



Abortion Reporting:

TOWARD A BETTER
NATIONAL STANDARD

CHARLES A. DONOVAN | REBECCA GONZALES

American Reports Series

Issue 12 | August 2016

The Charlotte Lozier Institute's American Reports Series presents analysis of issues affecting the United States at the national level. These reports are intended to provide insight into various issues concerning life, science, and bioethics.

Previous Reports:

Byron Calhoun, M.D., *Perinatal Hospice: Allowing Parents to Be Parents*, American Reports Series 1.

Gene Tarne, *The Ethical Stems of Good Science*, American Reports Series 2.

Charles A. Donovan; Sullivan, Nora, *Abortion Reporting Laws: Tears in the Fabric*, American Reports Series 3.

Charles A. Donovan, *The Adoption Tax Credit: Progress and Prospects for Expansion*, American Reports Series 4.

Gene Tarne; Mullins, Andrew, *Maryland Joins the Trend for Ethical Stem Cell Research*, American Reports Series 5.

Angelina Baglini, *Gestational Limits on Abortion in the United States Compared to International Norms*, American Reports Series 6.

Gene Tarne, *Cloning is Cloning is Cloning*, American Reports Series 7.

Mark Bradford, *Improving Joyful Lives: Society's Response to Difference and Disability*, American Reports Series 8.

Wesley J. Smith, *Assisted Suicide Is Not Compassion*, American Reports Series 9.

Daniels, Scott E. *Health Care Sharing Ministries: An Uncommon Bond*, American Reports Series 10.

Higgins, Anna. *Sex-Selection Abortion: The Real War on Women*, American Reports Series 11.

The full text of this publication can be found at: <https://www.lozierinstitute.org/abortion-reporting-toward-a-better-national-standard>

Comments and information requests can be directed to:

Charlotte Lozier Institute
1200 New Hampshire Ave., NW, Suite 750
Washington, DC 20036
E-mail: info@lozierinstitute.org
Ph. 202-223-8073/www.lozierinstitute.org

The views expressed in this paper are attributable to the author(s) and do not necessarily represent the position of the Charlotte Lozier Institute. Nothing in the content of this paper is intended to support or oppose the progress of any bill before the U.S. Congress.

ABORTION REPORTING: TOWARD A BETTER NATIONAL STANDARD

Executive Summary

Abortion is one of the most highly debated topics in public policy, and is almost always in the national spotlight. There were an estimated 1.1 million abortions in the United States in 2011.¹ If historical trends continue, by age 45, somewhere around a quarter of American women will have had an abortion. Therefore, abortion and abortion policies impact thousands of women's and families' lives every day. Consequently, abortion policy must be grounded on the most accurate, comprehensive and up-to-date statistical information and health data. Unfortunately, after 42 years and over 55 million abortions since the *Roe v. Wade* decision, the United States still doesn't have a timely and streamlined system to prepare and publish state abortion reports and national summaries.

¹"Induced Abortion in the United States," Guttmacher Institute (Washington, D.C.), at <https://www.guttmacher.org/fact-sheet/induced-abortion-united-states>. Guttmacher figures are based on direct reports from abortion providers, including clinics, hospitals and doctor's offices. These survey figures are consistently more complete, and average a third higher, than data compiled by the U.S. Centers for Disease Control, which relies on a non-uniform and voluntary system of data collection from the states. For a previous critique of the inadequacies and anomalies present in U.S. abortion reporting, see Donovan, C. A. and Sullivan, N., "Abortion Reporting Laws: Tears in the Fabric," Charlotte Lozier Institute (December 1, 2012) at <https://lozierinstitute.org/abortionreporting/>.

Table of Contents

Executive Summary	3
Introduction	5
History of the Problem	6
Ranking State Abortion Reports	10
Prevalence of Collected Information	13
Prevalence of Collected Information, by Type	14
The Minnesota Model	15

List of Illustrations

Table 1: Comparison of Data Points Recommended by the USRITP/CDC, Recommended by CLI, Both CLI and the USRITP, and by the State of Minnesota	8
Table 2: Abortion Reporting Score Sheet	10
Table 3: CLI Rankings: Abortion Reporting Requirements	12
Table 4: Abortion Reporting Score Sheet (Number of states achieving).....	14

