Persistence, timing and policy change: An interview with Arlene King

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Dr. Arlene King

Arlene King is an accomplished public health leader. This includes serving as Ontario's Chief Medical Officer of Health (CMOH) from 2009–2014. Prior to that, she was Director General for Pandemic Preparedness and later Director General for a new Centre for Immunization and Respiratory Infectious Diseases with the Public Health Agency of Canada. In the 1990s, Dr. King was a Medical Officer of Health in Burnaby and Vancouver, BC, and worked in senior positions at the BC Centre for Disease Control. Dr. King is an internationally-recognized expert in immunization, infectious diseases and pandemic preparedness and has been an active consultant on numerous initiatives for the World Health Organization (WHO), the Pan American Health Organization (PAHO), the World Bank and the Canadian International Development Agency. She received Health Canada's Deputy Minister's Award of Merit for her contribution to Canada's National SARS Response, as well as the Chief Public Health Officer of Canada's Medal for establishing Canada's Pandemic Preparedness Secretariat. Dr. King is currently working as an international public health consultant and continues to be an adjunct professor at the Dalla Lana School of Public Health at the University of Toronto.

Interview

Ross Graham (RG): *What attracted you to public health?*

Arlene King (AK): I chose a career in community medicine (public health and preventative medicine) after five years of general practice in Northwestern Alberta. Every August, I saw serious injuries due to the challenging conditions area farmers were under to complete their harvest. I felt these injuries were preventable, but I wasn't entirely sure how. In fact, it seemed many of the conditions I treated were preventable, including heart disease and infections. This led me to pursue a master's degree in population health with plans of returning to clinical practice. However, I soon realized I could have more impact by becoming a community medicine specialist.

RG: *What have been the most exciting experiences of your career so far?*

AK: There have been many. I'll distinguish between exciting, stimulating and rewarding experiences. The most *exciting* experiences have been those with 'unknowns.' For instance, I vividly remember months spent investigating a toxoplasmosis outbreak in Victoria, BC in 1995, the source of which was not known. SARS was another example. It was an unknown disease with unknown modes of transmission and epidemiologic parameters. We knew nothing about how the disease presented, nor its incubation period. Serving as a Director General at PHAC was also very exciting. This included being the technical lead for

the H1N1 pandemic in 2009, which among other [activities], involved extensive collaboration [among] the City of Toronto, Ontario public health practitioners, Health Canada and the WHO.

One of the most *stimulating* experiences was my time working with the WHO reviewing the International Health Regulations (2005) and the H1N1 pandemic. This was a fascinating experience with an excellent team led by Dr. Harvey Fineberg, who was the head of the US Institute of Medicine. I continue to find international work very stimulating. I suppose when you are a population health doc, the larger the population, the better.

One of my most *rewarding* experiences was developing and implementing Canada's first national immunization strategy. This strategy provided the first federal funding for new vaccines against four serious diseases – invasive meningococcal C disease, pertussis (in adolescents), invasive pneumococcal disease and varicella. This was critically important given the disparity in

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vaccine funding across the provinces. Rapid implementation across all jurisdictions in Canada followed, resulting in dramatic declines in the incidence of these diseases in children and adolescents.

Leading the development of *Make No Little Plans*, Ontario's first public health sector strategic plan, was also very rewarding. This plan will serve as a roadmap for the next 20–25 years for public health in Ontario. Numerous annual and other CMOH special reports will also serve as catalysts for the development of whole-of-government approaches to various health issues.

RG: *In contrast, what was one of the most challenging experiences of your career? How did you deal with this challenge?*

I did not realize until later in my career that public health was often viewed by governments as having a 'nanny state' approach to public policy development – the view that legislation or regulation was required to address many or all health issues. This is often in direct contrast to prevailing public and political views, and needs to be better appreciated and understood by the public health community. Even when the evidence suggests a legislative or regulatory approach might be most effective, it needs to be carefully and thoughtfully conveyed, and other alternatives considered. Furthermore, there needs to be public and political sentiment in favour of such actions.

RG: *What skills have been most valuable throughout your career?*

AK: Two skills I've found to be important are persistence and the development of a long-term perspective. This is particularly true for chronic disease prevention and changing public policy. This work requires significant time to develop and gain acceptance. Then implementation is also often a long journey. Persistence becomes important because despite your best effort, you won't always win the battle.

The ability to communicate using plain language and having a solid understanding of the evidence are also critical. If you want to change policy – or win the war, so to speak – which most public health people want to do, it isn't enough to provide scientific advice. Decision-makers are predominantly lay people without a science background. It is our job to translate the evidence and to convey it, in the best manner possible, to enable decision making. This usually is achieved [by] using brief, plain language and speaking with conviction, which requires having a solid understanding of the evidence base.

Over the years, I've also achieved a better, more inherent understanding of the importance of the epidemiologic triangle (i.e., a model for understanding the spread of communicable diseases in populations). In particular, I have a greater appreciation for how the built environment and natural environment interact with the host and agent (i.e., organisms harbouring the disease). Improving our understanding of this complex interaction is critical to improving health, regardless of whether we are talking about communicable diseases, chronic conditions or injuries. Advancing healthy public policy in the environments where we live, work and play has been my interest and focus in recent

years. While policy work is perhaps the most difficult aspect of public health, it is where we can have the most impact.

RG: *What are some opportunities for Canada's public health system to improve?*

AK: It is unfortunate that we rarely celebrate our victories and milestones. Celebrating success is a tradition for many public health organizations, like PAHO. They've found celebrations improve staff morale and keep practitioners energized. If we are to maintain persistence over a long period of time, we need to celebrate our successes, even what may appear to be small achievements and milestones. Another opportunity for improvement relates to how public health times its campaigns and interventions. Timing is everything in public health. For example, introducing new legislation in a minority government environment or during a provincial election is unlikely to gain much traction. Understanding public readiness is another critical aspect of timing. Policy windows and opportunities arise where introducing interventions and legislation will have a higher probability of success. Public health needs to be alert to these opportunities and respond accordingly.

We also too often forget that the public health perspective is just one of many perspectives that exist on each issue. There are important social, financial and political aspects that must also be considered, for example. We need to better understand these perspectives in addition to our own. Just because the public health evidence suggests an intervention is a good idea doesn't mean the evidence from other perspectives will as well.

RG: *What advice would you give to someone considering a public health leadership role?*

AK: Be sure to have a clear understanding of the position responsibilities and location in the organizational structure before accepting. This is important if you truly want to make a difference. You need to understand what you are getting yourself into and how much influence you are actually going to have. For example, some public health practitioners struggle to understand where and who is the policy lead on an issue. As an example, if we look at reducing motor vehicle fatalities, the responsibility in Ontario lies with the minister and ministry of transportation. Public health leaders need to develop a good working relationship with those in policy lead positions, such as the deputy minister and other senior government officials in that ministry. You must work with them to achieve a shared understanding of the problem and the evidence, so that they fully understand your perspective, and include it as part of a policy submission. Public health is not going to change speed limits on roads. That is transportation's responsibility. We also need to acknowledge, recognize and celebrate *their* successes in achieving shared goals. This is true regardless of where the policy lead resides within government on a specific issue (e.g., environment, education, housing, finance, agriculture or elsewhere). Essentially, public health provides the support, the evidence and the encouragement to enable healthy decisions to be made. I would add that you attract more bees with honey than you do with vinegar. That's been my philosophy throughout my career.