Rethinking the Principle of Justice for Marginalized Populations During COVID-19

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Abstract: In the face of limited resources during the COVID-19 pandemic response, public health experts and ethicists have sought to apply guiding principles in determining how those resources, including vaccines, should be allocated.

"This white man who is saying 'it takes time.' For three hundred and more years they have had 'time,' and now it is time for them to listen."
— Fannie Lou Hamer

I. Introduction

As COVID-19 continues to spread and vaccines are being distributed, policy makers and providers are faced with consequential decisions on how to allocate scarce medical resources. In addition to ventilators and hospital beds, health systems around the world are constructing plans to distribute vaccines, forcing life and death decisions. To guide this allocation process, public health experts and ethicists ordinarily apply the following four principles: maximize benefits, promote instrumental value, treat people equally, and give priority to the worst off.[1] Each of these subjective principles requires individual considerations that can create competing allocation priorities, leading to debates among healthcare providers and communities on what principles ultimately should govern in a crisis situation.[2] While these four principles may not on their face set up discriminatory allocation of healthcare resources, published data indicate that marginalized racial and socio-economic groups are disproportionately affected by disasters, including COVID-19.[3] These unjust outcomes have not been adequately considered in developing healthcare allocation frameworks. As the inequities in COVID-19 outcomes continue to be uncovered and marginalized communities disproportionately suffer from the pandemic, healthcare providers must consider their role in perpetuating or, alternatively, alleviating these sorts of injustices.[4]

Current data demonstrate that due to structural inequities Black, Latinx, Indigenous, and populations living in poverty suffer higher rates of morbidity and mortality from COVID-19, demonstrating a significant health inequity.[5] Additionally, as vaccines are being distributed based upon age, marginalized populations with lower life expectancies will not receive them at the same rate as White populations. For the purposes of this paper, two phrases require elaboration: A "health disparity" is defined as any differences between population cohorts in terms of incidence of disease, morbidity, mortality, or other adverse health events. A "health inequity" is a health disparity caused

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by avoidable systemic structures rooted in racial, social and economic injustice, and connected to environmental conditions in which people live, work and play.[6] Equity exists when all persons can attain their full health potential without interference from structures and factors that generate health gaps, including socioeconomic status, race, gender, ethnicity, religion, sexual orientation, or geographic factors.[7]

The inequity across health outcomes for Black, Indigenous and People of Color (BIPOC) diagnosed with COVID-19 has led to calls for states to amend their COVID-19 resource allocation guidelines.[8] In a recent effort to consider health inequities, the Massachusetts Department of Public Health revised its COVID-19 guidelines to advise allocation of resources to patients with the best chance of short term survival.[9] However, critics contest that this change addresses neither pre-

then addresses historical and current medical injustices to build the evidence and reason for the argument made in the final section. To better prioritize resource allocation, this paper finally advocates for three applicative justice-based recommendations: (1) when giving priority to the worst off, address historical and ongoing discrimination; (2) place a premium on equitable treatment rather than equal treatment; and (3) maximize healthcare outcomes between and among communities. Doing so will combat structural inequities in prioritizing those who have been historically disadvantaged and continue to be structurally excluded. Furthermore, by exploring applicative justice frameworks, this paper establishes an ethical framework for reparations to address the historical atrocities and the health inequities experienced by marginalized BIPOC communities.

This paper begins with a discussion around justice and the various ways philosophers have defined it. It then addresses historical and current medical injustices to build the evidence and reason for the argument made in the final section. To better prioritize resource allocation, this paper finally advocates for three applicative justice-based recommendations: (1) when giving priority to the worst off, address historical and ongoing discrimination; (2) place a premium on equitable treatment rather than equal treatment; and (3) maximize healthcare outcomes between and among communities. Doing so will combat structural inequities in prioritizing those who have been historically disadvantaged and continue to be structurally excluded.

existing structural inequities nor provider bias, thereby perpetuating worse outcomes in already marginalized groups who enter the care system with compromised health status from unjust exposure to risk.[10]

Members of the medical community have an important role in shaping policy for the allocation of scarce resources as well as mobilizing additional resources. In considering a historical perspective and medicine's role in society's structural inequities, healthcare providers have an ethical obligation to act in deliberation and collaboration with marginalized populations. They should change the current guiding ethical principles and consider persistent inequities between and among different populations, employing applicative justice (which frames injustice as a curable ill) to reform allocation of scarce resources in the healthcare system and achieve greater justice for all.[11]

