Emergency!

Saving New Zealand's Ambulance Services

Centre for International Corporate Tax Accountability and Research

WORKERS FIRST UNION

A Workers First Union-CICTAR production

CREDITS

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Foreword

Kia ora and welcome to Workers First Union and CICTAR's ***Emergency!*** report.

The following pages contain five key arguments for the full governmental funding of Aotearoa New Zealand's ambulance services, and collectively, they make a compelling case for their public ownership.

Ambulance services in our country are presently provided by two partially charity-funded operators: Hato Hone St John nationally, and in the Wellington and Wairarapa regions, Wellington Free Ambulance. While these two services are committed to delivering reliable life-saving emergency services to New Zealanders, both have struggled with the challenges of constrained political funding, a reliance on charitable giving and patient co-payments to fund aspects of their operations and capital expenditure, and the recruitment and retention difficulties associated with insufficient wage levels and the extremely stressful nature of the work.

The five arguments for full funding and eventual public ownership made in this report are persuasive, but even on the face of it, New Zealand's delivery of emergency medical services is an anomaly among comparable OECD countries, and a strange one. We would not tolerate, for example, the idea that hospital medical care was provided in large part by the State but that one specific group of frontline nurses – say, those who save lives in Emergency Departments only – were privately employed and partially funded by donations to the Salvation Army.

We wouldn't tolerate a scenario where the majority of police officers bargained collectively for wages and conditions while frontline constables were separately employed by St Vincent de Paul and partially resourced by a yearly community donation drive and co-payments received from the victims of crime. It would not make sense, and it would create chaos within the system as a whole.

"We're the lowest-paid emergency service and among the lowest-paid health workers."

- St John ambulance officer

But that is where we have ended up in our emergency medical sector – it is a Victorian-era model that has failed to keep pace with the changing world and the emergency health needs of New Zealanders.

Major troubles lie ahead for our ambulance services, and our union believes - along with the vast majority of New Zealanders - that this model is no longer fit for purpose.

As we outline in this report, five major challenges threaten to irreversibly break the model and jeopardise the resilience of arguably our most vital life-saving health service. They are, in order of the following chapters:

(1) An ageing population that will continue to increase both the number of ambulance callouts and the cost of delivering medical care to those patients;

(2) A vast remuneration and superannuation gap between New Zealand and Australia that accelerates the loss of experienced ambulance officers overseas, and costs the public millions in training costs that are not recouped;

(3) A cost-of-living crisis and demographically shifting charitable giving base that is shrinking the pool of donated income to fund our ambulance services, and increasing the reliance on patient co-payments for treatment received;

(4) A fleet of diesel ambulances whose necessary update to electrification carries a substantial cost that presently cannot be borne by the lightly-capitalised charities who deliver our ambulance services; and

(5) Growing coordination challenges within the health sector that do not take advantage of efficiencies within the system and exacerbate recruitment and retention difficulties between health professions.

All of this serves as a warning and a plea for a fully funded ambulance service that is publicly owned. After all, it could be an issue of life or death.

Anita Rosentreter

Deputy Secretary, Workers First Union

Introduction

New Zealand's emergency ambulance services are facing an unavoidable compounding crisis of growing work intensity, workforce retention and fuel security. Unlike most OECD comparator nations, these core public services are delivered by charitable entities that partly rely on donations to sustain their operations. Already stretched to its limits, that model will be increasingly overrun as our over-65 population doubles over the next four decades, leading to acute cost pressures. Persistent pay disparities with Australia are accelerating the loss of trained ambulance officers, whose education and early career development were largely publicly-funded.

The charitable funding model cannot withstand these mounting pressures.

We are already seeing the prolonged cost of living crisis hollowing out the charitable funding base on which the service depends, as housing, energy, food, and transport absorbs a growing share of household income. This will be compounded by the emerging fuel crisis, which has already exposed the vulnerability of emergency ambulance services to volatile fossil fuel supply chains, underscoring the scale of capital investment required to safeguard these essential frontline services.

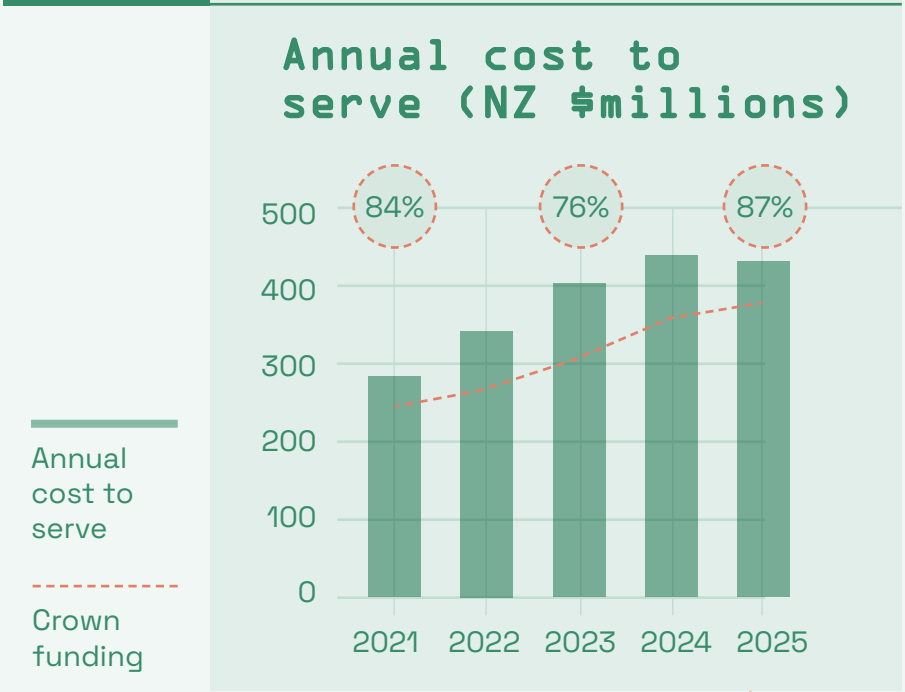
Fleet electrification, depot upgrades, and energy resilience measures demand levels of coordinated, long term investment that lightly capitalised charities simply cannot shoulder. These pressures expose broader, long-running investment deficits that ambulance officers experience daily in ageing vehicles, stretched stations, obsolete equipment, and, of course, chronic staff shortages that highlight how the constraints of the charitable model have already impacted service levels. As long- and short-term cost pressures mount, bringing our emergency ambulance service – the frontline gateway to our public health system – formally within that system, represents a crucial opportunity to address these challenges effectively.

Ambulance funding under consideration.

This question is crucial given ambulance funding is currently under consideration. Emergency ambulance funding is set in four-year funding cycles, with the last budget concluded under the previous Labour government in 2022, and another funding cycle due to begin in July 2026. That agreement covers operational expenditure,

such as labour costs, medical consumables, overheads and the cost of diesel. The last budget included substantial increases to funding,[1] including substantial improvements to ambulance officer remuneration, but much of the benefit of that has now been eaten away by inflation.

Figure 01



The National-NZ First coalition agreement committed to "[r]enegotiate the Crown funding agreement with St John with a view to meet a greater portion of their annualised budget." [2] Crown funding did in fact meet a greater portion of the annualised budget in 2024-25, however this was achieved through cutting costs rather than renegotiating the Crown funding agreement, including millions trimmed from workers' remuneration. Hato Hone St John's "annual cost to serve" declined by $6.7 million (1.6%) while Crown funding increased 4.9%, lifting the public share of costs from 81% to 87%. [3] This was achieved despite a 2.7% increase in emergency incidents and increasing average callout costs. [4] Personnel costs for the emergency ambulance service were cut by $4m, [5] indicating that fiscal pressure was absorbed through a real reduction in labour input and service capacity.

