

Perceiving and Addressing the Pervasive Racial Disparity in Abortion

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Health Services Research and
Managerial Epidemiology
Volume 7: 1-4
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DOI: 10.1177/2333392820949743
journals.sagepub.com/home/hme



Abstract

Black women have been experiencing induced abortions at a rate nearly 4 times that of White women for at least 3 decades, and likely much longer. The impact in years of potential life lost, given abortion's high incidence and racially skewed distribution, indicates that it is the most demographically consequential occurrence for the minority population. The science community has refused to engage on the subject and the popular media has essentially ignored it. In the current unfolding environment, there may be no better metric for the value of Black lives.

Keywords

abortion, racial disparity, Black abortion rate, premature death, YPLL

While induced abortion remains a contentious political issue, there is no credible scientific doubt that a unique human life begins at conception and, therefore, ends with an abortion. Even the Obama administration and the abortion-friendly Bill and Melinda Gates Foundation have acknowledged “the critical importance of a child’s first 1,000 days after conception in determining a healthy and productive life trajectory . . . to ensure that all children . . . have an equal opportunity to survive and thrive.”¹

Yet, the evidence is clear that for many decades Black children in the United States have not had, and do not have today, an equal opportunity to survive until birth. The most recent CDC report on abortion in the United States indicates that, in 2016, the Non-Hispanic Black abortion rate (25.1 abortions per 1,000 women age 15-44) was 3.8 times the Non-Hispanic White rate of 6.6.² One could reasonably hope, given the pattern of declining abortion rates for 3 decades, that the racial disparity in abortion also would be decreasing. However, between 2007-2016, the Black rate declined 29% and the White rate declined 33%—meaning that the racial disparity actually increased rather than decreased during that time period. It is also important to note that 5 states that did not report race-specific abortion data (or no data at all in the case of California) to the CDC (California, New York, Texas, Florida and Illinois) account for fully half of all U.S. abortions and a third of all Black women of child bearing age. Further, the CDC notes that non-reporting states have “populations of minority women so that the absence of their data reduces the representativeness of the CDC data.” This means that the existing CDC reports possibly underestimate the size of the racial disparity in abortion nationwide.

The racial disparity in abortion rates in the U.S. is pervasive and persistent. Between 1990-2014, 43 states and the District of

Columbia reported race-specific abortion data to the CDC.³ Many states reported intermittently and only 22 states reported for all 25 years. The national average (aggregating all available states and years) Black/White abortion rate disparity for the entire period was 3.44. The 1990 disparity was 3.00 (B 25.87/W 8.63) and by 2014 it was 3.64 (B 12.68/W 3.48). In data collected directly from the individual states (not from CDC) for the more recent calendar year 2018, the 27 reporting states average a Black abortion rate of 21.78 and a White abortion rate of 6.38 for a racial disparity of 3.41. Some noteworthy states and their racial disparity in abortion include: Wisconsin (5.59), Michigan (5.41), Minnesota (4.78) and Pennsylvania (4.80).⁴ Therefore, despite incomplete reporting especially from high-volume abortion states with large populations of minority women, Black women have been experiencing abortions at a rate nearly 4 times that of White women for more than 30 years. It is very likely that the disparity existed even before there was any reporting.

One way to measure the impact of race-specific abortion rates on the size and demographic composition of the U.S. population is to calculate the years of potential life lost (YPLL) from abortion and to compare its impact to other causes of death. YPLL is the preferred public health metric for quantifying the social, economic and demographic loss resulting from premature death.

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Submitted July 13, 2020. Revised July 17, 2020. Accepted July 17, 2020.

