

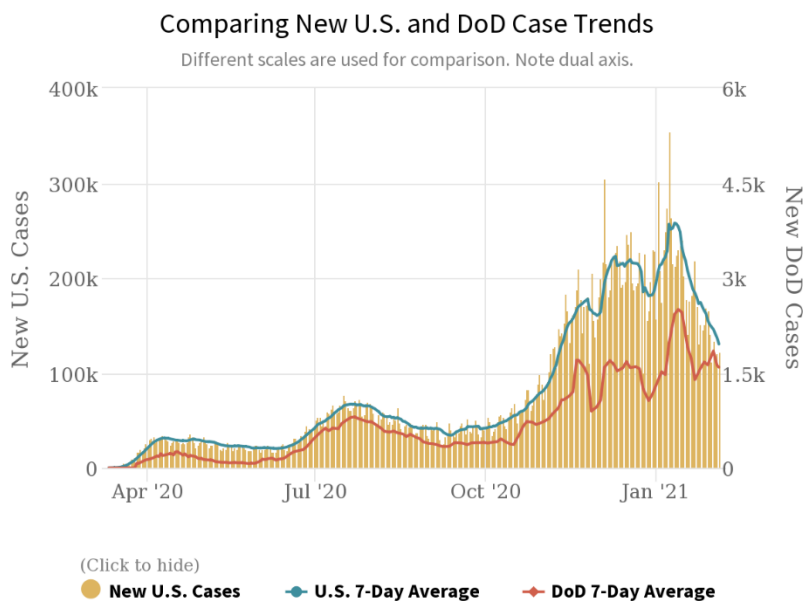
# Covid-19 and the Military: Maintaining Operations While Supporting Civil Society

*Adam Saxton and Mark Cancian*

The response to the coronavirus pandemic presents the Biden administration with its first defining challenge. The Department of Defense (DoD) played a central role in developing vaccines through Operation Warp Speed, and the Biden administration has made it clear that DoD will play an [important, though supporting, role](#) in getting “shots in arms.” Throughout the pandemic, DoD has properly taken a supporting role by deploying medical personnel to augment civilian hospitals, mobilizing National Guard personnel to provide logistical support, and providing rapid contracting capabilities to tap into the civilian economy. DoD itself has weathered the pandemic well after some initial missteps, with infection rates lower than the United States as a whole and death rates that are much lower. Military forces have figured out how to train, deploy, and operate during a pandemic.

## Q1: How has the pandemic affected DoD and military personnel?

**A1:** Although militaries have mechanisms to isolate themselves from the broader society, they cannot fully escape the effects of pandemics. Thus, DoD has experienced the same three waves of infection as broader U.S. society, and with the same increasing levels of intensity.



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Source: Johns Hopkins Coronavirus Resource Center  
& Coronavirus: DoD Response

Many observers expected that the military would become a [hotspot for infection](#), but this has not been the case. Military personnel have an infection rate about 15 percent below that of U.S. society overall. The infection rate for all DoD personnel (including military, dependents, and contractors) is about 40 percent below, as measured by cumulative cases from the beginning of the pandemic.

The fatality rate, as measured as deaths divided by confirmed cases, has also been lower. The fatality rate for military personnel is only 1/130th what it is for U.S. society (.013 percent versus 1.68 percent). This is not surprising since military personnel are generally younger and healthier than the general population. DoD personnel overall also face a much lower fatality rate (.15 percent). Again, this is not surprising, as this group is healthy enough to be working, has access to high-quality medical care, and does not include vulnerable elderly personnel.

## **Q2: How has the pandemic affected military operations, training, and recruitment?**

**A2:** Early on, DoD did not fully appreciate what was needed to continue operations in a pandemic environment. The [experience of the USS Roosevelt](#) captured these initial missteps, resulting in an outbreak so severe that the ship was forced to stop at Guam and offload the crew. Eventually, over 1,200 crew members tested positive for Covid-19. Of these, about [20 percent](#) were asymptomatic, [23 were hospitalized, four needed intensive care, and one died.](#)

In response to these early setbacks, the military services canceled exercises and halted the deployment of units, the [transfer of personnel](#), and the input of [new recruits into basic training](#) (those already in training continued). However, this was not a sustainable situation. As General David Berger, commandant of the Marine Corps, later noted, the [military cannot take a knee](#). The lack of recruits would cause military end strength to decline at about 2 percent per month, per our calculations. Halting new deployments would reduce U.S. global presence and produce power vacuums in volatile areas of the world. Pausing personnel transfers would disrupt the plans of hundreds of thousands of military families and strand some overseas for extended periods of time.