Introduction

In the summer of 2015, Charlotte Lozier Institute (CLI) undertook a review of state abortion reporting laws,² examining statutes and published reports, and talking with state officials about their practices regarding gathering and publishing information. Our review involved creating a comprehensive list of report elements, determining the time horizon between the gathering of data and the production of annual reports, and assessing the ease with which information about abortion can be gleaned from state governments, including public web sites. Using a scoring system that treated most data elements as of equal value, CLI proceeded to grade the states on the overall quality of their abortion data collection and dissemination. The assessments, published in Table 3 below, show a wide range of quality among the 50 states and a few instances where state scores were effectively zero. The ability of a number of states, however, to publish robust data on a timely basis, and at low cost, points to a potential pathway to more uniform, current and comparable data even in the absence of federal incentives or mandates. Federal and state policymakers can utilize strides already made to hasten the day when U.S. abortion reporting reaches a modern standard of excellence.

²The majority of states have specific statutory provisions or regulations concerning abortion reporting. See Ala. Code § 26-21-8(c); Alaska Stat. § 18.16.040; Ariz. Rev. Stat. § 36-2162; Ark. Code Ann. §§ 20-16-1505, 814; Colo. Rev. Stat. Ann. § 25.5-3-106(4); Conn. Agencies Regs. § 19-13-D54; Del. Code tits. 24, § 1790(c), 16, § 3133; Fla. Stat. Ann. § 390.0112 (West 2013) (amended by 2016 Fla. Sess. Law Serv. Ch. 2016-150 (C.S.C.S.S.B. 1411) (West)); Ga. Code Ann. § 16-12-141.1; Idaho Code. § 39-261; 720 Ill. Comp. Stat. § 510/10; Ind. Code §§ 16-34-2-5 (amended by 2016 Ind. Legis. Serv. P.L. 213-2016 (H.E.A. 1337)), 5.5; Iowa Code Ann. § 144.29A; Kan. Stat. Ann. § 65-445; Ky. Rev. Stat. Ann. § 213.101; La. Stat. Ann. § 40:1061.21; Me. Rev. Stat. Ann. tit. 22, § 1596; Mass. Gen. Laws Ann. ch. 112, § 12R; Mich. Comp. Laws Ann. § 333.2835(2); Min. Stat. Ann. §§ 145.4131, 4132, 4133; Miss. Code Ann. §§ 41-75-18, 41-41-77; Mo. Rev. Stat. §§ 188.052, 055; Mont. Code Ann. §§ 50-20-110, 306; Neb. Rev. Stat. §§ 28-3,107, 28-343; Nev. Rev. Stat. § 442.265; N.H. Rev. Stat. § 329:35; N.J. Stat. Ann. § 30:4D-6.1; N.M. Stat. Ann. § 24-14-18; N.Y. Gen. Bus. Law § 394-e (McKinney); N.Y. City Rules tit. 24, § 203.03; N.C. Gen. Stat. Ann. § 14-45.1(b), (c); N.D. Cent. Code, § 14-02.1-07(2), Ohio Rev. Code. § 3701.79; Okla. Stat. Ann. tit. 63 §§ 1-738j, m, 1-746.6; Or. Rev. Stat. § 435.496; 18 Pa. Cons. Stat. Ann. §§ 3207(b), 3214; S.C. Code Ann. § 44-41-60; S.D. Codified Laws §§ 34-23A-19, 41; Tenn. Code Ann. §§ 39-15-203, 68-3-505; Tex. Health & Safety Code Ann. § 245.011; Utah Code. Ann. §§ 76-7-305.7, 313; Vt. Stat. Ann. tit. 18, § 5222; Va. Code Ann. § 32.1-264; Wash. Admin. Code § 246-490-100; W. Va. Code Ann. §§ 16-2F-6, 2I-7; Wis. Stat. Ann. § 69.186; Wyo. Stat. Ann. § 35-6-107. One state has a statute concerning fetal death reporting, including deaths from abortions. See Haw. Rev. Stat. § 338-9. A few states have statutory provisions or regulations regarding fetal deaths, but which do not include induced abortions. See Cal. Health & Safety Code § 102100; D.C. Mun. Regs. Subt. 22-B, § 4504; D.C. Code § 7-213; Md. Code, Health § 4-213; R.I. Admin. Code § 31-1-2:6.0. Two states have amended their abortion reporting statutes since this report was prepared. For the sake of contemporaneity of the information included in this analysis, these states – Indiana and Florida – do not have updated scores in this report.