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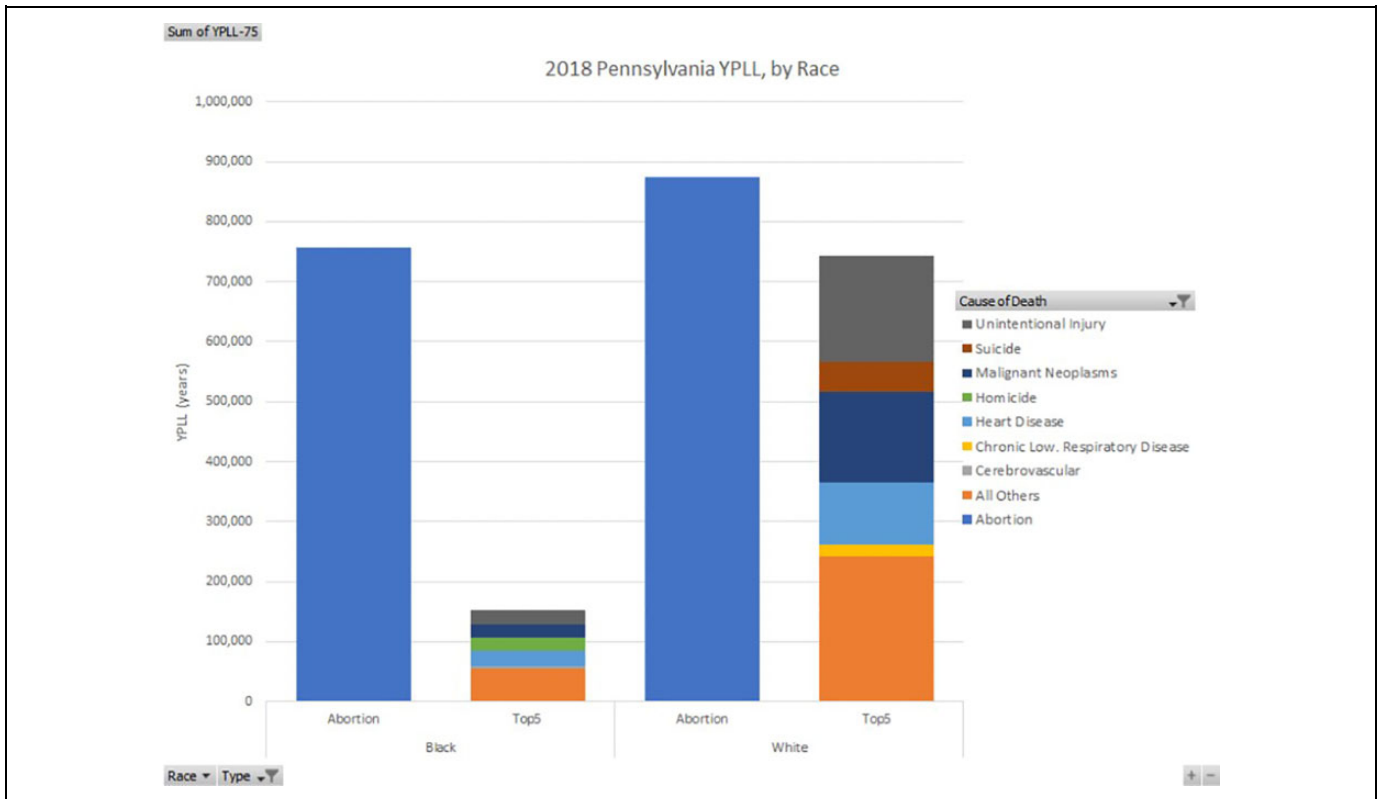


Figure 1. Pennsylvania 2018 YPLL by race and cause of death.

It allows the estimation of the burden of premature death for any cause and can assess socioeconomic inequalities by race (as in our application), education, gender or other available characteristics.⁵ YPLL 75 is calculated by accumulating all years from the age at death up to 75, for all deaths for each cause of death. We selected the state of Pennsylvania (2018) to illustrate the YPLL construct because of its relatively high abortion volume ($n = 30,364$), very high black abortion rate (37.16) and a high racial disparity in abortion rates (4.80).

In Pennsylvania in 2018, there were 61,011 White deaths (these are premature recorded deaths of all deceased persons up to age 75, plus abortions) from all causes and 20,976 Black deaths.⁶ Abortions were 23.9% of White deaths and 62.7% of Black deaths. To calculate YPLL we subtracted 23.8% of Black abortions and 20.9% of White abortions to reflect estimated natural fetal losses. Total White YPLL was 1,610,908 years and White abortions accumulated 866,916 YPLL or 53.8%. Total Black YPLL was 911,955 years and Black abortions accumulated 751,522 YPLL or 82.4% (Figure 1). In Pennsylvania in 2018, there were 472 Black homicide deaths that generated 20,964 YPLL. For comparison purposes, Black abortions represented 28 times more deaths and 36 times as many YPLL as Black homicides.

