisis feels eerily similar in many ways, and completely different in others.

Globally – in the early days of COVID-19 – when the virus was denied and healthcare workers who raised the alarm were disregarded (Thomson 2020), I felt a sense of *déjà vu*. The presence of social media has helped to call out behaviours and ensure better transparency now; albeit, it has also allowed for incorrect information and “fake news.”

Nationally, the public health systems in Australia and Canada are very similar, with universal healthcare.¹ Public hospitals are overburdened, working at 90–95% occupancy, making surge capacity extremely difficult. While hospitals around the world struggle to find the resources needed for the unprecedented need brought on by the pandemic, the difference between those that are successful and those that are failing is the ability to respond in a nimble way at the individual hospital, state/provincial and national levels.

Public health is inherently political. As Ontario’s chief nurse during the second wave of SARS, I saw first-hand the impact of misalignment between federal and provincial governments,

thus leading to delay in critical responses. In Australia, the COVID-19 crisis came immediately on the heels of the worst bushfires the country has ever seen (Calma 2020). The prime minister had been highly criticized for not coordinating emergency management nationally (BBC News 2020b), so when COVID-19 hit, he swiftly enacted a national approach. The first ministers immediately came together, and since then the states’ chief medical officers (CMOs) and federal CMO have been well aligned. That is not to say that there hasn’t been confusion, but it has been significantly less than what I witnessed in Ontario during the SARS outbreak. Additionally, Australia’s national regulatory system (one body for all health professions) was directed to rapidly develop a process for recent retirees to be reinstated to help with the surge. This is in stark contrast with Canada’s complex and unaligned regulatory system.

As an island nation, Australia was able to close its borders quickly to all but residents and citizens. This, along with strict quarantine “requirements” to self-isolate upon returning to Australia (including being taken straight from flights to hotels for 14 days with security guards on watch), has flattened the curve (BBC News 2020a). At the time of writing, Australia had seen only 6,800 cases and 65 deaths, and only 10% of transmission had been community acquired as compared to Canada’s more than 30,000 cases, with 76% community transmitted

Originally published in the Longwoods e-letter on April 28, 2020 (<https://www.longwoods.com/content/26209/covid-19-and-sars-learnings-from-2-health-systems-australia-and-canada>).

(ABC News 2020; Government of Canada 2020). During the SARS crisis, there was no “requirement” to stay at home, and the voluntary nature of the desired protocol likely led to many breaches. While I’m not in Canada for the COVID-19 crisis, from afar it looks like history is repeating itself.

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Coming back to Australia: at the state level, emergency management teams were reconstituted and augmented with trusted advisors, including calling upon those who had experienced the SARS outbreak. I was put onto state committees on the use of personal protective equipment and models of care – I was looking at ways to change models of care to address the virus, for example, using enrolled nurses (the equivalent of practical nurses) in ICUs to provide basic care and thus free registered nurses to focus on critical care activities.

At the organizational level, I used my experience with SARS to be “ahead of the curve,” closing off entrances and starting screening before directives were initiated, giving comfort to our staff, who felt supported knowing we were doing all we could to protect them. And, as CEO of Australia’s largest hospital dedicated to women and babies, I was particularly concerned about the impact of restrictions on women in labour and babies in the neonatal intensive care unit (NICU), remembering the negative impact of *no* visitors during SARS in Ontario. As COVID-19 ramped up, we knew that this was not best care and thus allowed one partner for women, and both parents in NICU – a practice that health officials paid heed to and used across the state.

Even with very similar health systems and commitment to universal healthcare, differing government processes have led to different levels of success – as I witnessed during the SARS outbreak in Ontario and am witnessing with COVID-19 in Australia. But, government processes aside, at the individual level, I am heartened by the universality of the

commitment of healthcare professionals, as the vast majority of them run toward a crisis. Whether in Canada or Australia, whether during SARS or COVID-19, healthcare professionals continue to put their hands up to help. Regardless of country or national, state/provincial and organizational approaches, we can be confident that healthcare professionals will always step up to do what is best for the patients we care for. That is universal. **HQ**

Note

1. Australia does have a private healthcare overlay.

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