The coalition Government is yet to confirm what its plans are for the next funding cycle. In October 2024, after months of industrial action, Associate Health Minister

Casey Costello announced a $21 million increase to the funding of Hato Hone St John to settle union negotiations. [6] That year, collective negotiations delivered ambulance officers a 4-5% pay increase and an increase in shift penalties, while rejecting proposed "claw-backs" (reductions to existing conditions). Negotiations also delivered lump-sum payments to compensate for industrial action. By April 2026, Minister Costello claimed that Government funding for ambulance services had increased by 47% (~$260m) over the past three years, apparently claiming credit for the previous Government's increases. [7] In the meantime, on 1 July 2025, St John increased their part-charge for the first time in eight years - a 28% jump to $125 - noting that their callout cost had risen to over $1000 per ambulance attendance. [8]

It's hard not to describe this piecemeal approach of holding down labour costs while edging up part-charges as an "ambulance at the bottom of the cliff" that treats symptoms while leaving the underlying investment deficit untouched.

If the Government is serious about safeguarding the sustainability of emergency services in an era of rising demand and higher-risk shocks, it needs to turn the model around, from crisis management to planned public investment. The state is the "economic employer" that sets the funding envelope, and is already undertaking multi-billion dollar infrastructure investments across the health, transport and energy systems. Public ownership aligns responsibility with reality—bringing emergency ambulance services into the public health system so the Crown can fund, finance and plan this essential national infrastructure on the most durable basis, for the public good.

I. Ageing population increases demand

New Zealand has an ageing population, which will bring with it increased cost pressures in funding health and superannuation. The NZ Treasury describes the scale of this demographic change, noting that, "[i]n the 1960s there were seven New Zealanders aged 15–64 for every Kiwi aged over 65. Now there are four, and in 2065 there are projected to be two." [9] Treasury modeling sees healthcare costs increase from 7.1% of GDP to 10% in 2065, while NZ Super rises from 5.1% to 8%. [10]

As the front door to our public health system, our ageing population will also substantially increase pressure on ambulance services. Our over-65 population require ambulances at much higher rates than younger cohorts, and often have more complex conditions that more regularly require transportation. This section uses public data to estimate the total projected cost increase based upon these pressures.

Figure 02 Stats NZ

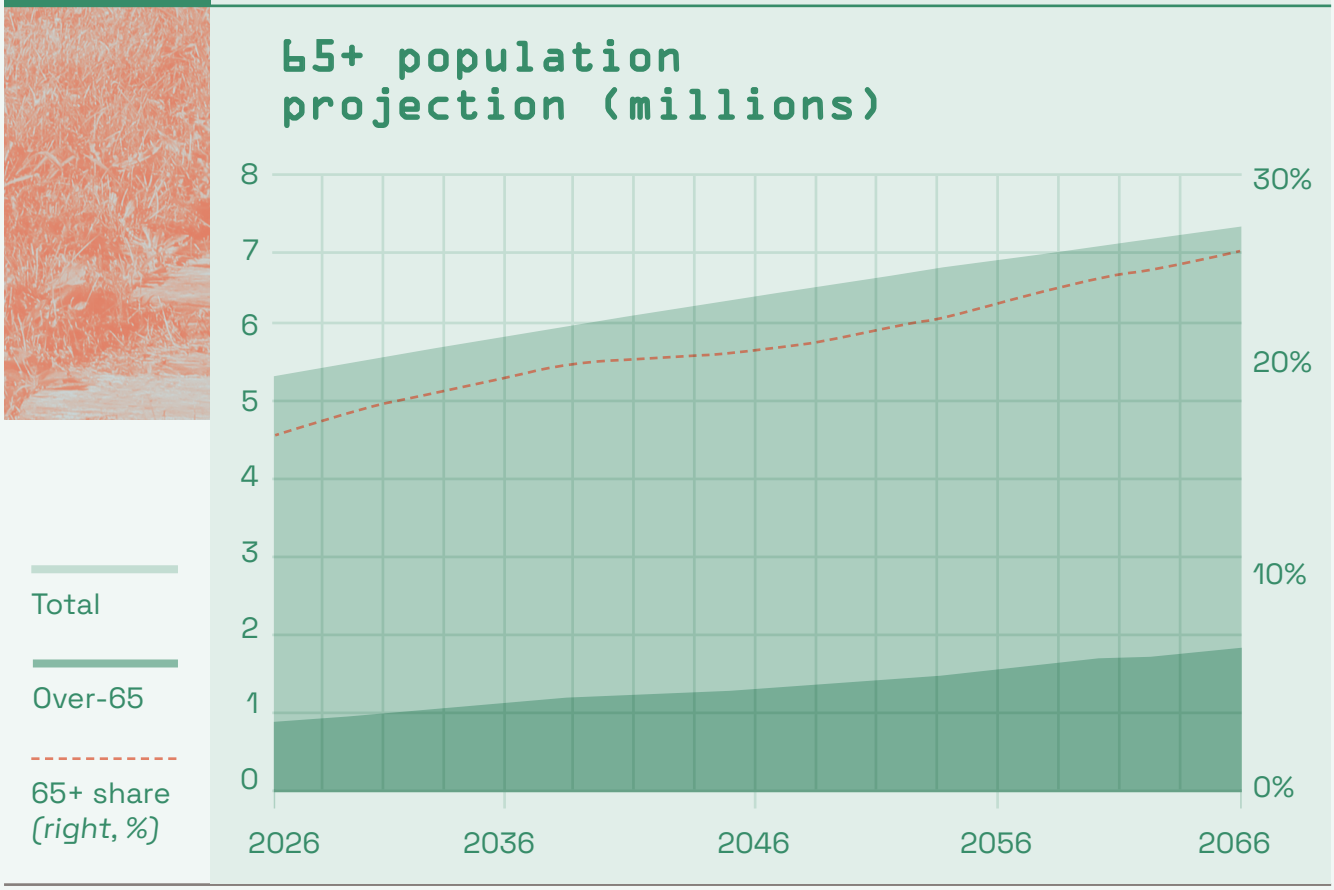
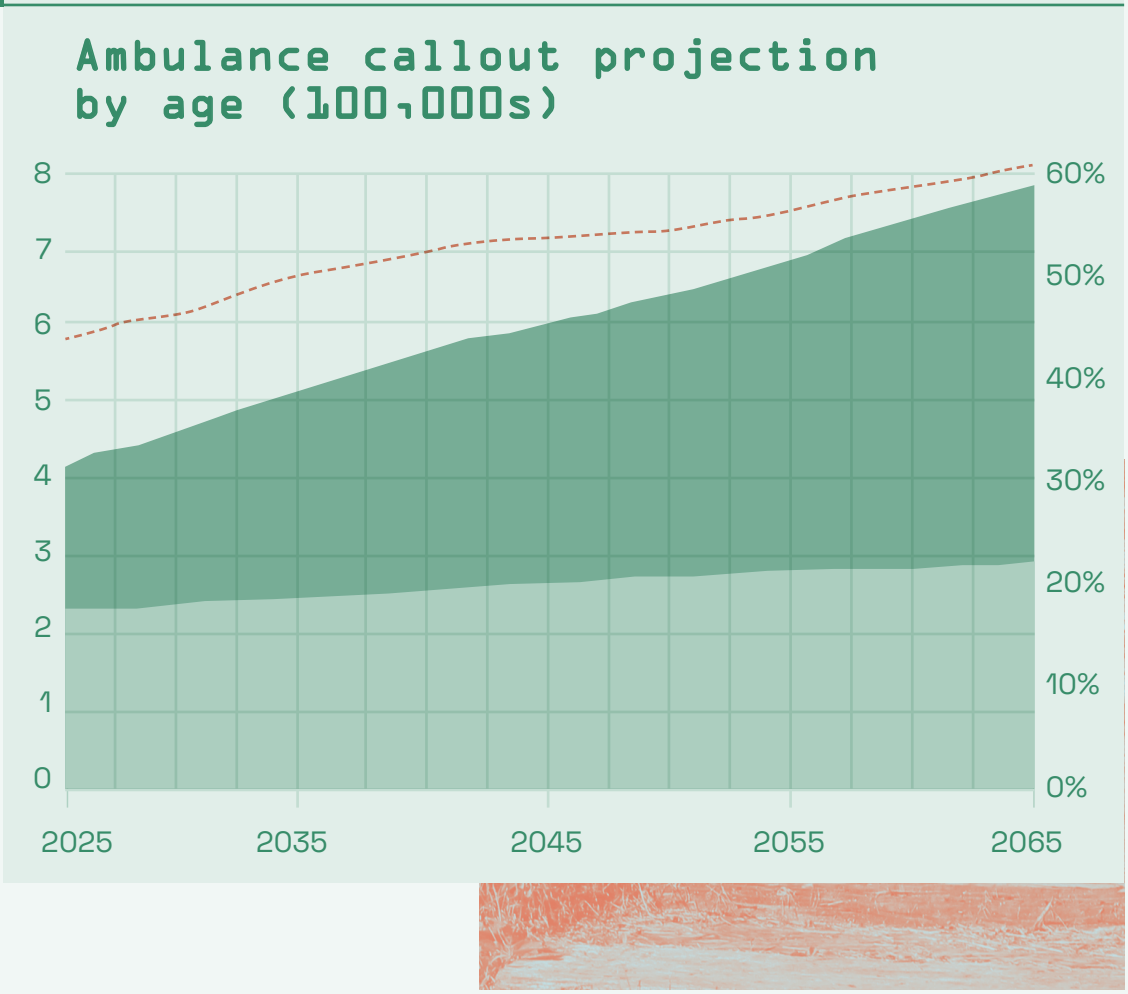