History of the Problem

Criticism of the U.S. abortion reporting system is longstanding and widespread. The U.S. system is routinely labeled “voluntary” or “completely voluntary,” a description that applies to the transfer of state data to the national authority that now collects and publishes an annual report, the U.S. Centers for Disease Control (CDC). The CDC reports have a significant lag time, reflecting the lag time that exists in many states between collection of data and the publication of the state report. This lag time appears to be narrowing but it can consume as much as three years at the state level and it is currently nearly a full three years at the federal level. The CDC abortion surveillance report for 2012, for example, was published on November 27, 2015.³

As the CDC notes, there is no national requirement driving the collection of this data. The vast majority of the states do provide CDC with abortion data and seek a variety of demographic information about the mother and medical information, including characteristics like gestational age, number of previous abortions, and method of abortion used. The significance of abortion method continues to grow because of the increasing utilization of medication abortions and the urgent need to assess the health impact of a process where the abortion itself and ensuing complications typically occur outside the clinic where the abortion was performed or medication was prescribed. In addition, on March 30, 2016, the U.S. Food and Drug Administration approved changes in the protocols for administration of medication abortions likely to lead to expanded use of the drug and an increased incidence of surgical follow-up to address incomplete abortions.⁴

The CDC has influenced the collection of data through its interpretations of the public health significance of abortion and its use and revision of the U.S. Standard Report of Induced Terminations of Pregnancy (USRITP). This form was originally developed by the National Center for Health Statistics (NCHS) in 1978 in the interest of encouraging the states to gather more consistent information and to ultimately permit NCHS to displace CDC as the federal locus for information about abortion. This was to be accomplished by a system of federal-state contracts that ultimately included only 15 states and was finally abandoned in 1993. Using NCHS rather than CDC’s non-communicable disease division for abortion data has appeal as NCHS is the locus for other federal analysis of trends in births, deaths, divorce, and marriage.

Given the continuation of public debate about abortion and factors that influence the abortion rate, which include questions about marital status, family structure, contraceptive funding patterns and availability, the desire for improved reporting while maintaining respect for historic federal-state prerogatives, as well as patient privacy, has been sustained and relatively uncontroversial. In preparation for analyzing the results presented in this article, CLI compared the standard USRITP with the full array of data collected by one or more states as one measure of comprehensiveness. It is apparent that, despite differences of opinion about the importance of particular items, the USRITP functions as a floor rather than a ceiling for abortion-relevant statistics states routinely gather.

³http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6410a1.htm?s_cid=ss6410a1_e

⁴<http://www.uptodate.com/contents/abortion-pregnancy-termination-beyond-the-basics>

For example, as a recent summary⁵ from the Guttmacher Institute notes, the number of states gathering and reporting data points of public interest remains very limited in certain instances. At a time when intense debate has resumed over public and taxpayer-subsidized abortion coverage, only eight states report how an abortion was paid for, i.e., using self-pay or insurance. Nearly half of the states do not require abortion complications to be reported by the provider, despite the presence among such providers of individuals with demonstrably substandard records of medical accomplishment.⁶ Only 10 states ask whether the abortion was performed because of a threat to the life or health of the mother. Fifteen ask whether the abortion is being performed because of a diagnosed fetal abnormality, a factor relevant both to public health concerns, especially in the wake of deepening concern about transmission of a virus⁷ damaging to the developing child, and to questions about diagnostic testing accuracy and even the rights of children with prenatal disabilities.

Some question the value of broad collection of abortion data by public agencies as potentially intrusive, burdensome, or irrelevant to public health concerns. One author points out that completion of the USRITP requires only 17 data points while the State of Oklahoma's form, which the author labels "egregious," requires 30 data points for adults and 38 for minors, with additional sub-questions.⁸ Excessive burdens on medical personnel are a legitimate concern. The most recent standards for International Classification of Diseases, ICD-10, require providers to comb through thousands of potential codes for particular procedures and diagnoses,⁹ and the standards even link physician reimbursement to provider identification of codes of an extremely granular nature. The 2010 World Health Organization instruction manual for implementing the system runs nearly 200 pages. Needless to say, the few dozen data points collected by some states with respect to abortion, a potentially life-altering decision, is modest in comparison.

