EDITORIALS

Fundamentals of U.S. Health Policy — A Basic Training Perspective Series

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It has been said that every system is perfectly designed to get the results it gets. The strengths, weaknesses, flaws, and complexity of every health care system stem in large part from health policies. The U.S. health care system did not arise randomly but through a series of deliberate policy choices, many of which have come with unintended consequences. Efforts to reform our system over the past century reveal the ways in which Americans think the system has fallen short. They also reveal what we hope our health care system will do for us.

Health policy — the choices made by the people who govern, manage, deliver, and pay for health care — shapes every aspect of a health care system. Through law, regulation, financing, and management decisions, health policy sets the opportunities and constraints that shape how clinicians and their teams deliver care each day. Choices by policymakers also set the conditions under which patients decide to seek care, the types of services available to them, the affordability of those services, and the patients' ability to adhere to treatments and derive benefit.

Health professionals are far from the only cooks in the U.S. health policy kitchen. Federal and state legislators, licensing agencies, regulators, insurance executives, and delivery-system executives also have a hand. In the United States, a large private industry also shapes policy by responding to the demand for new diagnostics, drugs, devices, and other treatment options. Another private industry shapes the rules for payment and negotiation between professionals and payers. Collectively, the decisions of these cooks determine what is possible, what happens, what it costs, and whether a health system achieves the optimal level of health for individuals and populations.

With this issue, the *Journal* is launching a brief Perspective series that will provide a primer on both the main challenges facing the U.S. health care system and key policy solutions that can address those challenges. The first article in the series[1] describes what we know about U.S. health care today and the policy context for what an engineer might call our "perfectly designed system." Appearing in alternate weeks, three subsequent articles will examine in depth each of three key challenges the U.S. health care system must tackle if it is to perform at a higher level: inequities in access and care, less-than-optimal quality, and high and escalating costs. Two final articles will explore potential government and market-based remedies for what ails our system.

Multiple polls suggest that decisions about health policy are extremely important to the public. Health care is both personal and political. As the Covid-19 pandemic has shown us all too vividly, everyone has a stake as both an individual and a member of society. Everyone will need health care at some point in life or will care for someone who is sick, and everyone will have to face fear, uncertainty, and sometimes heartrending decisions about life and death. We all have a stake in the fair allocation of resources in responding to the pain, suffering, and threats to life that modern health care can alleviate. Who will receive care? Who will pay for it? As the late health economist Uwe Reinhardt asked, "In America, should a child born to a poor family have the same right to health care as a child born to a wealthy family?"[2]

We find ourselves in the midst of an unprec-

edented public health crisis, an accompanying economic crisis that has cost millions of Americans their jobs and health care coverage, and a crisis in racial justice that is shining a harsh light on disparities in health and health care. As the U.S. elections approach, incumbent and aspiring policymakers at all levels must grapple with the far-reaching implications of the design and reform of our health care system. Physicians and other health care providers have an opportunity to influence the policies that shape the system in which they work. We hope to offer a foundation for a common understanding of where we stand and where we need to go.

Disclosure forms provided by the authors are available with the full text of this editorial at NEJM.org.

From the Commonwealth Fund, New York (E.C.S.).

1. Schneider EC. Health care as an ongoing policy project. N Engl J Med 2020;383:405-8.
2. Reinhardt UE. Priced out: the economic and ethical costs of American health care. Princeton, NJ: Princeton University Press, 2019.

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Disarming the Respiratory Syncytial Virus

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Respiratory syncytial virus (RSV) causes predictable, annual outbreaks of respiratory tract disease in temperate as well as tropical climates around the globe. Infants in the first 6 months of life are particularly vulnerable.[1] Natural infection does not result in sustained immunity, and reinfections are common.

RSV is a single-strand, negative-sense, enveloped virus containing an RNA genome that encodes for 11 viral proteins. Three structural proteins populate the viral surface envelope — the attachment (G) protein, the fusion (F) protein, and a small hydrophobic protein. F and G proteins play critical roles in infectivity and pathogenesis. The G protein binds to receptors on ciliated epithelial cells of the respiratory tract, which allows the F protein to fuse the viral and cellular membranes and enable the viral genome to access the intracellular environment where viral replication occurs. After infection, more than 90% of neutralizing antibodies are directed against the F protein, which exists in both prefusion and postfusion conformations.[2] The epitopes on the F protein that are most sensitive to neutralization are hidden in the postfusion state, which poses challenges to the development of both a monoclonal antibody and a vaccine.

Although studies in healthy RSV-infected volunteers have shown that antiviral drugs may reduce the RSV viral load, a clinical trial with presatovir in compromised patients naturally infected with RSV did not show significant clinical benefit.[3] The lack of an effective treatment has placed emphasis on preventing disease with either passive or active immunity. Palivizumab, a monoclonal antibody directed against the F protein, has been shown to reduce the risk of hospitalization for RSV among infants with recognized risk factors and was approved by the Food and Drug Administration in 1998 for this indication.[4] However, its modest efficacy, the requirement for monthly intramuscular administration, the emergence of viral strains with mutations in F protein (escape mutants), and the high cost limit its usefulness. Neutralizing monoclonal antibodies to G protein are being studied for both prophylaxis and treatment for RSV infections.[5] Because a highly conserved domain in the G protein plays an important role in modifying the immune response in the host, it is hypothesized that a monoclonal antibody against this proinflammatory protein may reduce disease severity.

Most of the approximately 100,000 young children in the United States who are hospitalized annually for RSV infection have no recognized risk factors and do not qualify for monthly prophylaxis. This partly explains why prophylaxis with palivizumab has a minimal effect on the overall burden of RSV infection in the United States and elsewhere. A more practical approach to prophylaxis would be the administration of a long-lasting monoclonal antibody to all infants born shortly before or during the RSV season. If a single intramuscular dose at birth could provide several months of protection, the burden of infection would be shifted to older children who are at lower risk for hospitalization.

In this issue of the *Journal*, Griffin et al.[6] re-