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II. Background: Defining Justice

In the medical sphere, multiple philosophical theories have sought to explain how justice should be implemented. Modern bioethical frameworks for conceiving justice include models from utilitarian, libertarian, egalitarian, feminist, deontological, and religious ethics. Two of the most used theories are (A) egalitarianism and (B) utilitarianism. This paper argues why these leading theories are inadequate and that (C) applicative justice provides a framework for appropriately increasing resource allocation to marginalized communities. Each of these theories has its merits and limitations in guiding decision-making, particularly regarding the issue of resource allocation.

A. Egalitarianism

An egalitarian approach to justice is that all individuals are equal and, therefore, should have identical resources.[12] In the allocation of resources, an egalitar-

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ian approach would support a strict distribution of equal value regardless of one's attributes or characteristics. Putting this theory into practice would place a premium on guidelines based upon first-come, first-serve or random selection. Current guidelines put forward by ethicists for treating people during COVID19 recommend using random chance as a way to distribute resources between patients of similar prognoses.[13] The benefit of an egalitarian approach to distributing resources is that implementation is simple; a patient's complex individual characteristics are not considered.[14] Proponents argue that this approach embodies justice by allowing equal access to all regardless of income.[15]

In practice, however, the egalitarian approach continues to worsen health inequities, as research in the United Kingdom specifically demonstrated that a lack of institutional policies and leadership focusing on equitable access across ethnicities further perpetuated inequities.[16] Data reveal that while an egalitarian approach may provide equal access, due to historical and ongoing institutional and structural racism it does not achieve equal outcomes. Beyond this fundamental flaw, the UK's National Health Service has seen a breakdown in its egalitarian approach during the current COVID-19 pandemic, resulting in the institution of a utilitarian approach (discussed below).[17] This paradigm shift provides evidence that an egalitarian approach may work efficiently when resources are plentiful, but it fails when they are scarce.

B. Utilitarianism

A utilitarian approach to justice emphasizes maximizing overall benefits. The founders of classic utilitarianism, including John Stuart Mill and Jeremy Bentham, defined utilitarianism as the greatest good for the greatest number of people.[18] In times of disaster and limited resources, the utilitarian principle has been a historical foundation for guiding decision making.[19] Strict utilitarianism is perceived as impartial because it does not consider inequities if the overall outcome is maximized. In contrast to the egalitarian focus on equal distribution, utilitarianism focuses on managing distributions to maximize outcomes. The benefit of a utilitarian approach is that by focusing on outcomes, resources can be used most effectively. Epitomized by phrases such as "saving the most lives possible," ethical guidelines for allocating resources in the COVID-19 response are primarily built upon utilitarianism.[20] The use of triage (i.e., individuals are categorized into groups based upon their likelihood of survival so that resources can be allocated to ensure survival for the highest number of people) is another manifestation of an utilitarian approach.[21]

Research has shown that in settings of pressure and time constraints, triage misdiagnosis is commonplace, particularly in crisis implementation.[22] Further, utilitarian principles often have been misused to justify withdrawing care from a patient for the sake of conserving resources for future cases. Examples of this phenomenon are the alleged euthanasia of patients at New Orleans' Memorial Medical Center in the wake of Hurricane Katrina or the case of a Black quadriplegic man who did not receive advanced care in a Texas hospital, defended by some as justified to maximize the outcome for all patients.[23] These patients, however, were not sick or dying, but instead had chronic medical conditions that made their care difficult, their prognosis poor, and possible evacuation challenging; withdrawing care from these patients violated the ethical principles of patient autonomy, non-maleficence, and justice. Patients from whom care was withdrawn were more likely to be Black or Latinx and of lower socioeconomic status.[24] In situations where resources are limited and the utilitarian paradigm is applied to maximize outcomes, marginalized populations risk being harmed disproportionately because they are already excluded from accessing the healthcare system, have been subjected to historical harms, and are unfairly exposed to risk leading to higher rates of chronic disease.

