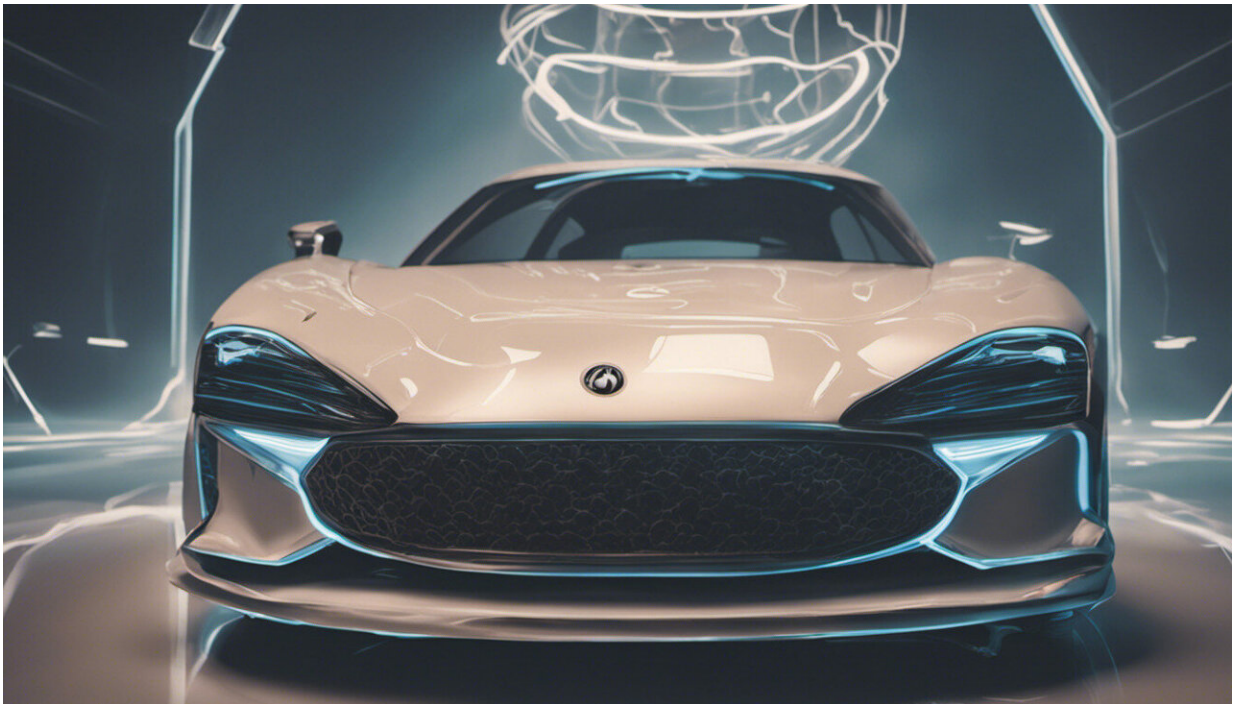


# Who's taking COVID antivirals like Paxlovid? Hint: it helps if you're rich

June 22 2023, by Nicole Allard

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Credit: AI-generated image ([disclaimer](#))

When it comes to COVID, people living in disadvantaged communities are hit with a triple whammy. First, they're [more likely](#) to get infected, and when sick, are more likely to have serious disease. Second, they're more likely to develop long COVID. Third, our [recent research](#) suggests they're less likely to get antivirals and when they do, it's on average later.

We've just [published the data](#) to map how disadvantage is linked with access to COVID [antiviral drugs](#) you can take at home.

Here's why our findings matter and what we can do to level the playing field for this critical part of Australia's COVID response.

## **What we did and what we found**

Our team looked at Victorian and national prescribing data trends for the oral antiviral medications eligible Australians can take at home—Paxlovid (nirmatrelvir/ritonavir) and Lagevrio (molnupiravir).

My health department colleagues linked data from the Pharmaceutical Benefits Scheme with information from the Victorian health department's COVID surveillance database. They then matched levels of socioeconomic disadvantage by postcode, according to criteria from the Australian Bureau of Statistics.

Their analysis showed people living in the most disadvantaged postcodes were 15% less likely to receive oral antivirals compared with those in the most advantaged postcodes.

Those in the most disadvantaged postcodes were supplied with the antivirals on average a day later (three days versus two days) than those in the most advantaged postcodes.

There are some limitations to our analysis. Not everyone who tests for COVID reports their positive result. And we suspect there may be more under-reporting of infections in disadvantaged areas.

Nevertheless, our findings about the influence of disadvantage on antiviral supply are not surprising. In the United States, there have been [similar results](#).

## Why has this happened?

We know [early access to antivirals](#), within the first five days of symptoms starting, is important to reduce the chances of severe disease and hospitalization in those at risk.

So why are people in disadvantaged areas less likely to have access to COVID antivirals? The answers are multiple and complex.

Some relate to [disadvantage](#) that existed before the pandemic—for instance, poverty, homelessness, lower levels of English or [formal education](#), and being less likely to have a regular GP.

Some factors relate specifically to antivirals. For instance, to access antivirals, you first have to know they exist and whether you might be eligible, then know how to access them and when. There may be [out-of-pocket costs](#) to see a GP to be assessed, then there's the cost of filling the prescription, even with a concession card.

## How can we address this?

We have an opportunity to address this inequity, whether that's by addressing social determinants of health more broadly, or specifically related to antivirals access.

Equity depends on continuing to address the structural inequalities in our health system that create barriers to people accessing primary health services, and tailoring responses to communities.

For instance, earlier in the pandemic we saw funding to house [homeless people](#), provide COVID-related health care to non-English speaking communities, and for people isolated at home. These initiatives need to

continue.

Other countries have also recognized the need for more equitable access to COVID antivirals. Initiatives have included:

- COVID medicine [delivery units](#) in the United Kingdom. These identify, triage and arrange for high-risk people to receive antivirals at home
- [pharmacists prescribing antivirals](#) in New Zealand, and
- "[test to treat](#)" services in the US. This is where people can get tested, assessed and access antivirals in one spot, in one visit.

### **What needs to happen next?**

As COVID waves continue, we must focus on reducing deaths and hospitalizations. Antiviral treatments are part of our armor and equity must drive our response.

Our ongoing COVID response should be designed with consumer input, supported by an adequately funded public health system and be data driven. Here's what needs to happen next:

- encourage a tired public to see COVID testing as an important first step to accessing antiviral treatment, and why they should consider treatment
- address the health care inequality in [primary care](#) (for instance, boosting timely access to a GP people can afford to visit) by increasing resourcing in areas where we know there are gaps

- provide culturally safe health care, delivered in community languages, co-designed with community input
- evaluate current and future antiviral medications
- communicate up-to-date information to the public and health professionals about antivirals, particularly GPs
- access more data on the coverage and equity of antiviral COVID treatments, to help direct us to the gaps in the health system that need to be plugged.

### **Why this matters now**

For many of us in the past year, COVID has become another "cold" we encounter and may not even bother testing. Yet, we continue to see [deaths and hospitalizations](#) across the country.

Serious COVID infections continue to affect our most vulnerable people. These include [elderly people](#), especially those over 80, First Nations people, people living with a disability and people who are socioeconomically disadvantaged.

We have a chance to ensure antivirals are used to reduce existing disparities in hospitalization and death—not to make them worse.

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