



AMEDD RESTRUCTURE

Impacts to the Mission and Readiness of the Force

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ABSTRACT

Since 2020, the Army Medical Department (AMEDD) has undergone sweeping structural reforms and personnel shifts designed to realign military medicine with future operational demands. Key changes, including the transfer of military treatment facilities (MTFs) to the Defense Health Agency (DHA), proposed reductions in uniformed medical billets, and the establishment of new entities such as the Army Medical Logistics Command (AMLC), have reshaped the medical enterprise. While these reforms aim to enhance efficiency and refocus the force on combat casualty care, they have also introduced significant challenges. This paper explores the consequences of AMEDD's restructuring and personnel reductions, with a focus on their impact to medical personnel workload, the department's ability to fulfill its dual mission, long-term readiness implications, and short-term effects on large-scale combat operations (LSCO).

AMEDD RESTRUCTURING AND PERSONNEL LOSSES POST-2020

The most visible shift in Army Medicine occurred in 2021, when management of military treatment facilities (MTFs) transitioned to Defense Health Agency (DHA), as mandated by the FY2017 National Defense Authorization Act (NDAA). In 2023, DHA consolidated its oversight into nine Defense Health Networks to standardize governance across the

has contributed to staffing shortfalls across hospitals and operational units, leaving gaps in essential skill sets. Meanwhile, the Army Reserve Medical Command (AR-MEDCOM) has shifted from individual augmentation toward whole-unit deployments, redesignating subordinate commands to better align with LSCO and mobilization requirements. Collectively, these changes mark a fundamental transformation in how AMEDD structures and employs its medical force.

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services. Although intended to streamline operations, a 2025 Government Accountability Office (GAO) report found that DHA had not fully validated staffing requirements under the new structure, raising concerns about efficiency and oversight.

In parallel, the U.S. Department of Defense (DoD) proposed a reduction of the total military medical workforce (GAO, 2023). While Congress froze these cuts in the FY2023 NDAA, the Army had been poised to absorb the largest share, including losses in critical specialties such as trauma surgery, intensive care, and behavioral health (GAO, 2023). Even without formal reductions, attrition

IMPACT ON WORKLOAD OF MEDICAL PERSONNEL

One of the most immediate consequences of personnel reductions has been a sharp increase in workload for those who remain. Under the billet reduction plan, more than a quarter of eliminated positions were absorbed by existing staff without replacement.

The Army Medical Corps continues to face mounting recruitment and retention challenges. A 2024 RAND study found that physician separations now outpace new accessions, leaving critical billets unfilled and undermining operational support. Nursing shortages are equally

severe. In 2024, Walter Reed National Military Medical Center operated at a reduced number of its authorized nurse strength, prompting temporary closures of clinical services in 2025. For clinicians still serving, the result has been heavier patient loads, expanded administrative responsibilities, and elevated stress levels. The behavioral health field is particularly strained, with a significant number of budgeted positions vacant as of 2022 (GAO, 2023). Service members referred to civilian providers often wait weeks for urgent appointments, compared to hours at a military treatment facility. These compounding pressures have contributed to burnout, declining morale, and rising separation intentions among medical officers.

ABILITY TO SUPPORT THE MISSION

CLINICAL CARE DELIVERY

Restructuring has led to a substantial shift in patient volume from MTFs to the civilian TRICARE network. The GAO cautioned that the DoD did not fully assess the civilian network's capacity to absorb this influx, resulting in long wait times and limited access in some regions. At the same time, declining patient volumes within MTFs have reduced opportunities for military clinicians to maintain trauma and surgical proficiency. In response, the Pentagon has set a goal to recapture patient visits by 2026 to help restore clinical readiness (Jowers, 2024).

MEDICAL LOGISTICS

The establishment of the AMLC has enhanced the agility of Army medical logistics, as demonstrated during the COVID-19 response, when the command successfully managed global distribution of vaccines and ventilators. However, AMLC's lean workforce operates at a sustained high tempo. To maintain global supply lines in a contested LSCO environment, both modernization and increased staffing will be essential.

ADMINISTRATIVE SUPPORT

The transition of administrative functions to DHA has introduced duplication and uncertainty. Many support roles remain unaligned, placing strain on personnel who must navigate dual reporting systems. Concurrently, MEDCOM headquarters has shifted its focus toward combat readiness metrics, including trauma training pipelines and the implementation of Tactical Combat Casualty Care (TCCC). While these initiatives are critical to mission success, they are resource-intensive and further burden an already limited workforce.

SHORT-TERM IMPACTS ON LSCO READINESS

The Army's current medical capacity is insufficient to meet the scale of casualties anticipated in LSCO. A 2021 Army War College study concluded that force reductions had left in-theater treatment capabilities inadequate. Compared to past conflicts, the Army now fields significantly fewer deployable beds.

Training exercises conducted between 2024 to 2025 have underscored these gaps. Global Medic 2025 simulated large casualty scenarios, overwhelming field hospitals and revealing evacuation challenges in contested environments. Mojave Falcon highlighted the critical need for prolonged field care when MEDEVAC was denied. Inspector General reports from 2025 further revealed that only a small percentage of Army emergency physicians met trauma proficiency minimums. (GAO, 2025).