C. Applicative Justice

Distributive justice is a twentieth century counterpoint to both egalitarianism and utilitarianism. Proposed by John Rawls in *A Theory of Justice,* distributive justice is composed of the concepts of "equal liberty" and the "difference principle."[25] Together, these concepts mandate that resources should be allocated to those with the greatest need in a manner that does not infringe upon individual liberties.[26] This approach requires sensitivity to societal inequality — a factor absent from consideration in egalitarianism and utilitarianism. However, Rawls neglected to address health in his theory since he did not see it as a resource.

Naomi Zack directly critiques this flaw and distributive justice in general, developing her own theory known as applicative justice, which reorients injustice as a curable illness that society can remediate.[27] Applicative justice extends beyond distributive justice to directly addresses social inequities and how one's access to resources, including healthcare, education, and employment, affects one's health and is therefore an issue that justice should address. This is vital for realizing a true theory of justice in the allocation of healthcare resources. This kind of approach in ethics is supported by the human development approach used in research which acknowledges that, "health

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status of individuals is affected by the matrix of political, social, [and] economic factors."[28]

Advocates of applicative justice believe that for justice to be achieved, systemic changes are needed in society's institutions to improve the lives of the most marginalized individuals. In many ways, applicative justice comes closest to providing a resource allocation framework that satisfies the Aristotelian definition of justice, namely, to distribute resources to account for differences in order to equalize outcomes.[29] While applicative justice seeks to balance inequities, effective implementation can be fraught in systems where White supremacy is normalized.[30]

The most common criticism of applicative justice is that its implementation can be intricate, complex, and potentially lead to errors. Applicative justice opponents assert that since there is no clear path to its implementation, none should be taken.[31] This argument for intransigent inaction perpetuates structural racism, heterosexual biases, and socioeconomic inequities.[32] White supremacy is pervasive in our current system, a system with inherent and overt biases in favor of economic elite White cis-gendered heterosexual norms and against all non-conforming groups.[33] In other words, White supremacy creates a culture in which discrimination against non-conforming groups (e.g., BIPOC) is purposely perpetuated. Our current medical system and its resource allocation approaches, overtly and covertly ensure that resources and opportunities are kept from BIPOC communities, gender minorities, and marginalized socioeconomic groups.[34] As we have seen for decades, any policy that looks to distribute resources equally rather than equitably will further perpetuate poor outcomes for BIPOC communities.[35] While it may be challenging to implement a system that considers intersectionality, applicative justice demands it.

In light of this philosophical framework, the next section details why our current medical system violates the core tenet of justice in medical ethics and reinforces White supremacy.

III. Ethical Grounding: Medical Injustices

Medical injustices have been perpetuated by social and medical institutions and White supremacy. Subsection A discusses this sordid medical history, and subsection B describes the current structures that fuel these inequities. These sections collectively build the evidence for the final argument in Section IV.

A. A Brief History of Injustice in Medicine

Past harms caused by the flawed delivery of medical care and medical research systems are ethical catalysts to act.[36] Below is a brief historical review of medical injustices, highlighting the need and obligation for reform.

Reports of medical discrimination against various communities are numerous in both practice and research. Medical discrimination based upon (1) race,[37] (2) biological sex,[38] (3) sexual orientation,[39] (4) gender identity,[40] and (5) socioeconomics[41] is well documented.

1. *Race*: Examples of discrimination based on racial grounds are plentiful. In her book *Medical Apartheid*, historian Harriet Washington has chronologically covered the horrific experimentation to which Black communities were subjugated from colonial times to the present day.[42] Her work describes the racial pseudoscience of eugenics, the Tuskegee syphilis study, and less well-known atrocities perpetuated by the government and private institutions. These events contributed to inequities in medical care, fostered mistrust, and resulted in unnecessary death (it is estimated that between 1970 and 2004 racism in multiple forms resulted in more than 2.7 million Black deaths).[43] These examples are often cited and barely begin to represent the violence experienced by Black communities.

   In the Latinx community, there is deep-seated, historical discrimination associated with the view that immigrants are less deserving of access to care.[44] Additionally, as a result of a series of legislative initiatives, Latinx people have been accorded fewer benefits and support in seeking and receiving culturally-appropriate medical care, and obtaining it in a manner that addresses language barriers.[45]

   Finally, at the hands of the United States government, Indigenous populations have experienced centuries of systematic genocide and ethnocide with scant public acknowledgement.[46] Examples specific to the medical community include the violation of research ethics to use blood samples from the Havasupai tribe and the involuntary sterilization of over 3,000 women by the Indian Health Service (IHS), a numerical figure likely to be higher since only four out of twelve IHS areas were studied.[47] The women sterilized by the IHS were coerced, threatened, and fed misinformation to ensure cooperation.