Figure 03 Stats NZ + Ducker et al



The over-65 population in 2065

The NZ population is expected to grow by 1.9 million people by 2065 to 7.3 million people, a 35% increase. [11] By comparison, the over-65 population is expected to grow by almost a million people by 2065 to 2 million over-65s, a 104% increase. This will push over-65s from 17.7% of the total population to 26.1% of the total population. Research from 2020 shows that while over-65s made up only 15.2% of the population in 2019, over-65s accounted for 45.5% of ambulance callouts, while under-65s – who made up 84.8% of the population – accounted for 54.5% of callouts. [12]

In Figure 3 we apply these incidence rates to the Stats NZ population projections out to 2065. According to this projection, ambulance callouts for under 65s increase by 64,469 (21%) to 295,913. Ambulance callouts for over-65s, on the other hand, increase by 291,787 (104 percent) to 485,011. The projection suggests that by 2065, ambulance callouts will reach 780,923, with 26.1 percent of the population accounting for 62.1 percent of the callouts. As a result, while the total population is only expected to grow by 35 percent over the coming four decades, ambulance callouts are expected to grow almost twice as fast, at 61 percent.

These projections are based on a static incidence rate, and there are many factors that may impact them over time. Population growth will likely differ from projections, although it's unclear in which direction. Some factors may decrease ambulance demand, such as medical breakthroughs allowing more conditions to be managed at home, strengthened community and urgent care pathways, alternative response models, or wider adoption of virtual triage systems that divert people away from ambulance callouts when clinically appropriate. Other pressures may increase demand, including a higher incidence of climate-related emergencies, worsening chronic illness patterns, rising injury rates linked to extreme weather or changing work environments, and gaps in primary or after hours care that push more people toward emergency services. While the exact mix of these factors may shift demand trajectories up or down, the general direction of rising demand for ambulance services is clear.

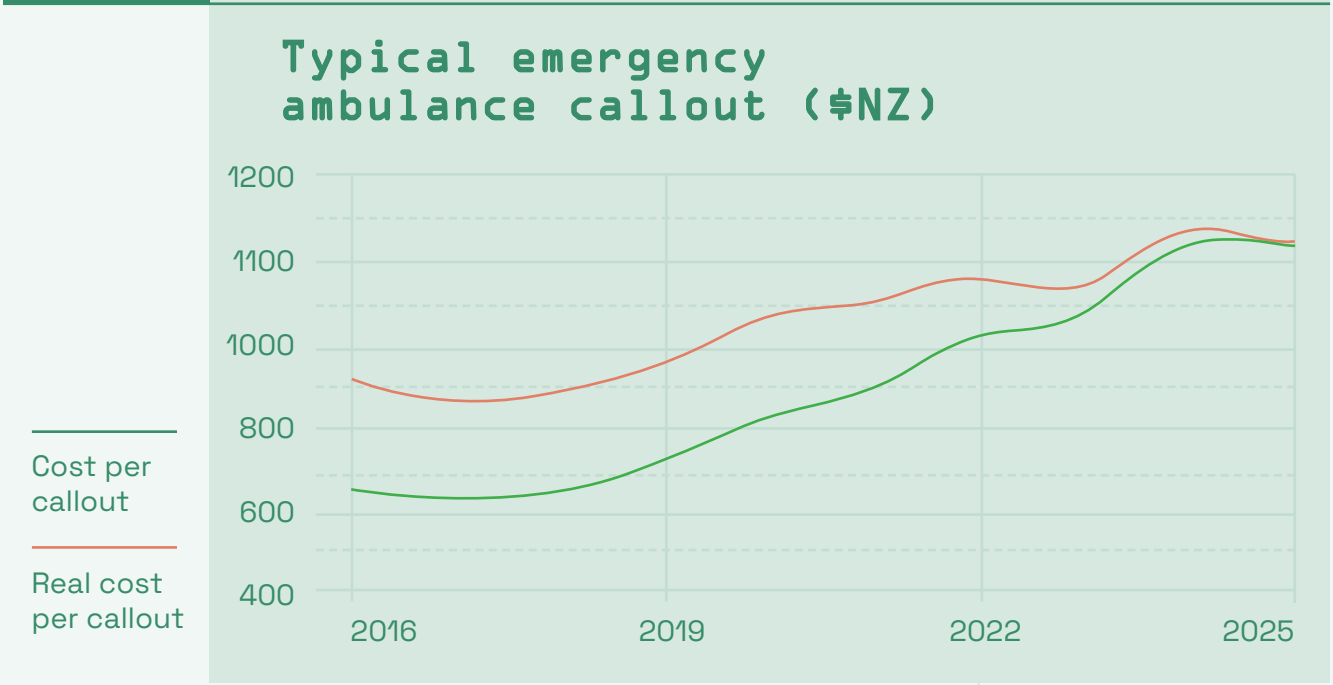
While NZ's population is expected to increase by 35% over the next four decades, more than half of that growth will be in the over-65 population. By 2065 this group will account for nearly two-thirds of ambulance callouts, with the increasing scale and complexity of these callouts leading to an almost 400% increase in the annual cost to serve them.

Callouts for over-65s are also typically more complex and resource-intensive than those for younger patients. They are also more likely to require hospitalisation, resulting in greater travel times and distances. The 2020 paper cited above notes 20% longer on-scene times for over-65s, and a 30% increase in hospitalisation rates. These factors materially increase labour inputs and vehicle utilisation per incident, contributing to higher average callout costs for older patients.