⁵"State Policies in Brief: Abortion Reporting Requirements," Alan Guttmacher Institute (Washington, D.C., February 1, 2016). <http://www.guttmacher.org/statecenter/spibs/spibARR.pdf>.

⁶Eyal Press, "A Botched Operation," *The New Yorker* (February 3, 2014), at <http://www.newyorker.com/magazine/2014/02/03/a-botched-operation>. See also David French, "The Abortion Industry Survives by Endangering Women's Lives," *National Review Online* (March 2, 2016), at <http://www.nationalreview.com/article/432254/abortion-supreme-court-substandard-care-facilities>.

⁷The zika virus was discovered in 1947 in Uganda and it is a member of the Flaviviridae family of viruses. It is transmitted by the bite of an infected *Aedes Aegyptii* mosquito. The virus usually leaves no lasting injury to adults but it is associated with cases of Guillian-Barre Syndrome in adults and of microcephaly and other birth defects in the unborn children of women infected while pregnant. Its impact in Brazil and subsequent spread throughout South America, Central America and now the United States has spurred some groups to call for the imposition or expansion of legal abortion. <https://lozierinstitute.org/baby-not-mosquito/>

⁸<http://www.guttmacher.org/pubs/gpr/18/2/gpr1804015.html>

⁹The ICD-10 includes an astonishing 71,924 codes for the type of procedure performed and 69,823 options for the diagnosis made. These codes represent a 19-fold increase in the number of procedure code options and a five-fold increase in the number of diagnosis options from the system previously in force. See http://www.cdc.gov/nchs/icd/icd10cm_pcs_background.htm. The new code also regroups the coding options and represents a change from a numerical to an alphanumeric system of coding. The system is very unpopular with the medical profession; in one small poll, 86% of primary care physicians stated that the coding system, which is linked to their eligibility for cost reimbursement, takes time away from their patients (<http://hitconsultant.net/2015/10/09/frustrated-primary-care-doc-shares-9-ways-icd-10-impacted-patient-care/>).

A comparison of the USRITP data requests with those of the state of Minnesota, a potential model for improved reporting nationwide, illustrates the additional information that can be sought beyond the baseline recommendations of the CDC:

Table 1: *Comparison of Data Points Recommended by the USRITP/CDC, Recommended by CLI, Both CLI and the USRITP, and by the State of Minnesota (**bold**)*

CLI and Minnesota+	Both CLI and USRITP	USRITP
Maternal mortality	Mother's Education Level	Facility name
If minor, were parents notified	Date	City, town, location of termination
If minor, was judicial bypass obtained	Marital status	County of termination
Type of contraceptive used	Race/ethnicity	City, town, or location of residence
	# of previous pregnancies	Inside city limits?
Informed consent process followed	# of previous miscarriages	Zip code
Injury identified in-clinic	# of previous induced abortions	Name of attending physician
Injury identified extramural to clinic	State of residence	Name of the person completing the form
Type of injury reported	County of residence	Patient's Numeric Identifier
Pre-existing maternal condition	Age	Date last normal menses began
Fetal length, weight, other physical	Gestational age of fetus	
Sex of baby	Abortion method	
Nature of medical emergency		
Evidence of fetal viability		
Reason for termination		
If late-term, reason for termination		
Pregnancy/other test performed		
Ultrasound performed for any purpose		
Infants born alive or as a result of failed termination of pregnancy		
Specialty of physician		
Source of payment		
Type of facility		
<i>Method of disposal of remains</i>		

+ Other states besides Minnesota require the collection of much of this information; see Table 4.

*Minnesota report elements shown in bold

**Minnesota-only element shown in bold italics

Apart from the question whether certain types of data collection are onerous, there are other compelling reasons for states to gather more – and more uniform – kinds of data about abortion. The most important of these are the currency and accessibility of data about a practice that has so many public policy and individual health implications. Data is valuable not only for long-term uses but also for evaluating rapidly changing environments. For example, it will be useful for policy makers to know whether a phenomenon like the Zika virus, which has been found to cause birth defects, is contributing to a spike in late-term abortions carried out for that reason.¹⁰ Data like this cannot be assembled if there is no cited rationale for late-term abortions in most states. Moreover, if reports about the virus are contributing to changes in public behavior, it is better to know within months, rather than several years, whether and why such changes are happening.