   Collectively, these examples just scratch the surface of the racist atrocities in medicine driven by normative White supremacy. They also show why many BIPOC communities have vaccine hesitancy and why many institutions are not trustworthy.[48]

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2. *Gender and Sexual Orientation*: The lesbian, gay, bisexual, transgender, queer, intersex, asexual, (LGBTQIA+) communities in the United States have a history of stigma and abuse by the medical establishment with their personhood being classified as a pathologic diagnosis.[49] These communities have suffered healthcare marked by insensitivity, prejudice, and ignorance, leading to higher rates of chronic health disease and mental health disorders. Up until the 1970s, not being of heterosexual orientation was considered a pathological mental disorder classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM).[50] Further, efforts to eradicate homosexuality in individuals have been considered reasonable and treatment by conversion therapy previously garnished medical support. Systematic reviews of conversion therapy have shown it not only violates human rights, but it also leads to physiological and psychological harm.[51] Transgender and gender non-conforming individuals have faced systemic abuse, as gender identity disorder was considered a pathologic diagnosis up until the latest DSM.[52] This population has continually experienced abuse and refusal of services from the healthcare system and has been blocked from accessing gender conversion services.

3. *Economic Status*: The medical community has harmed impoverished groups, which are disproportionately BIPOC, by a) withholding care (and distributing care based on ability to pay), b) providing lower quality care, and c) targeting members of this community for research.[53] In contrast to many other countries, healthcare in the United States is not considered a human right but rather it is thought to be a commodity requiring paid access. Because we ration health services by ability to pay, this history has kept necessary care out of reach for the economically disadvantaged, perpetuating their poor health and thereby impacting their opportunities for socioeconomic advancement. In the 1940s, as a means of increasing access to healthcare, this dynamic began to change with adoption of the Social Security Act, and further expansion was achieved by the passage in 2010 of the Affordable Care Act.[54] Despite some gains in insurance access, other barriers, including availability and location of providers and healthcare centers, still exist and prevent impoverished patients from obtaining the same quality of care received by others.[55] While the medical field may not have control over all of these factors, research has shown that physicians consciously and unconsciously discriminate against patients with public or low-cost health insurance.[56] This discrimination happens both at the interpersonal level between patients, staff, and providers, as well as structurally when it comes to how patients are treated by healthcare and insurance systems and hospitals.[57]

Collectively, this history of abuses and inequities contradicts the goals and principles of egalitarianism, utilitarianism, distributive justice, and applicative justice. This brief review of historical brutalities and discrimination committed by the medical community offers necessary context to propel action to take definitive steps towards achieving applicative justice and systemic changes that remove White normative biases.

B. Current Structural Inequities

An influential essay by Dr. Camara Jones, entitled "Levels of Racism: A Theoretic Framework and a Gardener's Tale," outlines the levels of racism in our society and how it perpetuates healthcare inequities.[58] The essay defines *institutional racism* as unequal access to goods, services, and opportunities through structural systems, often manifested as inaction in the face of need. This definition extends beyond race and includes other forms of discrimination based upon biological sex, socio-economic status, and other social factors, which indirectly and directly affect one's health. These factors help explain why, even after controlling for individual risk factors, people with lower incomes and BIPOC live shorter lives.[59] As mentioned previously, any system that has the net effect of benefitting White communities over BIPOC, is one of White supremacy. For example, it is clear that our education, housing, insurance, and employment systems uphold White supremacy by perpetuating racial inequities, leaving the medical community with the obligation to consider the contributing role it plays.

It is a fact that medical treatment is unfairly allocated based on race and the social interpretation of people's appearance.[60] Even when insurance coverage is considered, reviews have found that there is a notable racial gap across many therapeutic procedures.[61] A recent study showed that this gap may be due to the causal relationships that healthcare providers construct across racial groups.[62] For example, a meta-analysis covering the last twenty years found that Latinx and Blacks were significantly undertreated for pain compared to their White counterparts.[63] This is partly due to bias and racist beliefs that providers hold. In interviewing trainees, a study

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by the National Academy of Science found that half of medical students and residents harbored racist beliefs such as "Black people's nerve endings are less sensitive than White people's" or "Black people's skin is thicker than White's."[64] This evidence points to why direct and systematic action is needed counter the prejudices that people of color experience.

