

The road ahead: transforming New Zealand ambulance (out-of-hospital) services

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Ambulance services have moved far beyond patient transport to deliver advanced emergency, urgent and primary care. Paramedics now perform complex procedures, such as rapid sequence intubation, under robust clinical governance.¹ Yet, unlike the police and fire services, they have never been recognised in statute as an emergency service.² This omission contrasts with Australia, Canada and the United Kingdom, where ambulance services have clear legislative mandates.³ A new *Emergency Management Bill* aims to correct this disparity. At the same time, demand for ambulance care is rising because of an ageing population, growing chronic disease, inequities, pressure on hospitals and a mental health crisis.^{4,5} New Zealanders increasingly call 111 for frailty, minor illness and psychosocial distress, exposing structural weaknesses in out-of-hospital care. A desire to reverse this trend has policymakers placing further pressures on ambulance services rather than addressing the drivers of increased ambulance demand, such as primary care market failure.

Evolving paramedicine: regulation, workforce and scope

Until 2021 anyone could call themselves a paramedic. Registration under the *Health Practitioners Competence Assurance Act* established national standards and protected the title for practitioners with a Bachelor of Health Science (Paramedicine) and demonstrated competence.⁶ Teams comprise of volunteers, unregulated emergency medical technicians (EMTs) and degree-qualified paramedics. The Paramedic Council is developing specialist endorsements for critical, extended and intensive care paramedics.⁶ Volunteers and EMTs remain outside regulated scopes, leaving many rural stations reliant on responders who cannot offer comprehensive care. Expanded scopes enable “see and treat” care at home, prescribing under standing orders and telehealth-sup-

ported triage. Current practice has far outgrown the scope of existing legislation, which now needs to be updated to allow independent prescribing and diagnostics.⁷

Rising demand and changing demographics

Emergency call volumes have climbed steadily over the past decade.⁸ Ageing, multimorbidity and persistent inequities mean more patients have complex needs that must be managed in the community. Mental health demand is a significant driver: a recent police review found that 11 % of calls to the Emergency Communications Centre were for mental health crises, equating to one call every 7 minutes.⁹ As the police adopt higher thresholds for attendance and set shorter emergency department handover times, paramedics are increasingly the sole responders, despite a lack of legislation enabling safe and appropriate responses.^{10,11} A qualitative study of New Zealand paramedics attending suicide callouts reported nightmares, flashbacks and post-traumatic stress, with participants feeling they were filling gaps left by under-resourced mental health services.¹² Limited access to primary and urgent care clinics amplifies demand; many people call 111 for non-acute conditions, and call takers who answer these calls follow scripted algorithmic responses rather than providing a clinical lens, potentially perpetuating inequities.¹³ Rural response times are longer and rely heavily on first responders. Stark post-code lotteries exist—for instance, south of Peka Peka on the Kāpiti Coast may have a dual paramedic crew response, in contrast to north of Peka Peka where this may be a single EMT response.

Funding, workforce and system pressures

Unlike police and fire services, ambulance

organisations lack guaranteed funding. Hato Hone St John receives about 83% of its budget from the government and must raise the remainder through donations and co-payments; Wellington Free Ambulance also relies heavily on fundraising.⁸ Capital costs for stations, vehicles and equipment are largely unfunded and dependent on donations. Fragmented commissioning for road, air and non-emergency transport creates inefficiencies, and fragmented delivery contributes to preventable serious adverse events. Salaries lag behind those of nurses and other allied professionals and have been eroded by wage freezes, prompting industrial action.⁸ Understaffed shifts, rural recruitment challenges, reliance on volunteers and rising burnout underscore the need for workforce investment. Prolonged “ramping” at overcrowded emergency departments reduces ambulance availability and is linked to poor mental health among paramedics.^{9,14} Funding reforms must also honour Te Tiriti o Waitangi by embedding Māori governance and cultural safety.¹³

Innovation, technology and future opportunities

Electronic health records, real-time data sharing and predictive analytics could improve triage and resource deployment;⁹ however, long-term underfunding has resulted in creaking and vulnerable digital emergency management systems. Community responder apps mobilise trained volunteers (e.g., GoodSAM) but remain entirely privately funded. Telemedicine and tele-EMS programmes demonstrate the potential of remote consultation, yet policy-maker responses appear to lag.^{15,16} Horizon scans suggest artificial intelligence could automate dispatch and triage, though evidence is limited.¹⁷ Updated legislation will be required to support paramedic prescribing, portable diagnostics and other innovations.

The road ahead: recommendations

The forthcoming *Emergency Management Bill*'s recognition of ambulance services as an emergency service² provides an opportunity to strengthen the sector. However, legislative recognition must be matched with policy action:

1. *Secure and equitable funding:* Fully integrate ambulance services into the publicly funded health system, with baseline operational and capital funding that reflects demand and inflation. Ambulances are the key movement strategy of any public health system yet in New Zealand frequently remain absent from strategic discussions. Co-payments for emergency transport and reliance on charitable donations challenge equity. Policymakers and New Zealanders must consider whether they can continue to be comfortable with the free system present in the capital and surrounding regions while leaving people in other regions to cover co-payments. The joint commissioning of road, air and non-emergency ambulance services should be streamlined to support integrated planning and accountability, alongside a cohesive strategy for the medical/trauma retrieval system.
2. *Pay parity and workforce investment:* Align paramedic salaries with comparable health professions to attract and retain staff. Expand recruitment and bonded-scholarship schemes for rural and remote practice. Fund capacity building through dedicated schemes, rather than relying on private service providers to determine this. Fund continuing professional development and mental health support for staff, including debriefing and counselling services.
3. *Strengthen rural and remote services:* Develop incentives and flexible rostering to recruit registered paramedics to rural stations. Invest in telehealth and virtual supervision. Support volunteer first responders with training and equipment. Ensure equitable access to advanced paramedic practice.¹⁸
4. *Integrate mental health response:* Scale up co-response teams pairing paramedics with mental health professionals and invest in crisis respite facilities. Provide paramedics with specialised training in de-escalation and culturally safe care. Establish clear protocols for when police should assist, ensuring that patient and staff safety are maintained. Recognise that paramedics experience significant psychological trauma when attending suicide callouts¹² and ensure access to support services.
5. *Improve integration and flow:* Ensure robust integration of ambulance clinical governance within the national clinical governance system, rather than under a contracted provider mechanism—similar to

every Australian jurisdiction, including the privately funded Western Australia service. Address ramping by investing in hospital (ward) capacity, community care and rehabilitation services. Implement real-time data sharing between ambulance services and emergency departments to coordinate arrivals and reduce waiting times. Adopt systemwide policies to minimise negative ramping experiences, which are linked to poor mental health among paramedics.¹⁴

6. *Foster innovation*: Support research on and evaluation of new technologies, including artificial intelligence–assisted triage, digital health platforms and mass-casualty response systems. Provide regulatory frameworks for paramedic prescribing and independent decision making consistent

with international best practice.

Conclusion

New Zealand's out-of-hospital care system stands at a crossroads. Recognising ambulance services as an emergency service is essential, but must be accompanied by secure funding, workforce investment, improved rural services, integrated mental health care, system-wide flow improvements and innovation. By supporting paramedics with appropriate training, remuneration and resources, and by harnessing technology and Te Tiriti principles, New Zealand can build a resilient, equitable ambulance service capable of meeting the diverse needs of its communities in the decades ahead.

COMPETING INTERESTS

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