In response, DoD instituted a number set of procedures and adaptations, paralleling those in broader U.S. society. These precautions included extensive telework, the provision of personal protective equipment and sanitizer, deep cleaning of workspaces, social distancing, and restrictions on gatherings. DoD was further able to take actions not available to most civilian organizations, including requiring personnel to quarantine before they can be deployed, board ships, or participate in exercises, and enforcing isolation measures when deployed to minimize infections among U.S. personnel and host nations. These restrictions are possible because of the discipline instilled in the workforce and enforceable penalties under the Uniform Code of Military Justice.

These measures have been essential in convincing allies and partners that U.S. forces do not constitute a health threat. For example, the U.S. Forces Korea Command took aggressive action in the face of the pandemic to prevent infection, limit the spread when it occurred, and took particular pains to prevent any spread into its host country. These [aggressive actions were described](#) as “the gold standard.”

As a result of these efforts by DoD, deployments, training, and personnel movement have been able to recommence without the collapse of readiness, the fraying of alliances, or the emboldening of adversaries. Input of recruits into basic training resumed after a pause of about three weeks. The Army began [major collective training exercises](#) in mid-July after a test rotation in June. Precautions were elaborate: two weeks of isolation before deployment, temperature checks twice a day, and issuing individual personal protective equipment that included eye protection, gloves, N95 masks, face shields, and two bottles of hand sanitizer allocated each day. After the debacle with the USS *Roosevelt*,

the *Nimitz* strike group and the *USS America* were able to deploy in April using new protocols, which [have been continually updated](#).

Recruitment was forced to go fully remote, which was a significant departure from military recruiters' previous reliance on person-to-person connections. However, all the services [met their recruiting targets](#) for FY 2020, helped by economic uncertainty and high unemployment levels.

### **Q3: Do the forces have the same level of readiness? Are they as capable as before Covid-19?**

**A3:** DoD has been emphatic that U.S. forces remain capable of meeting all national requirements. However, the long-term effects of the pandemic are less clear. [General Mark Milley, chairman of the Joint Chiefs](#), stated early on: "I can report to you that our readiness is still high, our readiness is still strong, and we are able to deter and defeat any challengers that may try to take advantage of these opportunities at this point of crisis." Senior officials have continued to make [similar statements](#). When [the secretary of the Navy, the chief of naval operations](#), and the [commandant of the Marine Corps](#) testified to the Senate Armed Services Committee about readiness, they did not list the pandemic as a cause for any readiness problems.

However, General Charles Brown, in his [confirmation hearing](#) to be chief of staff of the Air Force, did say that "the full impact of Covid-19 to overall Air Force readiness is not fully known, but there will be a negative effect." Nevertheless, he also affirmed that the Air Force remained ready to carry out operations.

Training readiness might well continue at a high level because deployments, exercises, and major training events restarted early in the summer of 2020. Nevertheless, there have been training restrictions. Some events have been cut from basic training, and many other training exercises have been curtailed or limited. For example, [Defender Europe 2020](#), slated to be the third-largest exercise since the Cold War, was significantly scaled back with far fewer U.S. personnel involved than originally planned. What is unknown is whether there will be long-term readiness reductions due to limitations on training.

### **Q4: How did the military assist civil authorities, and what lessons can be drawn from this for the future?**

**A4:** Defense support for civil authorities is a long-standing military mission [with a well-developed body of doctrine and guidance](#). During the pandemic, this support consisted of four main elements: medical augmentation, logistics and administrative support from the National Guard, rapid contracting capabilities to tap into civilian capabilities, and Operation Warp Speed.

First, early in the pandemic, the military committed to several highly visible military medical deployments, including sending the hospital ships *USNS Comfort* and *USNS Mercy* to New York and Los Angeles, respectively. However, the ships possessed [few isolation wards](#) suitable for infectious diseases and ended up treating fewer than 300 patients between them, even after adaptations were made to accept Covid-19 patients. Field hospitals established in cities like [New York City and Seattle](#) had a similar experience. While the [Army Corps of Engineers \(ACE\) built a variety of overflow facilities](#) in convention centers, hotels, and dormitories, civilian hospitals generally had sufficient capacity that led to minimal [usage of the surge facilities](#). Recognizing the problem, the military instead began to [send medical personnel](#) to augment hard-pressed local hospitals. This augmentation by medical personnel was much more successful in enabling doctors and hospitals to handle the surge in workload, rather than providing new facilities.