It is a fact that in the United States patients of different biological sexes do not receive the same quality of healthcare.[65] To this day, compared to men, women experience complex health conditions that are not always properly managed.[66] From barriers in accessing quality reproductive healthcare to how much care women receive overall, health inequities persist for women. Middle-aged and older women are more likely to have fewer hospital stays and physician visits compared to men of similar demographics and health risk profiles.[67] In the field of critical care, women are less likely to be admitted to the ICU, are less likely to receive interventions such as mechanical ventilation, and are more likely to die compared to their male ICU counterparts.[68] These inequities can be attributed to both provider bias and the traditional use of male subjects to develop treatment algorithms.[69] The data on unequal treatment in ICUs are particularly troubling as COVID-19 places thousands of women with acute respiratory needs at risk of needing ICU care.

It is a fact that in the United States, patients living in poverty do not receive the same quality of healthcare as their higher economic status counterparts.[70] Patients with lower incomes are more likely to have higher rates of infant mortality, chronic disease, and a shorter life span.[71] This is also seen by how the United States treats those who experience homelessness who have a life expectancy decades shorter than the overall population and one in three of their deaths could have been prevented by timely and effective medical care.[72] As previously mentioned, this discrimination is multifactorial and includes discrimination based on insurance plans (or lack thereof), and includes receiving lower quality care, longer wait times, poor communication, and even emotional and verbal abuse.[73]

Justice in medicine has not been applied equitably across our nation, and this is particularly evident as the lives of BIPOC and impoverished communities are being lost to COVID-19 at higher rates than other populations. As described in the research studies cited above, the factors at play are complex though not immutable, and involve structural, institutional, and interpersonal elements. Taking no action to address these factors is unethical and perpetuates white supremacy.[74] Therefore, it is necessary to end these inequities.

IV. Expanding Justice for COVID-19 Response

There will never be a convenient time to consider how to respond to these inequities, but with the harm that COVID-19 has and will cause to marginalized populations, any further delay in addressing them means unjust and unnecessary mortality. This is particularly highlighted by how the average life expectancy gap widening among races with a new drop in life expectance of 2.7 years for Blacks, 1.9 for Latinx, and 1 year for Whites.[75] As vaccines are being rolled out based upon age, these factors must be considered to make sure every population is getting equitable access. The literature indicates there are both structural and individual factors that require consideration. While states such as Massachusetts have started to contemplate these factors in formulating guidelines, they are not being fully addressed. Redefining justice is especially pertinent now as the vaccine is just beginning to be distributed. There is no simple solution to resolve these inequities, but they are overlapping and interdependent, and therefore require individual and collective attention.

We can start with expanding our current model of justice to acknowledge and account for inequities. Current models of justice such as egalitarianism and utilitarianism are insufficient; instead, we must follow the dictates of an applicative justice approach to expand health care coverage and adjust COVID-19 guidelines to provide equitable care and prevent further harm to marginalized communities. Of note, applicative justice is one of the only ways to combat historical medical injustice and structural inequities. This is because it is the only framework that prioritizes equity based on health outcomes and individuals who are disadvantaged for social or cultural reasons. Subsection A, below, describes the nature of the proposed allocation reform, Subsection B then details the implications associated with reform, and Subsection C describes how an applicative justice framework demands medical reparations.

A. Nature of Proposed Reform

In a manner consistent with applicative justice, there are a number of ways in which medical reforms could

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be instituted. Three specific reforms to allocation of healthcare are suggested below.

1. By giving priority to the worst off, historical and ongoing discrimination will be addressed.
Current recommendations suggest that when aligned with maximizing benefits, the sickest and the youngest should receive resources.[76] As we note, prior to COVD-19, marginalized groups were worse off for a multitude of reasons, including institutional biases, structural barriers, and unfairly distributed co-morbidities. Therefore, this guideline addressing factors associated with discrimination should be added to ensure that allocation aligns with maximizing benefits for the most marginalized.

