In a sharp and historic policy shift, the US Department of Veterans Affairs (VA) announced that it now will offer abortion counseling and care to veterans in cases of rape, incest, and life or health endangerment, even in states where abortion is illegal. The proliferation of abortion restrictions following the Dobbs v Jackson Supreme Court decision has created a medical crisis for many individuals in the US, including the nearly half of reproductive-aged women veterans who reside in states with current or pending abortion bans and restrictions. The VA's decision, which acknowledges abortion as a lifesaving and health-preserving medical treatment, will thus have profound implications for the safety and health of veterans nationally.

Prior to this announcement, the VA had the most stringent abortion policy of any federal institution and excluded abortion counseling, referral, provision, and coverage without any exceptions. In contrast, other federal programs, including Medicaid and the US Department of Defense, which also prohibit use of federal funds for abortions, have had exceptions for rape, incest, or life endangerment of the pregnant person. Despite this exclusion of abortion provision and coverage in the VA, however, women veterans have accessed abortion services at similar rates to their nonveteran counterparts, presumably at their own cost through online resources or community-based clinics that have now disappeared in states with abortion bans.

Lack of abortion care disproportionately harms the more than 200,000 women and gender-diverse veterans 18 to 44 years of age who receive care within the VA. As many as 1 in 3 women veterans experience military sexual trauma and many incur medical and mental health illness as a result of their military service—experiences that render unwanted or mistimed pregnancies more likely, more fraught, and more dangerous. Compounding the higher burden of medical and mental illness observed among veterans compared with nonveterans is that veterans tend to experience pregnancy at older ages, which independently elevates the risk of pregnancy-related complications. Furthermore, nearly a third of reproductive-aged women veterans are Black, and Black pregnant people in the US experience starkly elevated risks of pregnancy-related death compared with White pregnant people due to the effects of structural and interpersonal racism. Preliminary data suggest similar racial disparities in pregnancy-related morbidity and mortality among veterans who use VA care. Recent estimates predict that abortion bans will not only worsen the pregnancy mortality crisis, but also will further widen the already unconscionable racial disparity.

Several aspects of the VA's policy outlined in the interim final rule afford key protections for veterans and VA clinicians. First, the policy explicitly states that self-report of rape or incest constitutes sufficient evidence to access abortion care, unlike many state laws that require reporting to law enforcement to invoke exceptions. Because veterans experience intimate partner violence and sexual assault at higher rates than nonveterans, this stipulation removes evidentiary barriers to receiving timely care and will help ensure that survivors are treated with dignity, respect, and compassion. Second, the VA's policy specifies that decisions about endangerment to life or health will be made on a case-by-case basis between the VA clinician and the veteran, allowing clinicians to use their clinical judgment to protect patients. These protections apply even in states without rape, incest, or health exceptions based on the bedrock principle that federal law supersedes conflicting state law.

The VA's nationally integrated system is well positioned to introduce abortion care for select cases into routine reproductive health care. First-line reproductive health services in the VA, such as cervical cancer screening and contraception, are provided by women's health–trained primary care...
clinicians, who use established referral networks with VA gynecologists or contracted obstetrician-gynecologists in the community to provide more complex gynecologic care such as surgical procedures. All clinicians caring for veterans capable of pregnancy, including women’s health primary care clinicians and gynecologists, can be trained to provide pregnancy options counseling and deliver medication abortion care through established US Food and Drug Administration protocols; these services could be further supported by a centralized virtual care consult. Existing referral pathways to gynecologists could be leveraged to ensure timely care for those patients who need abortion procedures. The policy states that the VA will also cover travel for necessary abortion care, which provides a critical alternative when local access cannot be established.1

As a learning health system, the VA is poised to gather important insights and understanding of pitfalls as it navigates this process, which can in turn be shared with other health care systems. The majority (95%) of abortions in the US, most of which are first-trimester medication abortions or procedures, occur in freestanding clinics, with only a minority of obstetrician-gynecologists offering abortions as part of their practice and even fewer primary care clinicians providing these services.9 While the growth of freestanding clinics following the 1973 Roe v Wade decision was intended to provide safe spaces for high-quality and compassionate abortion care, an unintended consequence has been the segregation of abortion from the traditional health care system, exposing clinics, clinicians, and patients to protests, harassment, and violence. If carried out successfully, the VA will be able to provide a model for delivering abortion care within its existing structure, potentially mitigating the isolation and stigmatization attached to these services.

Numerous external and internal threats stand to affect the extent and speed with which the VA is able to operationalize its policy. On the external front, the policy change will undoubtably face legal challenges. Attorneys general in states with abortion bans are already threatening to bring legal action against VA clinicians who provide abortion care, despite the federal supremacy clause. Internally, little is known about how readily and widely VA primary care clinicians and gynecologists will embrace provision of these services or how many will request exemptions based on conscience protections. Beyond the clinicians directly delivering abortion counseling or care, it is unclear the extent to which the many other VA employees whose services are necessary to provide abortion care—such as pharmacists, anesthesiologists, and operating room nurses and staff—may facilitate or impede implementation. Quality improvement and research investigations will be critical to understand barriers and facilitators and inform implementation efforts.

Robust scientific data indicate that access to abortion, regardless of indication, is linked with improved physical, psychological, social, and economic outcomes.10 The VA’s policy acknowledges the importance of abortion care for the safety and health of veterans; however, it stops short of offering abortion as an option for any veteran.1 Even so, the policy still stands to have an important effect on veterans’ health and well-being, and sends a signal within and beyond the VA that abortion care is an essential health benefit. At this moment, as US residents are witnessing the rapid and widespread erosion of their reproductive rights and the attendant adverse effects on their health and well-being, this action by the VA should be recognized as a major step toward ensuring comprehensive and integrated reproductive health services as part of high-quality health care.

ARTICLE INFORMATION
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