

# health policy and management academic policy advisor

## A TRUE TALE

When he attended medical school at the University of Michigan in the late 1960s, James Curran, MD, MPH, was interested in family planning and maternal and child health. After he graduated from medical school, he entered the Public Health Service. “Many newly graduated male physicians went



James Curran, MD, MPH

into the service in one way or another,” says Curran. Dr. Curran was given the choice of joining the Air Force or of joining the military commissioned corps in the Public Health Service with the Centers for Disease Control and Prevention (CDC). Choosing the latter, he took a position as a commissioned officer working in the Sexually Transmitted Diseases Control Division in Atlanta. He enjoyed his experience so much that he remained with the CDC at the end of his tour of duty and residency training, rather than returning to clinical medicine.

In 1974, Dr. Curran received his MPH from the Harvard School of Public Health. He then went to Ohio State University to run a sexually transmitted diseases (STD) research project. Eventually he returned to Atlanta in 1978, where he became Chief of the CDC’s Sexually Transmitted Diseases Research branch.

In 1981, Dr. Curran and his colleague were researching the efficacy of hepatitis B vaccine in the homosexual community when physicians from across the country started describing unusual cases of *pneumocystis carinii* and *Kaposi’s sarcoma* in their patients. These reports heralded the first signs of what would eventually — and quickly — grow into the AIDS epidemic. It was just as those early cases surfaced that Dr. Curran was asked by the CDC to head a three-month task force to investigate the disease.

“Sound policies should be based upon sound science, and an important part of sound science in public health is founded on outcomes research and health economics.”



## Academic Policy Advisor Checkpoint

Are you interested in the policy aspects of public health?

Can you visualize the “big picture” and turn issues into what will eventually become health policy?

Are you prepared to put in long hours and wait to see issues transformed into law?

If so, read on



### Did you know?

During the first session of the 107th Congress in 2001, public health, preventive medicine and dentistry programs grew 10.6 percent due to new legislation.<sup>1</sup>

Instead of three months, that assignment lasted 15 years, during which time he was named Associate Director for AIDS at the CDC and established himself as one of the leading experts in the field. During that time, he helped set policies that are still in place today, such as making AIDS reportable in all states and setting limits on who can donate blood. Dr. Curran also helped develop guidelines for testing pregnant women for HIV and offering antiviral therapy to those who tested positive.

In 1995, Dr. Curran was appointed Professor of Epidemiology and Dean of the Rollins School of Public Health at Emory University, where he also directs the Emory Center for AIDS Research.

### Profiling the job

Successful delivery of public health rests on a base of sound policy. Legislation, procedural rules, economic issues and other factors create and regulate the public health infrastructure, and health policies emerge and develop from the dynamic interplay of that infrastructure and the forces and people that created it. Among “other factors” are policy decisions made by important non-governmental organizations such as the Red Cross, recommendations of associations such as the AMA, grassroots political advocacy and feedback from hospital administrators. The many avenues for initiating and influencing policy include federal agencies such as the Department of Health and Human Services (HHS), the CDC, the Office of the Surgeon General, and the Food and Drug Administration (FDA). At the state and local level, policy is made in the governor’s or mayor’s office, state or local health department and in state or local legislative branches. Policy is also made in the private sector through health care and professional organizations.

Professionals trained in health policy and management have many employment options, including positions at governmental health agencies such as the CDC or the National Institutes of Health (NIH), or state and local health departments. They might also work in academic settings, such as university health sciences centers or hospitals, or in the private sector, such as pharmaceutical companies, managed care organizations and other health finance organizations.

Whatever the decision maker’s chosen occupational venue, health policy and management professionals must be prepared to make hard decisions about resource allocation. According to Dr. Curran, public health priority setting should be rational and easily understood. “A logical way to prioritize public

health issues,” Dr. Curran explains, “is to first determine the number of people affected by a problem, the severity of the problem, and our ability to make a difference in number or severity.” A health problem that either affects or might affect millions of people will usually take priority over one that affects small numbers, while a problem that causes either mortality or severe disability would take precedence over one that is less severe. One in



which the patient might be cured or the illness prevented would take precedence over a problem in which neither prevention nor cure is feasible, according to Dr. Curran.