2. In lieu of equal treatment, there should be equitable treatment.
Under current recommendations for COVID-19 guidelines, the only principle recommended in the section on "treating people equally" is using random selection to allocate resources among patients with similar prognoses. As the research above has shown, BIPOC, those of lower socioeconomic status, LGBTQIA+, and women are less likely to receive appropriate care. These inequities have occurred in our system since its inception. Given these systemic inequities, we must pursue equitable policies to assure that these populations receive the resources they deserve — otherwise the current observed inequities will persist, and our inaction will continue to actively perpetuate harm.

3. Across communities, maximize medical benefits.
We use the value of maximizing benefits to guide healthcare decisions in and out of crises and to set priorities, agendas, and budgets, including those in the COVID-19 response. It is this current principle that is directing guidelines in Massachusetts and California.[77] However, simply maximizing benefits favors privileged White individuals since they tend to be healthier and more likely to have a favorable prognosis compared to marginalized communities. A more just benefits allocation will be mindful of the need to apportion resources across communities equitably, accounting for historical and current biases against communities at the intersection of non-normative race, gender and class, meaning BIPOC and LGBTQIA+, and impoverished communities. This principle would also consider demographics in allocation of vaccine, acknowledging that specific communities are more likely to contract and die from COVID-19. By doing so, the unjust distribution of COIVD deaths due to systemic discrimination could directly be addressed providing greater equity across the total population.

Justice in medicine has not been applied equitably across our nation, and this is particularly evident as the lives of BIPOC and impoverished communities are being lost to COVID-19 at higher rates than other populations. As described in the research studies cited above, the factors at play are complex though not immutable, and involve structural, institutional, and interpersonal elements. Taking no action to address these factors is unethical and perpetuates white supremacy. Therefore, it is necessary to end these inequities.

B. Implications Associated with Reform

There are several implications associated with reform, as enumerated below.

1. Suggestions for Research-Based Implementation:
For successful implementation of the proposed policy changes, two important factors need to be considered: structural biases and individual biases.

More research is needed to understand the structural inequities in society at the local, state, and national levels. Institutions at each one of these levels need to initiate research cycles that continually evaluate inequities, outcomes, effectiveness of interventions, and systems of accountability. Completely rooting out flawed assumptions and biases is difficult; nevertheless, research efforts rooted in public health critical race praxis could, over time, systematically improve our healthcare systems at all levels.[78] It is important to note that while quantification through algorithms may be useful, recent research has shown how algorithmic approaches could incorporate biases and further perpetuate inequities.[79]

Individual biases expressed through healthcare provider attitudes and decisions are common and difficult to address. A research-based, adaptive approach with

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built-in community engagement has the potential to provide a counterpoint to cognitive biases that providers hold.[80] Each healthcare network should use the three proposed guidelines to amend their systems by first accounting for the ways in which they contribute to inequities among each marginalized group. This step requires engaging the communities experiencing discrimination and working under their direction to find appropriate solutions.

The advantages of the suggested revised COVID-19 guidelines based on an applicative justice ethic are clear. They acknowledge past discrimination marginalized groups have faced, combat current discrimination, and still maximize resources across the public served by the United States healthcare system. Further, these guidelines will help mitigate the inequitable distribution of COVID-19 cases and negative outcomes seen in marginalized populations. Building applicative justice principles into hospital guidelines is a progressive step that should result in decreased morbidity and mortality for the most at-risk individuals. Ultimately, this approach can and should be adapted to various disciplines in medicine outside the current pandemic.

2. Critiques of the Proposed Applicative Justice Approach: There are a few alleged critiques of these proposed guidelines that cannot be ignored.

First, the recommendations may be misconstrued as "reverse discrimination," or discrimination against a majority group that is historically advantaged.[81] In many respects, the idea of "reverse discrimination" is a fallacy for the following reasons:

a. Discrimination requires that one group uses its power and privilege to affect the opportunities and lives of another group. As previously noted, the power and privilege in American medicine has always been, and continues to be, held by Whites.[82] That being the case, any recommendation increasing access to marginalized groups cannot marginalize or oppress Whites since they generally continue to hold the power and privilege in the medical system and social structure. Instead, these recommendations attempt to increase access and opportunity for those being oppressed.
b. As the data presented in this paper reveal, our current system already unjustly benefits privileged groups, mainly middle and upper class Christian White cis-males and does not treat all individuals equally. Therefore any policy that does not acknowledge existing inequalities and their unjust outcomes, or that supports a colorblind approach, instead furthers White supremacy.[83] These measures aim to increase equity and enhance justice at a systematic level.
c. Overall, these proposed policies are not advocating for the betterment of marginalized groups at the expense of the White majority. Applicative justice does not seek to disenfranchise groups that hold power in the system but transform the system so that those in power do not continue to obtain unfair benefits. Further it accounts for unjust historical oppression and current injustices to provide equitable outcomes to all.
d. Finally, applicative justice does not intentionally target any privileged groups, but seeks to raise up those who have been marginalized. The only reason that a privileged group (i.e., the White majority) might "lose" something is because they are unjustly receiving a disproportionate number of resources at the expense of others in the current system as it exists.

Second, critics might argue that these guidelines could start a chain reaction of policy reconsideration leading to reverse discrimination in medicine and elsewhere in society. This slippery slope argument is a classic logical fallacy and not a true critique. Considering our nation's historically embedded institutional and interpersonal discrimination based on normative White supremacy, we can hardly expect an avalanche of change. Instead, these measures will likely face intense opposition from those leading current structures. And again, reversing biased public health responses is not an example of reverse discrimination so long as the focus is on equitability.

A third critique is that applicative justice-based guidelines fail to achieve the ultimate maximization of resources from a utilitarian perspective and that such guidelines unethically waste resources in a crisis. While there may be fewer overall life-years saved per available resource, it is the goal of these guidelines to maximize resources while ethically and equitably distributing them across the sick population. Using utilitarian phrasing, this is the greatest good for the greatest number of people across demographics. Therefore, these policies still fulfill the utilitarian maxim, but do so in a way that applies the maxim fairly across all people. This ethical imperative for this measure has been addressed previously in our need to account for historical and current inequities.

C. The Case for Reparations

The proposed policy changes are an attempt to provide equitable care in the context of the current pandemic.

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Yet, they do not address all the historical atrocities committed against marginalized communities or the systemic, institutional, interpersonal, and internalized biases that created today's expansive health inequities. Under the applicative justice framework, it is clear that justice demands not only that inequities be tackled going forward but past injustices be acknowledged and addressed.

If we had enacted reparations for Black American descendants of enslaved persons, projections demonstrate that COVID-19 transmission would have been reduced by 31-68% in Louisiana.[84] This is partially due to the complex interplay of factors that Cedric Robinson defines as racial capitalism.[85] Robinson outlines how all layers of capitalism are built upon racial stratification, which has led to exploitation of BIPOC communities and subsequent inequities. To generate equity, the underlying economic system must be rethought and transformed.

To directly right health inequities, the medical community needs to support wide spanning financial restitution to systematically address historical discrimination and resource extraction from BIPOC communities. Using the framework of William Darity and A. Kristen Mullen, reparations should be structured in a process that ensures acknowledgement, redress, and closure that is led by the affected community.[86]

V. Conclusion

Structural inequity continues to create the conditions for poor health outcomes in BIPOC communities and the devastating impact of COVID-19 only makes that longstanding pattern more obvious. Applicative justice makes it clear that it is unethical to let these inequities continue without decisive action. New policies and actions must be implemented to help providers and institutions alleviate ongoing health inequities, especially as the vaccine is now being distributed. Supported by data-driven principles, our three proposed guidelines seek to improve current recommendations and to make an ideological shift in healthcare resource allocation. Using the guiding principles of applicative justice, additional initiatives are also needed to transition the healthcare system from White supremacy towards equity and racial justice. While critics may suggest this is reverse discrimination, the proposed theory and guidelines — which, over time, will require further refinement — do not discriminate; rather they seek to remedy existing inequities and policies that discriminate against BIPOC.

The disruption caused by COVID-19 is a unique opportunity to adopt changes that should have occurred long ago, curtailing unfair disability and death amongst marginalized populations, righting injustice, and starting to rebuild trust. While implementation of these guidelines may achieve a more just outcome, restitution is also needed to correct historical systemic biases and attempt to heal the centuries of violence and neglect committed by the medical community against BIPOC. Collective action grounded in applicative justice can bring our medical system closer to equity during the present crisis and in the future.

Note

The authors have no conflicts to disclose.

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