While the Army Reserve's shift toward whole-unit deployments has improved cohesion, the active force remains heavily reliant on Reserve mobilization to surge medical capacity. In the short term, LSCO readiness remains fragile, with personnel shortfalls directly limiting the Army's ability to treat mass casualties.



Anesthesiologists from William Beaumont Army Medical Center watch the surgical team react to the simulated emergency scenario in the classroom next door to the simulation operating room at the hospital

LONG-TERM IMPACTS ON FORCE READINESS

Over time, AMEDD's challenges extend beyond combat medicine to broader issues of soldier readiness. Staffing shortfalls at MTFs can delay routine care, prolonging non-deployable status for service members. Behavioral health shortages pose a deeper risk, undermining morale, retention, and long-term force stability.

The talent pipeline presents another concern. Fewer physicians and nurses are choosing long-term Army careers, threatening the sustainability of graduate medical education programs. Senior leaders have warned of a potential repeat of the historic "Walker Dip," the postwar erosion of combat medical skills during interwar periods.

To mitigate these risks, Congress and the DoD have introduced several reforms. The DoD has committed to surge civilian staffing through contracted support. Most importantly, Army Medicine is expanding partnerships with civilian trauma centers and refining training pipelines to preserve combat proficiency. If sustained, these initiatives could stabilize AMEDD and yield a smaller, more combat-focused medical force. However, without sufficient

manpower and continued investment, long-term readiness risks remain.

OPERATIONAL VOICES ON AMEDD CHALLENGES

An interview with SFC Michael White, Ms. Catelyn Biles, and LTC (Ret) Ben Kocher provides frontline perspectives that reflect broader systemic issues. Their observations, ranging from Soldiers performing duties outside their military occupational specialty (MOS) to persistent gaps in behavioral health staffing and limitations within LSCO training environments, mirror findings from oversight agencies (personal communication, August 2024). The GAO (2023) identified widespread workload absorption and extensive vacancy rates in behavioral health roles. RAND's 2024 analysis similarly highlighted challenges in physician retention and skill sustainment, noting that rising administrative burdens contribute to medical officer attrition.

Concerns raised in the interview regarding contested evacuation and extended casualty care are echoed in Army War College studies and validated through exercises such as Mojave Falcon 25 and Global Medic 25-02 (U.S. Army, 2025). Interviewees also emphasized bureaucratic barriers and delays in implementing change within AMEDD, concerns that align with the GAO's 2025 critique of DHA's management inefficiencies and lack of validated workload analysis.

The convergence of firsthand operational insight and independent research underscores a consistent narrative: those delivering care on the ground are witnessing the same vulnerabilities such as personnel overextension, contested logistics, and institutional inertia, that external assessments identify as threats to readiness. Collectively, these voices convey a clear and urgent message: without prioritized investment in staffing, training, and structural reform, Army Medicine will remain strained in both garrison operations and LSCO environments.

READINESS IMPLICATIONS FOR TOMORROW'S FIGHT

The post-2020 restructuring of Army Medicine has produced both advances and challenges. Streamlined governance, enhanced medical logistics, and a

renewed emphasis on combat readiness represent both advancement and meaningful progress. However, personnel losses and persistent vacancies have increased workloads, limited access to care, and reduced short-term capacity to support LSCO.

In the near term, Army Medicine faces significant risk if called upon to respond to mass casualties in a major conflict. Long-term readiness will depend on reversing physician and nurse attrition, stabilizing staffing at MTFs, and preserving trauma proficiency through patient recapture and targeted training. Ultimately, AMEDD must strike a deliberate balance between efficiency and effectiveness. Its success will be measured not only by its ability to deliver in peacetime healthcare delivery, but by its readiness to save lives on tomorrow's battlefields.

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REFERENCES

- GAO. (2023). *Defense health care: Additional assessments needed to determine effects of active duty medical personnel reductions* (GAO-23-106094). U.S. Government Accountability Office. <https://www.gao.gov/products/gao-23-106094>
- GAO. (2025). *Defense health care: Actions needed to address long-standing management challenges in DHA's medical facility oversight* (GAO-25-107432). U.S. Government Accountability Office. <https://www.gao.gov/products/gao-25-107432>
- Jowers, K. (2024, January 25). Pentagon plans to fix 'chronically understaffed' medical facilities. *Military Times*. <https://www.militarytimes.com/news/your-military/2024/01/25/pentagon-plans-to-fix-chronically-understaffed-medical-facilities/>
- Ong, M. (2024, August). *Notes from interview with SFC Michael White, Ms. Catelyn, and Mr. Ben Kocher (Retired PA)*. Personal communication.
- RAND Corporation. (2024). *Reimagining the Army Medical Corps: Five ideas for raising recruitment, restoring retention, and restructuring requirements* (RRA2119-1). RAND Corporation. https://www.rand.org/pubs/research_reports/RRA2119-1.html
- U.S. Army. (2025, May 19). *Mojave Falcon 25: Army Reserve's largest exercise ever*. https://www.army.mil/article/285625/mojave_falcon_25_army_reserves_largest_exercise_ever
- U.S. Army Reserve. (2025, August 19). *Global Medic 25-02: Testing medical readiness for large-scale combat operations*. <https://www.usar.army.mil/News/Article/4279366/global-medic-25-02-testing-medical-readiness-for-large-scale-combat-operations/>