The same is true in reverse, as public and private campaigns are frequently undertaken to achieve the goal of making abortion less common or even more common, in the sense of more widely available. These campaigns can be broad or highly localized. Events like the opening of new clinics, whether offering abortion or alternatives to abortion, can have an impact on abortion incidence in a community. Data about this incidence is of interest not only to policy makers but to courts that are asked to review legislation designed to affect or indirectly affect abortion rates or abortion “access” in one direction or another. Making this data timelier, more comprehensive, and more accessible is a basic responsibility that is within reach and that only government agencies can fulfill. Private data collection and analysis, particularly on other questions of enduring interest, including such topics as abortion and unexpected pregnancy and contraceptive use patterns, will always be valuable and can be pursued through traditional investigative methods.

The fact remains that public agencies, however, have a duty to make information available to researchers irrespective of the researcher’s views and priorities on underlying or unrelated questions of social policy. Data itself can inform a variety of public policy judgments (e.g., verification of informed consent, parental involvement in abortion) that transcend topics of exclusive interest to medical judgment. Moreover, many of these topics have an undoubtedly strong public health component even if that is not their exclusive value; innumerable studies confirm, for example, that high levels of parental involvement in children’s lives correlate with better behavioral and health outcomes. Nonetheless, the protection of individual patient privacy is of the utmost importance and care must be taken to avoid practices that pose a substantial risk of compromising information about individuals.

¹⁰States are also paying new attention to proposals to limit abortions performed for reasons of fetal disability, based on ideas embodied in anti-disability discrimination legislation. Some medical authorities are pressing, on the other hand, for changes in policy to make abortion more available due to the association between the Zika virus and development of microcephaly. See Sharfstein, J., M.D., JAMA Forum, “The Zika Virus and Abortion Politics,” at <https://newsatjama.jama.com/2016/05/11/jama-forum-the-zika-virus-and-abortion-politics/> (June 9, 2016). Measuring changes in abortion incidence due to new and controversial factors such as Zika and anti-discrimination legislation is clearly in the public interest.

Ranking State Abortion Reports

To evaluate the relative quality, timeliness, and thoroughness of state abortion reports, CLI developed a score sheet that includes reporting elements required by at least some states and assigned to each a value of at least two (2) points. To these data points we added several measurements of quality such as timeliness (based on the most recent year for which a report was available), transparency (the availability of the reports online for use by the public and researchers), and graphic displays (use of charts and other visual materials to ease interpretation of changes in the data). We added as well data of potential utility in public policy and public health discussions, whether or not states currently or commonly obtain such information, including, for example, the sex of the fetus (one state) and whether or not ultrasound was used for any purpose (e.g., confirmation of pregnancy).

Table 2: *Abortion Reporting Score Sheet*

State:	Year:	1	2	3	4	5	Date of Release:	Web site:			
Years Available Online:							1 (1 year)	2 (2-5 yrs)	3 (6-10 yrs)	4 (11-15 yrs)	5 (16+ yrs)
General Report Characteristics (2 points each)											
Mandatory? Y/N	Available to Public? Y/N	Available on Web? Y/N		Released annually? Y/N		Electronically collected? Y/N		Cost reported? Y/N			
Characteristics of the Woman (2 points each)											
Guaranteed Anonymity under State Law: Y/N			Other steps taken to prevent inadvertent release of identity: Y/N			Age: Y/N	Marital Status: Y/N	Race/ethnicity: Y/N	State of residence: Y/N		
# of prior births: Y/N	# of prior miscarriages: Y/N		# of prior induced abortions: Y/N		Education level: Y/N	Maternal mortality noted: Y/N		County of residence: Y/N			
If minor, were parents notified: Y/N	If minor, was judicial bypass obtained: Y/N		Contraceptive used: Y/N		Type of contraceptive used: Y/N		Informed consent process followed: Y/N				
Injury identified in-clinic: Y/N			Injury identified extramural to clinic: Y/N			Type of injury reported: Y/N		Pre-existing maternal condition: Y/N			
Characteristics of the Pregnancy/Abortion Procedure (2 points each)											
Gestational age: Y/N	Date of abortion: Y/N		Method of abortion: Y/N		Fetal length/weight/other physical: Y/N		Sex of baby: Y/N				
Nature of medical emergency, if any: Y/N		Evidence of fetal viability: Y/N		Reason for termination: Y/N		If viable, reason for term.: Y/N		Pregnancy/other test performed to confirm: Y/N			
Ultrasound performed for any purpose: Y/N			Infants born alive or as a result of FTP: Y/N								
Characteristics of Provider and Facilities (2 points each)											
Specialty of physician: Y/N			Type of facility: Y/N								
General qualities (2 points each)											
Source of payment: Y/N	Abort. report issued separately: Y/N		Volume of info (e.g., no of charts)		Report in multi-media formats (e.g., audio, Braille)						
Comment							Cost:		Score:		