These are likely among the factors that are driving the increase in the typical emergency ambulance callout cost, which we can see

in Figure 4 has increased by 75% in the last decade, from $615 per callout in 2016 to $1074 in 2025. [13] When adjusted for inflation this is a real increase of 31% (in June 2025 dollars). [14] Over the same period, the number of callouts increased by 24% to 455,469 while the population increased by only 13 percent. [15] In other words, ambulance callout cost grew 86% faster than the general population over the last decade.

Figure 04 Hato Hone St John financial statements



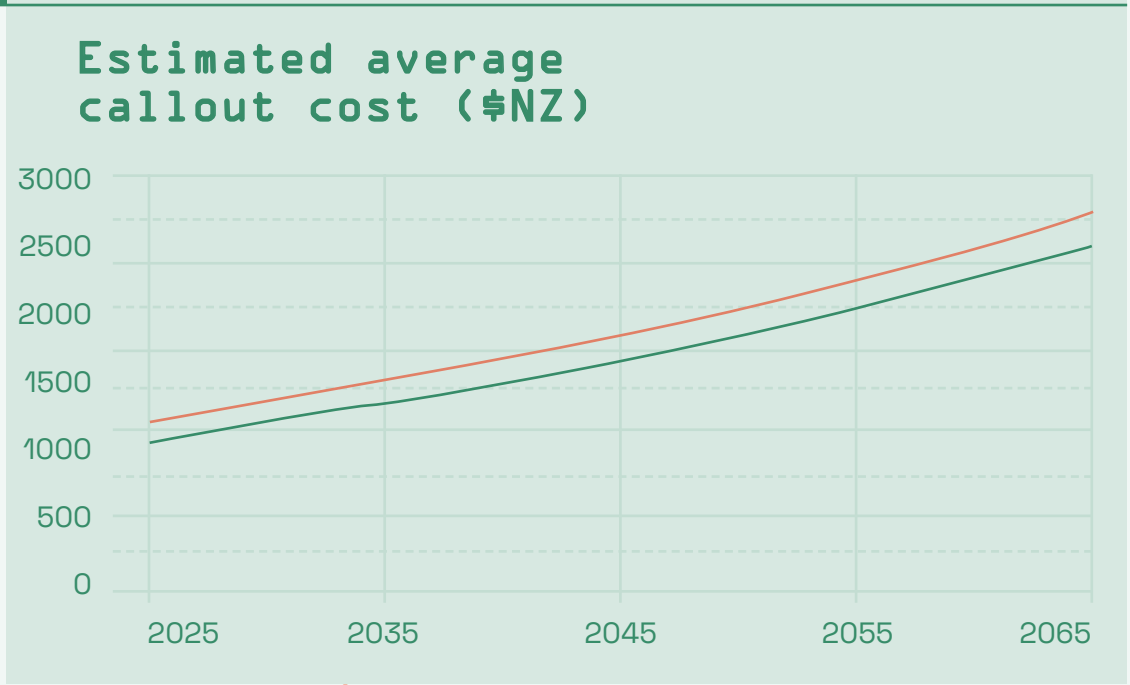
Estimated cost to serve

We can estimate how the projected shift in call-out composition – towards more complex over-65s callouts – will impact the average cost. Using the incidence rates calculated above, we estimate that by 2025, over-65 callouts would have accounted for 48.6% of all callouts. If we assume, for example, that callouts for over-65s require a 30% greater cost (primarily labour cost), then we can apply a 1.3x intensity multiplier to those callouts. This would suggest an average over-65 callout cost of $1218 in 2025, versus an under-65 average callout cost of $937. [16]

Figure 4 inflation-adjusts these estimates. Here we have used projections from the February 2026 RBNZ Monetary Policy

Statement out to 2029, [17] followed by the RBNZ long-term estimate of 2%. [18] According to this calculation, the cost of an ambulance callout for an over-65 will have increased by 122% by 2065, reaching $2708 that year. With over-65s accounting for 62.1% of demand by 2065, we estimate that this will increase the average cost of an ambulance by 130% to $2471 over this period.

Figure 05

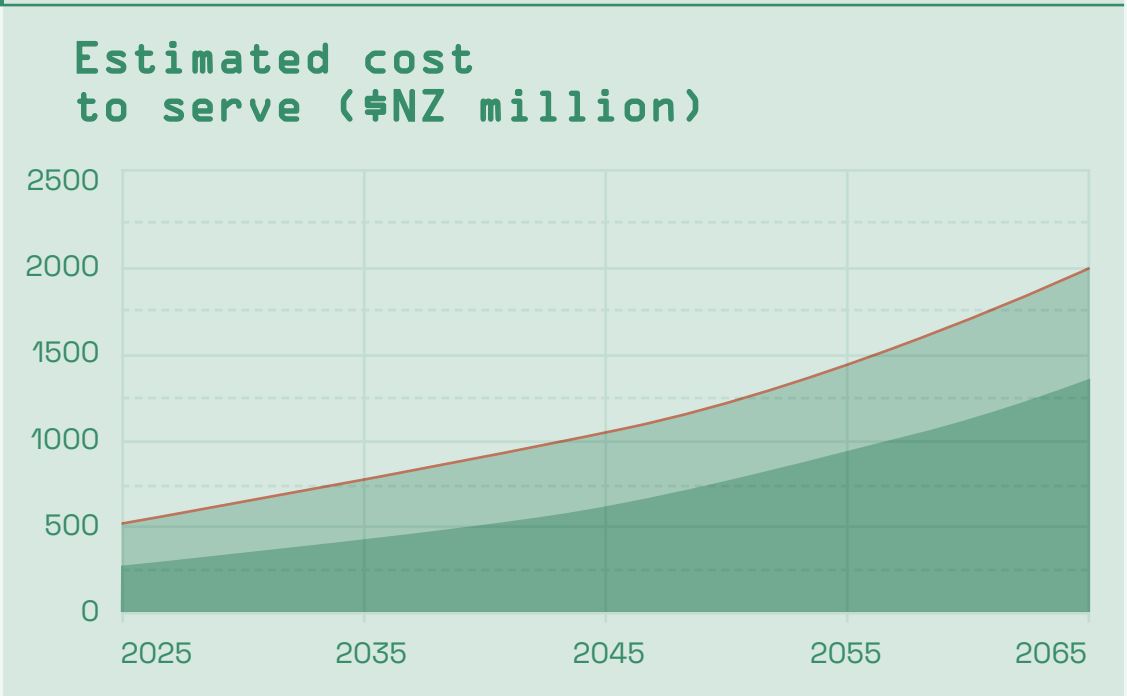


These figures were calculated before the US-Israeli invasion of Iran and the closure of the Strait of Hormuz. At the time of writing, the Minister of Finance had already stated that we will surpass RBNZ and Treasury's current inflation projections. It is unclear how long the conflict will last and how substantial the overall impact on NZ will be. Regardless, in the near-term, NZ inflation was previously expected to be largely driven by domestic factors and moderated by slower international price growth. This is unlikely to be the case in the short-term, with the fuel crisis compounding the effects of domestic inflation, meaning that the above estimates may indeed undercount the total.

Figure 6 uses our calculations of the rising number of ambulance callouts for over-65s, under-65s and across the population, as

well as our calculations of the rising cost of callouts for over-65s, under 65s and across the population, to calculate the national ambulance total cost to serve. The total cost to serve is estimated around $508 million in 2025, with roughly 55% of this cost – $280 million – going towards over-65s. By 2041, the cost to serve the over-65 population doubles, pushing the total cost to serve to $906 million. By 2045, the total cost to serve is expected to pass the $1 billion mark for the first time, at which point 62% – $636 million – goes toward serving the over-65 population.

