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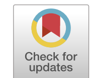
A call to action: A need for initiatives that increase equitable access to COVID-19 therapeutics



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Structural racism is endemic in the United States and causes inequitable health outcomes that have been amplified throughout the COVID-19 pandemic.[1,2] Non-Hispanic Black, Hispanic/Latino, and Native American individuals have been disproportionately affected, and are twice as likely to be hospitalized or die from COVID-19 or related morbidities when compared to White Americans.[2] Social determinants of health inequities contribute to these disparate outcomes, given that minoritized individuals are more likely to occupy essential worker roles and to live in high-density settings.[1] Despite their higher risk of severe COVID-19 illness, racially and ethnically minoritized individuals are less likely to receive potentially lifesaving COVID-19 therapeutics.[3] While several state health departments attempted to implement race-conscious interventions and narrow the disparities, these efforts have been met with fallacious claims of 'reverse racism' and the reversal of the proposed implementations.[3]

Barriers to healthcare access with racially and ethnically minoritized groups

Economic and environmental injustices, psychosocial trauma, state-sanctioned violence, separation from traditional lands, and political exclusion through voting restrictions are key contributors to the lack of access to the healthcare system that racially and ethnically minoritized groups experience.[1] American Indian/Alaska Native, Hispanic/Latino, and Black Americans have higher uninsured rates at 22%, 20%, and 12%, respectively, when compared to 7% of White Americans.[4] States electing to not expand Medicaid have further exacerbated these inequities, as Medicaid expansion has been associated with more equitable access to care and improved health outcomes.[4] Racially and ethnically minoritized individuals are also more likely to live in a primary care provider desert- where there is on average, one full-time provider for over 10,000 individuals.[5] Inevitably, this lack of healthcare providers alongside systemic barriers perpetuates the recognized COVID-19 inequities, including the access to preventive care as well as novel therapeutics to manage disease severity.

The need for federal initiatives that ensure equitable access to COVID-19 antivirals

In March 2022, the Biden Administration announced the nationwide "Test to Treat" initiative as part of the National COVID-19 Preparedness Plan.[6] This initiative aims to grant Americans who test positive for SARS-CoV-2, rapid access to oral antivirals (i.e., molnupiravir, nirmatrelvir/ritonavir) at pharmacy-based clinics and federally qualified health centers (FQHCs), through direct allocations from the Department of Health and Human Services and the Office of the Assistant Secretary for Preparedness and Response.[6] There are

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approximately 1,375 FQHCs serving nearly 28 million patients, and greater than 60% identify as a member of a minoritized group.[5] On the surface, this initiative has the potential to vastly improve the poor COVID-19 outcomes observed in minoritized communities.

However, the "Test to Treat" plan in its current design fails to address several key barriers to the access of COVID-19 therapeutics recognized within minoritized communities. While FQHCs primarily serve a minoritized patient base, these health centers are unevenly distributed throughout the country.[5] This poses challenges in minoritized communities where inequities in transportation significantly segregate these individuals from accessing healthcare, stemming from unreliable mass transit modalities and associated transportation cost.[7] Additionally, patients must be able to locate the FQHCs that will provide the needed health services online.[6] Similar to transportation, digital access inequities have been observed within minoritized communities.[7] Furthermore, the lack of internet access was a noted limitation in accessing the COVID-19 preventive therapeutics (vaccines) across minoritized groups.[8] Consequently, these gaps have persisted and, in some cases, widened within these communities.[7] Therefore, FQHCs as the main prescribing entities does not fully address the current pattern in the inequitable distribution of the novel COVID-19 oral therapies.[5]

Ideally, the 60,000 pharmacies in the U.S. could work in tandem with the FQHCs to lessen the recognized inequities. Unfortunately, the plan—along with the current Food and Drug Administration (FDA) Emergency Use Authorizations (EUAs) specific to the oral antivirals—omits pharmacists from the designated list of prescribers able to test *and* provide patients with these antivirals.[6,9] The exclusion of pharmacists creates unnecessary barriers to care, especially across minoritized groups. It also squanders the opportunity to leverage pharmacists' ability to quickly establish low-barrier, easily accessible (mobile/community) pharmacy options.[10] This would be significant in vulnerable areas that have been disproportionately affected by COVID-19 inequities and would add an additional layer to COVID-19 "*pharmacoequity*". Nonetheless, if the "Test to Treat" plan and/or specific EUAs were to be altered to include pharmacists as authorized prescribers, it would be critical to ensure that prescribing practices remain collaborative between pharmacists and physician and/or advanced practice providers. Thus, the development of an interdisciplinary, rapid, bidirectional, communication mechanism regarding the prescribing of the COVID-19 oral antivirals would be essential. Of further note, the system may also aid in expediting the identification and treatment of a COVID-19 case. This would not only mitigate the virus spread within minoritized communities, but also prevent deleterious complications requiring hospitalization.

Conclusions

Though COVID-19 case rates have subsided in some communities, the negative effects of the pandemic remain among minoritized groups. The lack of prioritization of race and ethnicity within treatment algorithms for COVID-19 directed therapeutics will inevitably translate to a widening of health equity gaps. If correctly curated, federal programs like "Test to Treat" can expand access to novel COVID-19 therapies; however, for that to succeed, it must acknowledge the barriers to effective and optimal patient care within minoritized communities. Finally, we call on professional healthcare organizations to collaborate to mitigate these barriers and collectively lobby for improved patient outcomes rather than individual organizational interests.

Contributors

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Declaration of interests

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