A vivid national-level illustration of the gap between the crucial demographic importance of abortion and its relative scientific and media obscurity can be found in its comparison with maternal mortality. The racial disparity in maternal mortality, that is, non-accidental death related to pregnancy, has received an abundance of attention both in the popular media and the professional

community. Stories expressing alarm over the high rate and racial disparity in maternal mortality have recently appeared in every major newspaper in the United States. Many states have formed expert committees to determine the causes of pregnancy-related maternal deaths and to implement preventive programs. The racial disparities in maternal mortality and induced abortion are of the same magnitude and in the same direction, a ratio of about 3-4 times. Yet, maternal mortality, in stark contrast to the high incidence of abortion, is an extraordinarily rare event. During the 5-year period 2011-2015, there was an average of 682 maternal deaths per year in the entire nation.⁷ That is an average annual age-adjusted YPLL of 29,996 years. In 2015, there were 900,135 abortions, derived from a linear interpolation of Guttmacher Institute 2014 and 2016 estimates. The fetal-loss-adjusted YPLL was over 52 million years. Therefore, there were 1,320 abortion deaths for every maternal death and 1,744 years of potential life lost to abortion for every year lost to a maternal death!

Abortion has been euphemistically described as a “choice” or a human “right.” The undeniable objective reality, whatever one’s political persuasion or ideological posture, is that each abortion is a death. Death by abortion, however, has proven to be an inconvenient reality for many of our politicians and scientists alike. Mortality and fertility are 2 of the 3 principal determinants, along with migration, of the size and demographic composition of the U.S. population.⁸ Given its high incidence and racially skewed distribution, abortion is unquestionably the most demographically consequential occurrence for the minority community. Its impact on the size and racial composition of the nation

is undeniable. The exclusion of the major cause of death from the vital statistics system and the national psyche, one which disproportionately affects a racial minority, is a distressing denial of science. Cause-specific mortality rightly remains a major influence on public policy and resource allocation, and research suggests that notions about the relative importance of the mortality patterns of certain subpopulations often reflect subjective beliefs about the nature of the society.^{9,10} The silence of the popular media and the lack of a robust scientific dialogue on the longstanding racial disparity in induced abortion suggest that a disconnect exists between its overwhelming demographic importance and the willingness of thought leaders to engage on the subject. The current upheaval unfolding may portend at last, hopefully, a return to serious scientific inquiry, public transparency, and effective response.


Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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James Studnicki is currently Vice President and Director of Data Analytics at the Charlotte Lozier Institute in Arlington, Virginia. Over a span of four decades, he held academic appointments at the Johns Hopkins University School of Hygiene and Public Health, the University of South Florida College of Public Health, and the University of North Carolina, Charlotte, where for ten years he served as the Irwin Belk Endowed Chair in Health Services Research. Dr. Studnicki holds Doctor of Science (ScD) and Master of Public Health (MPH) degrees from Johns Hopkins and a Master of Business Administration (MBA) from the George Washington University.

John W. Fisher is currently an Associate Scholar at the Charlotte Lozier Institute. Following a 22 year career as a nuclear submarine officer, he served as the Director of Life Support and Engineering at the Florida Aquarium, Chief Financial Officer of Technology Transfer Services, and 10 years as an Assistant Professor at the University of North Carolina at Charlotte College of Health and Human Services. Dr. Fisher holds a PhD in Information Systems and Decision Sciences from the University of South Florida, a JD from Massachusetts School of Law, and Master's degrees from the Massachusetts Institute of Technology (Ocean Engineering), University of Notre Dame (Administration), Indiana University (Business Administration), the United States Naval War College (National Security Policy), and the University of South Florida (Management Information Systems). He is a member of the bar in New Hampshire and Massachusetts.

James L. Sherley graduated from Harvard College in 1980 with a BA degree in biology; and he completed joint MD and PhD degrees at the Johns Hopkins University School of Medicine in 1988. After post-doctoral studies in cancer cell molecular biology at Princeton University, he joined the Fox Chase Cancer Center as a principal investigator in 1991. In 1998, he joined the faculty of the future Department of Biological Engineering at Massachusetts Institute of Technology, where he undertook research and teaching in the areas of cancer cell molecular biology, tissue stem cell bioengineering, toxicology, and environmental health science until moving to Boston Biomedical Research Institute (BBRI) in 2007. As a Senior Member of BBRI's research programs in Regenerative Biology and Cancer Biology, Dr. Sherley established an academic center for developing adult stem cell-based technologies for advancing cellular medicine. After leaving

BBRI, in October 2013 he founded stem cell biotechnology development company Asymmetrex, LLC, which he now directs. Asymmetrex has the mission of advancing technologies for stem cell medicine. The company recently developed the first method for determining the dosage of therapeutic stem cell treatments. Dr. Sherley's awards

include 1993 Pew Biomedical Research Scholar, 2003 Ellison Medical Foundation Senior Scholar in Aging Research, and 2006 NIH Director's Pioneer Award. Since 2016, he has served as an Associate Scholar of the Charlotte Lozier Institute, the education and research institute of the Susan B. Anthony List.