Figure 06



By 2065, the total cost to serve the population is up 279% to $1.93 billion, with 68% of that – $1.31 billion – required to serve the over-65 population. While the total population of over-65s is expected to increase by 107% by 2065, the total cost to serve that over-65 population will increase at more than three times that rate, with a 368% increase over that period. This increased weight does get shared across a growing total population, but on a per capita basis the total annual cost to serve increases by 178% from 2025 to 2065, reaching $265 per person (up from $95).

In summary, a 35% increase in New Zealand's total population over the next four decades is projected to contribute to more than a tripling of the total annual cost to serve – a worrying illustration of the fiscal pressure that demographic ageing places on our ambulance services.

2. Trans-Tasman pay parity

"Our pay rates versus our daily reality around other people's health don't match. Other employers with less accountability or responsibility have better pay rates."

Section 1 looked at how NZ's ageing population means that a 35% increase in population could result in an almost 400% increase in the cost of ambulance services by 2065. Here we look at the disparity between NZ and Australian ambulance officer remuneration, which, if unaddressed, could serve as a multiplier on those costs.

Already, the persistent loss of ambulance officers to Australia and elsewhere – whose training is largely shouldered by the public purse – implies a poor return on investment. Increasing ambulance officer remuneration is crucial to helping reduce the structural drag imposed by losing trained professionals to Australia. We estimate that the current disparity between NZ and Australia is between 14 and 33 percent, depending on where in Australia they end up. In our view, domestic remuneration is a necessary capital preservation strategy to protect the significant investments already made in clinical training.

We estimate the after-tax Trans-Tasman wage gap at 14–33%, with a substantially more generous, flexible and lightly-taxed super scheme further increasing the financial pull of crossing the ditch. Given each additional 1% of annual attrition translates into roughly $5 million in retraining, supervision, and monitoring costs, we believe closing this gap could serve as an effective cost containment strategy.

The all-in wage gap

Remuneration in NZ is primarily determined through collective bargaining with both Hato Hone St John and Wellington Free Ambulance, which set ambulance officer wages and salaries, penal and overtime rates at or above statutory minimums. In Australia, there are two layers of bargaining, with national awards setting sector-wide minimums, and unions then bargaining enterprise agreements at or above those minima. Different tax systems do narrow this gap somewhat, but the effect is more pronounced at the higher end of the salary scale, meaning the greatest incentive to migrate to Australia is for graduate paramedics.

In Annex 1, we provide a detailed comparison of wage rates across five positions in the 2026 St John multi-employer collective agreement. These positions are compared to rates for equivalent positions in the current Australian ambulance award, as well as the rates in the South Australian ambulance enterprise agreement; currently the highest-paying agreement in Australia. This gives a range of rates from lowest to highest within Australia, and these figures are presented in New Zealand dollars at the current exchange rate. Average penal rates are incorporated, and the figures are adjusted for relevant income tax bands.

Table I: Trans-Tasman after-tax remuneration gap

Role	NZ (HHSJ)*	Australia - Award	South Australia - EA
EMT	$60k – $65k	$73k – $79k *(+21–25%)*	$81k – $87k *(+33–35%)*
Paramedic	$76k – $83k	$89k – $97k *(+17–20%)*	$97k – $107k *(+28–30%)*
ECP/Intensive Care	$97k – $106k	$115k – $126k (+19–21%)	$126k – $140k (+30–33%)

See Annex 1 for further details.

The loaded after-tax figures show that every clinical role within the collective is at least 17% better off on the Australian award rates, whether at the top or bottom of the wage progression. This ranges from 17% for paramedics, with a paramedic in Australia at the top of the scale earning almost $14,000 more in after-tax income than in New Zealand. Entry-level emergency medical

technicians enjoy almost an extra $13,000 in after-tax income in Australia.

These award figures account for the lowest an ambulance officer can be paid in Australia, while the new South Australia enterprise agreement now represents the highest rates in the country. There, we estimate that emergency medical technicians at the top of the scale earn above $20,000 more in after-tax income; 33% more than in New Zealand. An intensive care specialist at the top of the wage scale may earn as much as $140,240 in after-tax income in South Australia; almost $35,000 more than working in New Zealand that year.

Table 2: Superannuation comparison

Role	NZ - KiwiSaver	Australia - Award	South Australia - EA
EMT	~$2.8k – $3.1k	~$9.7k – $10.7k	~$10.6k – $11.6k
Paramedic	~$3.7k – $4.0k	~$12.1k – $13.5k	~$13.3k – $14.7k
ECP/Intensive Care	~$4.9k – $5.4k	~$16.6k – $18.6k	~$18.1k – $20.2k

See Annex 1 for further details.

Ambulance officers moving from NZ to Australia can also take advantage of Australia's substantial employer superannuation contributions, which are almost four times that of NZ Kiwisaver contributions. In New Zealand, employer contributions are typically around 3%, while Australian contributions under both the national award and state enterprise agreements are currently around 11–11.5%. In other words, not only are salaries higher, but contribution rates are substantially higher, resulting in vastly higher superannuation contributions in Australia. Over even a relatively short period of employment, these higher contributions materially widen the total remuneration gap and significantly increase the long-term financial return to working offshore.

The different tax treatment on employer super contributions makes the move even more attractive.

In New Zealand, employer contributions are subject to the Employer Superannuation Contribution Tax (ESCT), which is generally equivalent to the employee's marginal income tax rate. For a senior ambulance officer, this may swallow as much as 33% or 39% of the employer contribution.

In contrast, Australian employer contributions are typically taxed at a concessional rate of 15% for most earners. The lower tax rate ensures a much larger portion of that money remains in the fund to grow.

Under the Trans-Tasman Social Security Agreement, these savings are portable, meaning they can be brought back to New Zealand after a stint working in Australia. These are "ring-fenced" and can be accessed at the Australian preservation age of 60, rather than the standard New Zealand retirement age of 65. This enables ambulance officers to book the benefit of higher contributions while working in Australia, then once they return to NZ, they can collect universal superannuation, supplementing their living costs with their (relatively higher) Australian retirement savings.

While Australia gets the benefit of their income taxes and higher wages during their productive working life, NZ is left to pick up the tab once they stop working.

The public cost of attrition

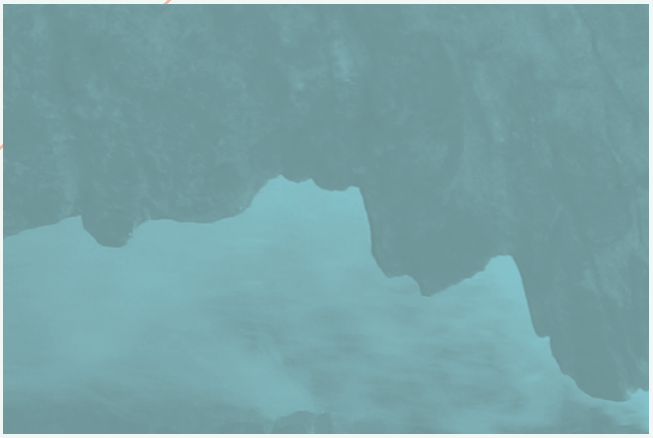
The upfront cost of producing a registered ambulance officer in New Zealand is substantial, and is largely borne by the public purse. Roughly three-quarters of the cost of the three-year Bachelor of Health Science (Paramedic) is funded by the Tertiary Education Commission, which exceeds $22,000 per year. Upon graduation, in Wellington Free Ambulance, for example, a paramedic typically completes a clinical internship that takes around 24 months before gaining their "Authority to Practice". During this period, they receive a full graduate salary but are required to be under constant supervision from a senior clinician. Because they cannot yet exercise independent authority, the service must effectively fund two professional salaries to deliver a single clinical decision-maker. In addition, the senior paramedic must be paid a supervisory allowance, and the unit's operational throughput (i.e. the pace of work) is typically lower, further increasing the effective hourly cost of service delivery during the internship period.