“Much of health policy is determined by health outcomes,” Dr. Curran says. An example is the relatively new procedure of combining angioplasty with the placement of a stent in a narrowed coronary artery. “In

order for that procedure to be covered by health insurance, it must be demonstrated, through large population-based studies, that it is more effective, more successful and more cost effective than plain angioplasty or bypass surgery.” In the case of the angioplasty/stent procedure, research has justified insurance coverage.

Another health policy issue under consideration is insurance coverage for mammography in women over 40 versus women over 50. Research outcomes have ignited a policy debate about which diagnostic tests should be covered and in which subsets of patients. “The American Cancer Society, the National Cancer Institute, the American Medical Association or any concerned women’s health groups might recommend — or not recommend — such a policy of coverage,” says Dr. Curran. “Those recommendations and guidelines would then be researched and considered as a potential Medicare or Medicaid benefit, and/or part of normative benefits by health insurance companies.”

While federal policy regulates the disbursement of Medicare funding and hinders the interstate transmission of infectious disease, most public health regulations are developed at the state level. Communicable diseases must be reported to the state health department. State laws set smoking restrictions

and requirements for wearing bicycle and motorcycle helmets. Local laws tend to govern such areas as management of substance use and abuse, including provision of clean needles for needle exchange programs. “Some of these issues require balance between social control and individual freedom of choice — or *should*. To some extent social control may restrict unhealthy behaviors, but excessive control tends to drive it underground,” says Dr. Curran. He cites drinking and immunizations as examples. “Prohibition made it very difficult to monitor and evaluate alcohol use.” When asked about immunization policy, Dr. Curran says, “It was a long time before we could legally keep kids out of school if they weren’t immunized. However, such restrictions served the common good, because a single case of measles in a child who comes to class could trigger an epidemic. On the other hand, you don’t want to stop kids from going to school if they have religious reasons not to be immunized. It is a balance, but that’s how policies are made.”



### An AIDS story

The year was 1981. Dr. Curran was at the CDC when AIDS was first described. “In retrospect,” he says, “perhaps the most important actions we took at the time were to define AIDS, name it and do methodical surveillance for it. We did all this in the face of conditions never seen before.” The case definition of AIDS and the attention to making it reportable to all state health departments, and ultimately to the CDC, led to exceptional early tracking of the epidemic. “We developed and implemented in the United States perhaps the best surveillance system for an infectious disease. In fact, that same case definition and the same surveillance mechanism were utilized throughout the world.”

After the initial cases of AIDS were reported in homosexual men, case reports started coming in of AIDS occurring in persons with hemophilia.<sup>2</sup> By 1983, Dr. Curran and the others who were working with him quickly recommended that people who had been found to be at risk of AIDS refrain from donating blood and avoid having multiple sexual partners. They also recommended that people with AIDS avoid having sexual contact with others.

What makes the interventions of Dr. Curran and his associates all the more remarkable is that they were done *before* the actual HIV virus was discovered. But, says Dr. Curran, it was essential to move quickly because the pattern of transmission so clearly pointed to an infectious disease as the culprit. Those working on the outbreak were so certain of the completeness of their surveillance and the pattern derived that they felt prevention recommendations were urgently needed before absolute proof existed of the infectious etiology.

AIDS, more than many other health problems, involved the affected community from the beginning. People with HIV or AIDS were on the front lines of policy advocacy. Sometimes they worked closely with people in the government research establishment, often as close advisors. Sometimes they were protesters, he says. Curran believes such community involvement is a very important part of public policy development.

AIDS policy evolved and did not stop with methods aimed at the original infected core population. Landmark studies in the early '90s demonstrated that medications given to a mother during pregnancy and birth, and to the baby immediately following birth, could greatly reduce the transmission rates of HIV from mother to newborn. At the state and local levels, those critical research results translated quickly into policy for HIV testing of pregnant women and newborns, and into offering immediate antiviral therapy to those found to be HIV-infected. As a result, mother-to-infant transmission has been greatly reduced. "But there is always more work to do," says Curran.