Second, many states called on the National Guard for support during the pandemic—especially those states hit hard early on like [New York, Washington, and California](#). The troops mainly provided [emergency logistics](#) and [administrative support](#) until civilian mechanisms could be put into place. The National Guard thus supported, but did not supplant, civil authorities. For example, they delivered personal protective equipment and food, cleaned spaces, staffed call centers, and ran testing centers. Activations of National Guard troops for pandemic support peaked at 47,000 in early May 2020—about 11 percent of the total Guard available—and thus did not overstretch National Guard capabilities.

Some support also came from active-duty forces. For example, the U.S. Air Force airlifted [Covid-19 test kits](#) and transported back to the United States [U.S. citizens who had been stranded abroad](#). These are good examples of the limited occasions where the military needs to step in because civilian capabilities are unavailable.

Third, DoD provided rapid contracting capabilities. Civil society contains many capabilities that governments need during a pandemic, such as light construction, transportation, and supplies. The challenge is getting access to these capabilities, and rapid contracting allows such access. This was the major contribution of the ACE, which was able to rapidly contract with civilian construction companies to build alternative care and temporary facilities. In addition to the ACE, DoD used its extensive expeditionary contracting capabilities, which were built in response to the contracting scandals in Iraq and Afghanistan during the 2000s.

#### **Q5: What is the state of Operation Warp Speed and the role of the military in distributing vaccines?**

**A5:** Operation Warp Speed, the fourth element of the military’s support to civil authorities, is the [civilian-military partnership](#) to develop and distribute Covid-19 vaccines on an accelerated timeline. Operation Warp Speed leverages DoD’s extensive [military medical research and development](#) establishment and its rapid contracting capabilities. These have allowed the federal government to quickly push money out to pharmaceutical companies to develop, test, produce, and distribute vaccines.

The military is also providing logistics and administrative support. For example, [National Guard troops will help with distribution](#) in many states. President Biden’s [national Covid-19 strategy](#) specifies a DoD role: “The [DoD] will bring its logistical expertise and staff to bear, with the Federal Emergency Management Agency (FEMA) managing set-up and operations [of community vaccination sites].” This support includes both the Guard and the Army and Navy Medical Corps.

#### **Q6: How should DoD support the Biden administration’s fight against the pandemic?**

**A6:** First, the Biden administration is right to have civilian agencies take the lead while the military supports. Despite the military’s extensive organizing and logistics capabilities, a military lead is not appropriate since there are many civilian organizations dedicated to public health. Further, militarizing a response has many downsides, from disrupting traditional civil-military balances to diverting DoD attention from more traditional warfighting medical concerns to disrupting existing medical delivery systems. The focus should be on DoD supporting civil authorities, not replacing them.

Further, DoD’s focus should be on augmenting the civilian medical establishment instead of duplicating it. Military medical forces were most successful when they augmented the existing civilian medical establishment by providing additional medical personnel and assisting with supplies and logistics, rather than creating new hospitals and facilities.

Second, DoD should maintain expeditionary contracting capabilities. These were crucial for tapping into the vast capabilities of the private sector. However, these capabilities are often regarded as “overhead” and vulnerable to reductions during management reform efforts. The Biden administration needs to avoid that when it looks for efficiencies within the Department of Defense.

Third, the Defense Production Act (DPA) should be used to establish medical supply chain robustness. The DPA provides a mechanism to sustain certain U.S. industries that provide important national security capabilities. This should include having some domestic sourcing of key medical supplies, which the Biden administration has committed to. That commitment needs to be followed through year after year, lest budget pressures gradually drive the federal government and medical institutions to lower-cost, overseas suppliers.

Fourth, DoD should make low-cost enhancements to its dual-use pandemic capabilities. These include upgrades to military field hospitals so that some of them can provide more isolation for infectious diseases, which also facilitate deployment to future overseas disease outbreaks, such as [DoD did for Ebola in 2014](#). The hospital ships could also be reconfigured to contain more isolation beds. Emergency use inventories could further include a full set of medical equipment and supplies suitable for dual use.

Finally, DoD should publish more data related to the Covid-19 pandemic. For example, DoD should recommence publishing data on National Guard and reserve mobilization along with active and reserve troops deployed. It would be particularly helpful to include the number of medical personnel sent in support of domestic hospitals. Further, the [DoD website](#) should explain the composition of its reported cases of Covid-19 to prevent confusion, for example, by publicly clarifying whether or not reserve forces are included in the reported military case numbers.

## Author

**Adam Saxton** is a research associate with the International Security Program at the Center for Strategic and International Studies (CSIS).

**Mark Cancian** is a senior adviser with the International Security Program at CSIS.

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