Taken together, the loss of a single early career paramedic represents not just the loss of a trained clinician, but the loss of a substantial public investment made in education, supervision and early professional development.

> We estimate that the public cost of producing and supervising a registered paramedic is almost $150,000 before any independent clinical service is delivered.

This figure represents a weighted average between both St John and Wellington Free Ambulance.

Ongoing attrition functions as a persistent capital drain on the ambulance system, diverting funding towards replacement and oversight rather than building a stable and experienced workforce.



For each percentage point increase in early career attrition, the system incurs the loss of the full upfront investment described above, alongside the ongoing costs of recruitment, supervision, and reduced operational efficiency. Applied across the national workforce, even a 1% annual attrition rate is likely to translate into around $5 million per year in replacement and inefficiency costs, based on the scale of employment [19] and the conservative replacement costs outlined above. If attrition were closer to 5%, the fiscal impact would rise toward $25–30 million annually. These are recurring costs that persist each year workforce instability remains unresolved, representing foregone public value that must be continually re-spent rather than retained within a stable, experienced ambulance workforce.

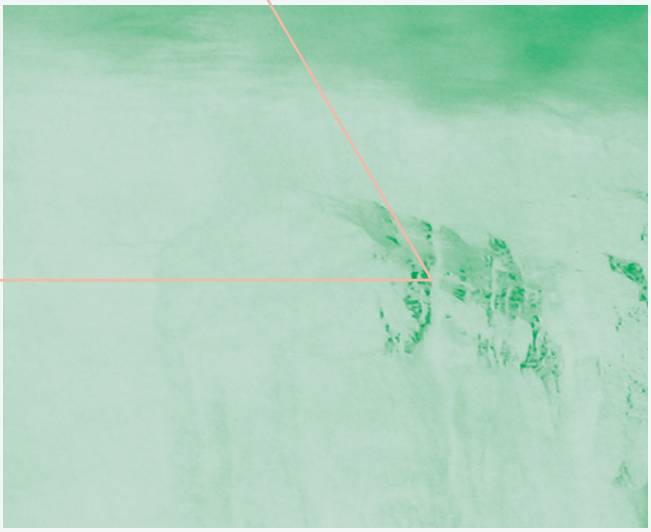
This risk is not evenly distributed across the workforce, but skews towards early- and mid-career ambulance officers, who may face larger proportional pay gaps but also enjoy greater social mobility. Where New Zealand bears the upfront cost of clinical

education, supervision and early career development, Australia's better remuneration means it captures the productivity gains achieved as they develop and mature in their roles.

From a fiscal perspective this represents another systemic leakage of public capital.

Retaining early-career ambulance officers delivers an outsized return on investment, while failure to do so locks us into a cycle of ongoing training, loss and replacement that drives up per-patient costs and undermines workforce stability.

Just as the demographic changes will increase demand on emergency ambulance services, the persistent loss of ambulance officers places heavy training and supervision costs onto the system, reducing throughput, and amplifying per-callout expense. Addressing the Trans-Tasman wage gap is equally focused on fairness, productivity and fiscal prudence: retaining early career ambulance officers preserves public investment, stabilises workforce capability and reduces the need for repeated retraining and replacement. In this way, Trans-Tasman pay parity operates as a cost containment strategy that is designed to keep trained professionals and their skills within our workforce and delivering for our national health system.



3. The collapse in charitable giving

Rising inequality and prolonged cost of living pressures are rapidly eroding the charitable funding base that has historically underpinned New Zealand's ambulance services.

As housing, energy, food, and transport costs absorb a growing share of household income, the surplus that once sustained regular community giving is shrinking, particularly among working age households. At the same time, charitable donations are becoming increasingly concentrated among older and wealthier donors, even as demographic change accelerates demand for ambulance services. The result is a widening structural gap between rising clinical costs and the revenue capacity of a charitable model never intended to support a billion-dollar national emergency service.

Cost-of-living crisis and declining donations

Decades of neoliberal economic policy and rising inequality have steadily eroded the capacity of households to sustain charitable giving. For many Kiwi households, the cost-of-living crisis began decades ago, but surging price increases in the last five years have substantially increased these pressures.

From 2021 to 2025, the consumer price index (the standard measure of inflation) increased by 22%, [20] while the labour cost index (which measures wage growth) increased only 14%. [21] Costs are growing fifty percent faster than wages. And that's if you're lucky enough to have a job. Unemployment has grown every quarter since the government came to power, [22] including large legacy manufacturers across parts of rural New Zealand where there are few other employers.