### **A day in the life**

A few years ago, Dr. Curran brought his daughter to the office. "It was take-your-daughter-to-work day," he recalls. "I thought it would be fun to show her around and give her a firsthand look at what I did all day." A few days later, she gave her dad a pin she'd bought. "It read, 'When can we have the meeting about the meeting to plan the meeting?'"

Dr. Curran laughs when he tells the story, and admits his daughter's humor isn't without some basis in truth. "My work breaks out into three main areas: university administration, AIDS work, and work with students and colleagues," he says. "That kind of workday will inevitably entail a certain number of meetings."



*"People are starting to understand public health; that what affects our health isn't only our physician, pharmacist or our nurse. It involves a far broader look at society."*

**James Curran,  
MD, MPH**

As one of Emory's nine deans, Dr. Curran is in a position to engage other academic disciplines in the pursuit of public health objectives. "A public health agenda is a great thing to have at a university with a strong health sciences center, because it really leverages our interdisciplinary strength," he notes. "We have very strong ties with the social sciences, with economics, business, nursing, sociology, anthropology and psychology as well as biology, chemistry and medicine. So I spend a lot of time pulling people together at university meetings and scouting opportunities for interdisciplinary collaborations on public health issues." Dr. Curran also sits on many association boards, including Health Care Georgia, the Institute of Medicine Health Sciences Policy Board, two NIH review panels, some CDC boards, AID Atlanta, Jerusalem House, the World Health Organization and the International AIDS Trust.

While he no longer does much direct research, Dr. Curran is involved in coordinating research and recruiting faculty for the Center for AIDS Research at Emory. He also is a member of the Executive Committee for that Center and the Association of Schools of Public Health. "I spend a great deal of time on those public health-related issues that are compatible with the mission of the school," he says. "Because we are a school of public health in what we refer to as the 'public health capital of the world' — the CDC is located in Atlanta — I believe I have both an obligation and an opportunity to get out there and get my hands dirty. If we want our faculty to be involved, then the dean should also be involved."

# career at a glance



## James Curran, MD, MPH

2000–Present	<b>Adjunct Professor</b> Department of Medicine, Emory University School of Medicine
1999–Present	<b>Affiliate Professor</b> Department of Family and Community Nursing, Nell Hodgson Woodruff School of Nursing, Emory University
1997–Present	<b>Director</b> Emory Center for AIDS Research, Robert W. Woodruff Health Sciences Center, Emory University
1995–Present	<b>Dean and Professor of Epidemiology</b> Rollins School of Public Health, Emory University
1995	<b>Director</b> Division of HIV/AIDS Prevention, CDC
1992–1995	<b>Associate Director for HIV/AIDS and Director</b> Office of HIV/AIDS, CDC
1991–1995	<b>Assistant Surgeon General</b> U.S. Public Health Service (USPHS)
1989–1992	<b>Director</b> Division of HIV/AIDS, Center for Infectious Diseases, CDC
1988–1992	<b>Associate Director for HIV/AIDS</b> Center for Infectious Diseases, CDC
1985–1989	<b>Director</b> AIDS Program, Center for Infectious Diseases, CDC
1984–1985	<b>Chief</b> AIDS Branch, Division of Viral Diseases, Center for Infectious Diseases, CDC
1982–1984	<b>Director</b> Acquired Immunodeficiency Syndrome (AIDS) Activity, Center for Infectious Diseases, CDC
1978–1982	<b>Chief</b> Operational Research Branch, Venereal Disease Control Division, Center for Prevention Services, CDC
1976–1979	<b>Clinical Assistant Professor</b> Departments of Preventive and Community Medicine and Medicine, Ohio State University College of Medicine
1975–1978	<b>Assistant Commissioner of Health for Medical Services</b> Columbus City Health Department
1975–1978	<b>Clinical Research Investigator and Coordinator</b> Operational Research Branch, Venereal Disease Control Division, CDC
1973–1975	<b>Career Development Training</b> CDC (USPHS)
1971–1973	<b>Clinical Research Investigator</b> Venereal Disease Branch, CDC

1 [http://www.apha.org/legislative/wrapup\\_2001.htm](http://www.apha.org/legislative/wrapup_2001.htm)

2 <http://uhavax.hartford.edu/bugl/rise.htm>