The maximum point total available under this scoring system was 100. While the scoresheet treated most data points as being of equal value, two elements qualified a state for as many as five points, reflecting the importance of and potential for improvement in reporting that could make an immediate difference in the availability of the most recent data from as many jurisdictions as possible. States received the maximum point total of five if, as of mid-summer 2015 when this research was conducted, they had made or were on the verge of making their 2014 abortion statistics available online. Their score was reduced from the maximum of five by one point for each additional year's delay in publishing their report (e.g., if only 2013 statistics were available by mid-summer 2015, they received four points; if 2012, they received three points and so on). They also received as many as five points for the number of prior-year reports made available online, which allows for ready recognition and analysis of trends in abortion statistics.

States could lose up to five points, on the other hand, if they failed to make collected information accessible online. The measurement of accessibility was based on the percentage of data points that were collected by the state but not included in the published report. This required that both the published reports and the private report forms be examined. For instance, if the state collected, but did not publish anywhere between 10 and 20 percent of the data items, one point was subtracted from the state's score. If the state collected, but did not report 20 to 30 percent of the data items, two points were subtracted from the score. That pattern was maintained so that having more than 50 percent of data points collected but not published would cost the state five points off its total score.

Tabulations for each state were made after a variety of efforts to contact state health or vital statistics agencies, through internet searches, email contacts, and telephone calls to state officials. By and large, states were cooperative in sharing information about the data they collect and publish. It is worth noting that the quality of state abortion reporting is not strongly linked to other measurements of the states' attitude toward abortion as measured by its political climate or public policies toward legal abortion. The present study found that Oklahoma and Minnesota have the most complete and current abortion reporting laws, with the former generally classifiable as a state willing to regulate abortion and Minnesota as a state generally not considered hostile to the practice.

The chart below contains the ranking and raw score for each state CLI evaluated. The scores range from zero (for the several states that publish no annual report for abortions performed in the state) to 77, the value for the state of Oklahoma. The Sooner state has been criticized for collecting an extraordinary array of information, and indeed, for example, the state abortion report includes an element to record the sex of each aborted human life. Oklahoma is one of a handful of states to have adopted a sex-selection abortion ban.¹¹ The median state score is 49, near the midpoint on the 100-point scale, and the average score is 43.2, indicating that the typical jurisdiction collects roughly half of the information that one or more of these jurisdictions have deemed of value.

¹¹Nine states have enacted legal bans on abortion performed for reasons of sex selection, and seven of those statutes are in force. See "Abortion Bans in Cases of Sex or Race Selection or Genetic Anomaly," State Policies in Brief, Guttmacher Institute (March 1, 2016); at https://www.guttmacher.org/sites/default/files/pdfs/spibs/spib_SRSGAAB.pdf.

Table 3: *CLI Rankings: Abortion Reporting Requirements*

Rank	State	Score
1	Oklahoma	77
2	Minnesota	76
3 (tie)	Arizona	67
3 (tie)	Ohio	67
5	Indiana	66
6	Utah	65
7 (tie)	Michigan	64
7 (tie)	So. Dakota	64
9	Nebraska	62
10	Louisiana	61
11	Arkansas	59
12	Alabama	58
13 (tie)	Illinois	57
13 (tie)	Oregon	57
15 (tie)	Kansas	56
15 (tie)	Texas	56
17 (tie)	Idaho	54
17 (tie)	Wisconsin	54
19 (tie)	No. Dakota	53
19 (tie)	Washington	53
21 (tie)	Alaska	52
21 (tie)	West Va.	52
23 (tie)	Montana	51
23 (tie)	Pennsylvania	51
25 (tie)	Georgia	49
25 (tie)	Mississippi	49