Figure 07

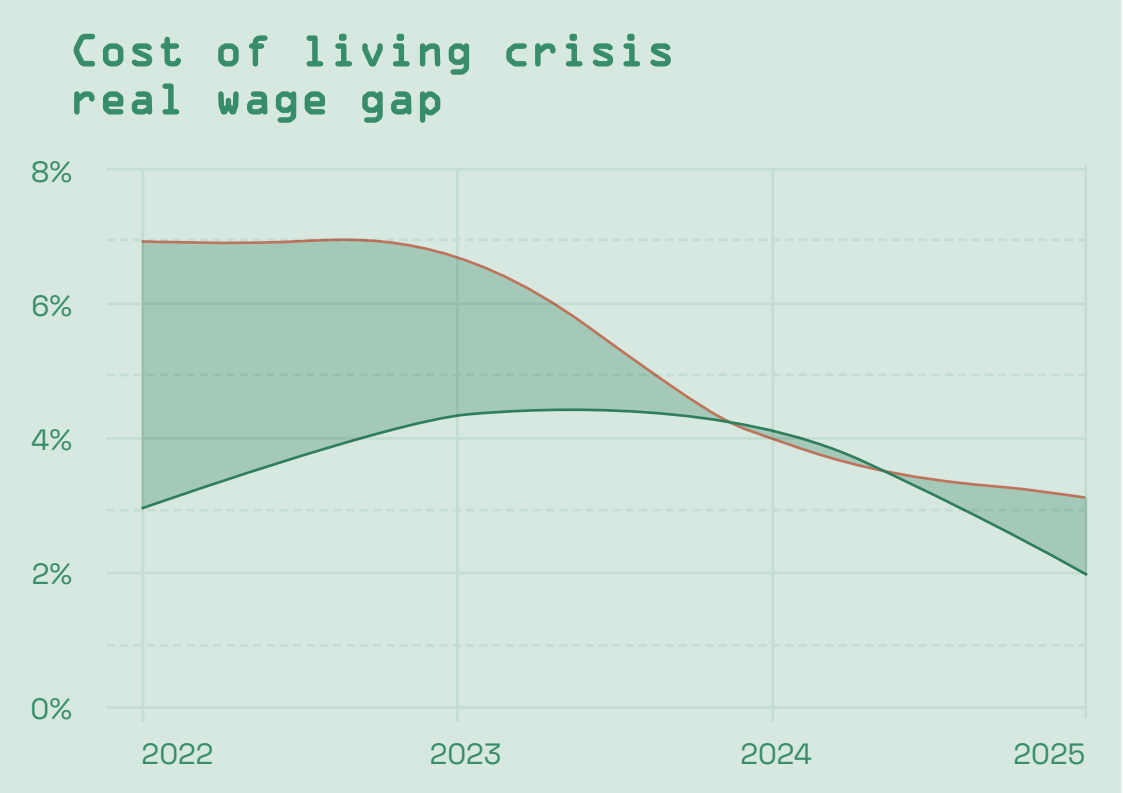
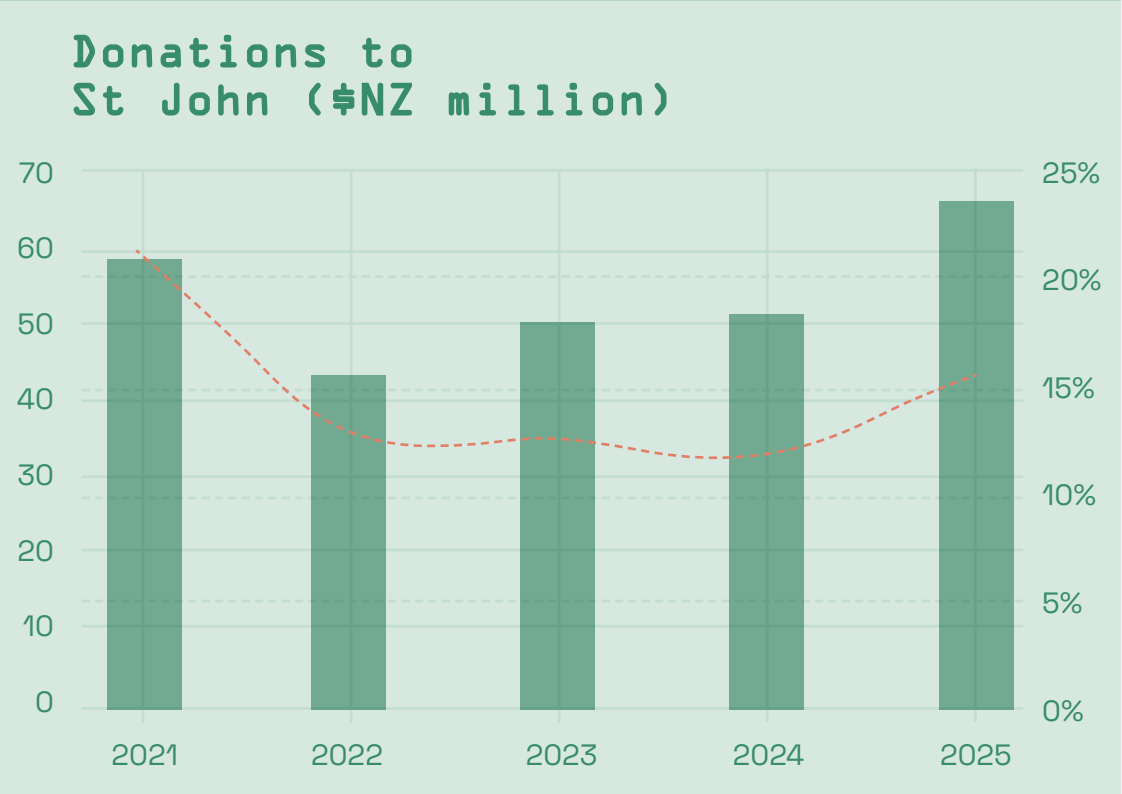


Figure 08



This pressure appears to be reflected in the donations data.

Donations received by Hato Hone St John fell by 25% in 2022, staying below 2021 levels over the next two years. While donations recovered slightly in 2025, they only marginally exceeded 2021 levels, even as service costs continued to rise. While the annual cost to serve declined slightly in 2025, it increased by $154 million between 2021 and 2024, underscoring the widening structural gap between required expenditure and available charitable revenue.

We are concerned that this dynamic will be dramatically exacerbated as second and third order effects from the global fuel crisis ripple through the NZ economy. By late April 2026, Treasury had warned of a new worst-case inflation scenario of 7.4%, in which projected growth rates are slashed and unemployment continues, reaching 6.6% in 2027. [23] The Government has already admitted that it was forced to "rework" parts of the Budget in response to the crisis. [24] Historically, periods of heightened volatility in basic household costs lead to reductions in discretionary spending, with charitable giving typically among the first areas to contract. In this context, the fuel crisis doesn't just raise operating costs for ambulance services; it constrains the possibility of any meaningful increase in community donations.

From charity to co-payment

Charitable donations data also shows a slowdown in giving. Data from the Benchmarking Project shows that while donation levels are holding up, they are increasingly concentrated among a small number of high-net-worth donors. [25] JBWere's 2025 New Zealand Bequest Report highlights that the average age of a regular donor in New Zealand has climbed to 71 years old, and we have a significantly lower rate of bequest participation (1.3%), far below levels seen in the UK or US. [26] As this older generation enters a fixed-income phase, there is no equivalent pipeline of younger donors - who face much higher housing and other costs - to replace them.

By the 2040s, the gap between the rising clinical costs of an ageing population and the available charitable revenue is expected to widen into a permanent shortfall. If participation rates continue to stagnate, the proportion of the ambulance budget covered by public donations will fall to a negligible fraction of the total requirement. Relying on community giving to fund a billion-dollar emergency service is no longer a viable fiscal strategy.

As charitable income has stagnated, the system has adapted not through secure public funding, but through a quiet shift toward increased patient co-payments, a user charge levied at the point of medical crisis. Unlike public funding (or, to a lesser extent, charitable giving) which distributes costs across the community and over time, co-payments concentrate costs on individuals at moments of acute vulnerability, and disproportionately on those least able to absorb sudden financial shocks.

Declining donations, rising operating costs, labour compression, and increasing co-payments are not independent developments, but predictable responses to a system operating beyond the limits of its original design.

Substituting falling donations with higher charges does not resolve this mismatch; it shifts risk onto patients and undermines the principles of universal and timely access that underpin the public health system. The collapse in charitable giving therefore strengthens the case not simply for higher Crown contributions, but for complete integration of the emergency ambulance services within the public health system.

4. Rising fuel crisis prompts ambulance decarbonisation

"The current operational climate is becoming increasingly untenable, as starting a shift trucks down has become a regular occurrence that immediately compromises both staff well-being and patient safety."

Existing electrification trials already showed substantial savings on fuel and maintenance costs; the emerging fuel crisis has amplified these savings, and could also provide substantial resilience benefits. While the scale of investment required to realise these and other benefits is beyond what a thinly-capitalised charity could achieve, public financing could unlock these savings and resilience benefits at lower cost.

The 2026 fuel crisis has raised substantial concerns for the financial sustainability of emergency ambulance services in New Zealand. The national ambulance fleet is fuelled exclusively by diesel, making operating costs highly sensitive to movements in global energy markets. At the time of writing - two months into the conflict - we've already seen the price of diesel almost double, from a pre-war $1.97 per litre to $3.74 before returning to $3.25, [27] placing immediate upward pressure on the cost of keeping ambulances on the road.

At the same time, recent electric ambulance trials in the UK, Australia and now New Zealand, have shown strong results, indicating substantial cost-savings could be achieved across most of the urban fleet. Unlocking these cost savings, however, requires substantial upfront capital expenditure, on a level that a lightly-capitalised charity like Hato Hone St John or Wellington Free Ambulance would be unlikely to be able to achieve. Even if the charitable providers can justify some capital expenditure, it is likely to be slower and more expensive than if the government carried this out directly.

NZ's precarious fuel security

In 2021 Workers First Union representatives met with the then-Minister of Energy, calling for state intervention in the decision to close the Marsden Point refinery to safeguard national fuel security.

We proposed that Government should underwrite refining margins in the short to medium term to guarantee the supply and delivery of emergency and essential services, particularly ambulance services. In the meantime, we called on the Government to undertake a process of decarbonising the emergency services and essential service supply chains so they could continue to operate in the face of a catastrophic disruption to fuel supplies.