25 (tie)	Missouri	49
28	So. Carolina	48
29 (tie)	No. Carolina	46
29 (tie)	Virginia	46
31 (tie)	NYC	45
31 (tie)	Vermont	45
33 (tie)	Iowa	44
33 (tie)	Tennessee	44
35	Colorado	42
36 (tie)	Delaware	40
36 (tie)	Maine	40
38	Nevada	39
39	NY State	33
40	Florida	31
41	Connecticut	29
42	New Mexico	26
43	Kentucky	25
44	Hawaii	24
45	District of Columbia	21
46 (tie)	California	0
46 (tie)	Maryland	0
46 (tie)	Massachusetts	0
46 (tie)	New Hamp.	0
46 (tie)	New Jersey	0
46 (tie)	Rhode Island	0
46 (tie)	Wyoming	0

It is noteworthy that abortion reporting is weakest in some states that rank in the highest quartiles in terms of their abortion rates. The following states that are among the lowest in information collection quality (< 40 raw score) are among the highest in abortion rate (state, abortion rate rank): New York state (1), Maryland (2), District of Columbia (3), New Jersey (4), Florida (5) and California (6). In fact, the top 12 states in the country (including the District of Columbia) in terms of abortion rate all rank in the bottom third of jurisdictions for the quality of their abortion reporting. Only Illinois, with a ranking of 13 for both abortion rate and the quality of its abortion reporting, deviates from the pattern of states with high abortion prevalence being among the lowest in terms of the completeness and timeliness of its abortion reporting. And even here Illinois has faced criticism for the number of abortions its state report misses, a feature not included in the present analysis.¹² Ironically, the more common abortion is in a particular jurisdiction, the less may be known through public channels about its major characteristics.

Prevalence of Collected Information

As the rankings suggest, the states and other jurisdictions vary greatly in the information they collect and publish, with some states collecting and publishing numerous tables and others collecting scant information or no information at all. We measured how frequently states collected individual data points and what we found is included in the score sheet below, where each number given corresponds to the number of jurisdictions collecting that particular type of information.

¹²Megan Twohey, "State Abortion Records Full of Gaps: Thousands of Procedures Not Reported to Health Departments," Chicago Tribune, June 16, 2011, at http://articles.chicagotribune.com/2011-06-16/news/ct-met-abortion-reporting-20110615_1-abortion-providers-fewer-abortions-national-abortion-federation.

Prevalence of Collected Information, by Type

Table 4: *Abortion Reporting Score Sheet (Number of states achieving)*

State:	Points for Timeliness	1	2	3	4	5	Date of Release:	Web site:					
Years Available Online:		1 (1 year)		2 (2-5 yrs)		3 (6-10 yrs)		4 (11-15 yrs)		5 (16+ yrs)			
General Report Characteristics (2 points each)													
Mandatory? Y/N	Available to Public? Y/N	Available on Web? Y/N		Released annually? Y/N		Electronically collected? Y/N		Cost reported? Y/N					
44	44	42		39		8		1					
Characteristics of the Woman (2 points each)													
Guaranteed Anonymity under State Law: Y/N			Other steps taken to prevent inadvertent release of identity: Y/N			Age: Y/N		Marital Status: Y/N		Race/ethnicity: Y/N		State of residence: Y/N	
43			44			44		40		44		40	
# of prior births: Y/N	# of prior miscarriages: Y/N		# of prior induced abortions: Y/N		Education level: Y/N		Maternal mortality noted: Y/N		County of residence: Y/N				
39	38		39		36		6		40				
If minor, were parents notified: Y/N	If minor, was judicial bypass obtained: Y/N		Contraceptive used: Y/N		Type of contraceptive used: Y/N		Informed consent process followed: Y/N						
9	8		6		6		11						
Injury identified in-clinic: Y/N		Injury identified extramural to clinic: Y/N		Type of injury reported: Y/N		Pre-existing maternal condition: Y/N							
23		10		23		4							
Characteristics of the Pregnancy/Abortion Procedure (2 points each)													
Gestational age: Y/N	Date of abortion: Y/N		Method of abortion: Y/N		Fetal length/weight/ other physical: Y/N		Sex of baby: Y/N						
43	35		42		5		1						
Nature of medical emergency, if any: Y/N		Evidence of fetal viability: Y/N		Reason for termination: Y/N		If viable, reason for term.: Y/N		Pregnancy/other test performed to confirm: Y/N					
7		7		13		4		2					
Ultrasound performed for any purpose: Y/N		Infants born alive or as a result of FTP: Y/N											
8		6											
Characteristics of Provider and Facilities (2 points each)													
Specialty of physician: Y/N		Type of facility: Y/N											
3		10											
General qualities (2 points each)													
Source of payment: Y/N		Abortion report issued separately: Y/N		Volume of info (e.g., no of charts)		Report in multi-media formats (e.g., audio, Braille)							
8		28				3							

Because of the lack of abortion reports altogether in a small (but demographically significant) number of states, no data item is publicly reported for all 50 states and the District of Columbia. A significant number of items are reported by more than 80 percent of the states, most notably characteristics of the mother, gestational age, abortion method, and other factors that have been recommended as part of national guidelines for many years. A handful of factors are reported by only a single state, most notably sex of the baby (required by Oklahoma but not reported to date) and the cost of compiling the annual report (required only by Minnesota). Other data items are reported by fewer than 20 percent of the states, including such useful information as how the abortion was paid for; the specialty of the physician, if any; evidence of fetal viability; and type of contraception used prior to the pregnancy and abortion.

The information gleaned on the recency of the reports was also illuminating. Of the jurisdictions producing reports, 19 were publishing or about to publish their data for 2014 (thus having a gap of less than a year between the period covered and issuance of the report), 15 were publishing or about to publish data for 2013, and four more were doing so for 2012 or 2011 data. National data, it should be noted, for 2012 was published by the Centers for Disease Control on November 27, 2015.¹³ The speed of this publication process could surely be improved and the key to doing so would be more rapid reporting by the states in a more uniform and consistent manner. A proper national goal would be the production of an annual abortion report no more than a full year after the year studied, so that the 2015 report, for example, would be issued in early 2017 rather than late 2018 as would be the pattern now.

The Minnesota Model

Our review of all 50 states' (as well as the District of Columbia's and New York City's) abortion reporting systems yielded a few that ranked high in terms of quantity of information timely collected and published, but one state has produced a report of particular utility for a considerable period of time: Minnesota. In 1998 the state legislature adopted a law¹⁴ requiring each physician licensed and practicing in the state who performs abortions and each facility in the state where abortions are performed to file a report for each procedure carried out. These reports are compiled by the Minnesota Department of Health (MDH) and published each year with a legislatively determined target date of July 1 of the year following the year covered by the annual report. Each report is to contain the new data plus corrections made to any prior year's report. When released the report is made available on the MDH web site, where it joins, in an easily scrolled format, all prior year reports issued under the law.

Consistent with this requirement, Minnesota released its 2014 abortion report – tables and charts – on time and at low cost on July 1, 2015. The legislature requires the cost of the report to be published on the state web site, and Minnesota is the only jurisdiction to do so. The MDH indicates

¹³ <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6410a1.htm>

¹⁴ MN Statutes, 145.4131 - 145.4136.

that the cost of preparing and publishing the annual report has been decreasing and now stands at just \$4,000 per year. The first report issued under the statute had a reported cost of \$17,000 for the first year-plus of its publication, dropping slightly to \$15,000 in 2003. In 2010 the reported cost dropped to \$4,000 for the year, where it has remained ever since. The report text for 2014 states that this cost includes “staff time and printing expenses.” It does not appear to include compliance costs, that is, the facility staff time and other expenses associated with completing the forms for each patient.

These costs are very modest and the state has clearly benefited from year over year consistency in the reporting process. Minnesota’s system offers a model for any other state wishing to increase the efficiency, completeness, and availability of its reports about the impact of abortion on its population. It offers an achievable alternative to existing reporting – or absent reporting in some instances – in the majority of states. States wishing to upgrade their reporting activity and to promote the goal of consistent collection and publication of research-relevant information can use the Minnesota Model to advance toward that goal with modest long-term cost to taxpayers. While national efforts to improve abortion reporting are still worthwhile, and recalcitrant states like California and Maryland may ultimately need federal incentives or disincentives to install reporting systems, the states themselves can move closer to the goal of ensuring that the most current information about abortion, a life-altering and even nation-altering practice, is available to researchers across the United States and around the world.

Charles A. Donovan is president of the Charlotte Lozier Institute. Rebecca Gonzales is a research associate of the Charlotte Lozier Institute.

The authors thank Daniel Grabowski, legal fellow of the Charlotte Lozier Institute, for assistance with citations.