The Government rejected this approach, choosing instead to lift minimum stockholding levels through a public diesel reserve. In July 2024, Associate Energy Minister Shane Jones opted instead for an industry-led approach, but gave the industry until 1 July 2028 to comply. The Government has since adopted a hybrid procurement approach.

Electric ambulance trials

A report published in March 2026 compiles insights from the first year of the electric ambulance trial. The ambulance travelled 13,671km to over 500 incidents, avoiding over four tonnes of carbon dioxide equivalent operating emissions. [28] It notes that the ambulance had similar costs of production to an existing internal combustion model, however it proved cheaper to run, with an average $9 saved per day, which was expected to increase over time. [29]

> Services costs were a fraction of internal combustion service costs, and HHSJ predicted over time that maintenance costs would be 50% less than an internal combustion engine. [30]

The next stage of the trial will target cold-weather testing in the South Island, which may also give greater opportunities to review the impact of regenerative braking on energy efficiency and maintenance costs. That trial will also likely show much more substantial cost savings than the Waikato trial due to the almost-doubling of diesel costs over the last two months. While future energy prices remain unpredictable, using April 2026 figures, the cost savings appear to be more like $37.30 per vehicle per day (on a like-for-like basis). [31] If these vehicles were powered by rooftop solar installed at depots, the savings could be even greater.

The Waikato trial was funded by ASB at a cost of $290,000, with ASB's Head of Sustainability, Carrie Gage, commenting

to NZ Stuff that this price was "relatively similar" to a diesel ambulance. [32] The vehicle used was a Ford E-Transit 420L medium-roof height with a compartment layout designed with Action Manufacturing. [33] This is quite a bit smaller than the high-roof Mercedes Sprinter, which is the current standard diesel model widely used in NZ. The trial report notes that the E-Transit "can feel quite cramped in the front, and when treating in the rear compartment it can be challenging with the lack of height and bench space." [34]

This reflects feedback shared among Workers First Union members that while the vehicle drove and handled well, it felt small in both the cab and the back, communication between the cab and the back were limited, there was no aircon in the back, and the vehicle held limited stock, meaning more regular restocking may be required. Officers in the Waikato trial told us they tended to opt for Sprinters over the E-Transit, but that if appropriate electric vehicles that addressed the size and aircon issues could be sourced, they would be happy to adapt, particularly in light of ongoing energy costs and security issues.

UK trials instead opted for the Mercedes E-Sprinter, which has benefits and drawbacks. Like the current diesel Sprinters in use in NZ, the vehicle is larger, but it also has a greater range of up to 350km. This range is supported by a large battery, but that battery increases the weight of the vehicle substantially, reducing its payload capacity. The use of lightweight composite internal construction materials has helped to offset that, but comes with additional cost. It therefore seems likely that the E-Transit was chosen because it met the Metropolitan range requirements at lower cost than the E-Sprinter.

Provided that worker feedback could be adequately addressed, it seems that a mix of both smaller and larger vehicles could meet the needs of most call-outs.

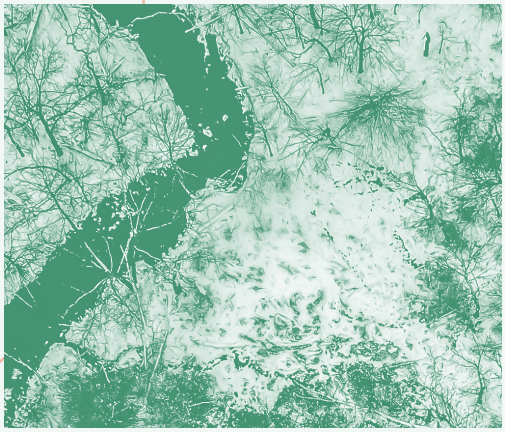
Estimated cost of a national rollout

Electrification of the national ambulance fleet would result in substantial savings in operating expenses. The current national fleet of ambulances – comprising both the Hato Hone St John and Wellington Free Ambulance fleets – numbers approximately 700 frontline ambulance vehicles.

In Annex 2 we estimate the cost of a national electric ambulance rollout at $236.2

million, assuming that half the vehicles are the Ford E-Transit vehicles used in the metropolitan trial, and the other half are the (more expensive) E-Sprinters. We estimate that the charging infrastructure for these vehicles at depots and emergency departments would cost an additional $23.1 million. While adding solar panels and batteries to the depots would further reduce operating cost, we estimate that they would require an additional investment of $40.2 million. Combined, we estimate the cost of electrifying the national ambulance fleet at $259.3 -$300.5 million.

The annual reports of Hato Hone St John and Wellington Free Ambulance both include financial statements, but balance sheet data is presented in a very brief form that does not break out borrowings or debt levels. Liabilities for Hato Hone St John totalled $159 million, of which $71m are lease liabilities, and a substantial proportion are likely employee entitlements (such as holiday pay accruals and long-service leave), while trade payables could account for more. [35] On this basis, we estimate that St John's current debt level is likely somewhere in the order of $25-40 million. Liabilities for Wellington Free Ambulance are only $14.2 million, with no finance costs listed, suggested it could be debt free. [36]



Crown financing represents the most realistic path to executing a rollout of this magnitude without compromising frontline delivery.

Expecting charities that are already struggling with their existing costs to take on a $250-300 million capital expenditure project is fiscally impossible. The Crown balance sheet, on the other hand, could easily absorb this scale of investment, and could do so at much lower borrowing cost than the private sector. The scale of Crown procurement would likely be able to unlock substantial discounts from global manufacturers in the vehicle, charging infrastructure and solar and battery sectors. Not only would fleet electrification result in substantial fuel and maintenance savings today, but these are long-lived assets with returns and savings that accrue over decades.

The Crown could, alternatively, undertake this procurement and financing exercise on the behalf of the current ambulance operators, and then lease the vehicles to

the ambulance operators. However under this approach, the Crown would not only be providing the vast majority of funding for operational expenditure, but would also be providing the financing for capital expenditure.

With the state already engaging at the nexus of national health, national energy and national transport infrastructure, the benefits of retaining the charitable model are diminishing.

Similar procurement issues arose during recent reforms of the bus sector, when the Government considered the question of whether electric buses should be publicly procured and leased to operators, or whether the companies should procure the vehicles themselves. Instead, the bus sector – which is dominated by foreign-owned for-profit multinationals – has proceeded down a private procurement path, not only because of their superior access to capital, but also because the depreciation of these assets can reduce taxable income, generating free cash flow for the company. [37] None of these benefits accrue to a thinly-capitalised charity, for whom a large capital investment programme would present a severe capital risk.

Decarbonisation co-benefits

Lower emissions would bring additional benefits for the Crown.

A frontline diesel ambulance could cover 45,000-60,000 km per year, and because they are heavy vehicles that are often idling and generating auxiliary power for medical equipment, the average ambulance could emit around 40 tonnes of carbon dioxide equivalent annually. Using the CBAx 2026 central shadow price of $135 per tonne, we estimate that electrifying the national fleet could therefore reduce emissions-related fiscal liabilities by up to $3.8 million per year. [38] Current projections see the shadow price figure rising to $185 per year by 2030, which would push the avoided liability up towards $5.2 million per year. [39]

The health benefits of emissions reductions may also feed back into fiscal benefits for the state.

Diesel ambulances that primarily operate in high-density urban areas also have substantial impacts on human health. Recent data shows that motor vehicle pollution is the primary driver of the $15.6 billion in annual social costs associated with carbon emissions, including more than 13,000 hospital admissions and 3,300 premature deaths per year. [40] 2026 modelling suggests that every kilometre driven by a heavy diesel vehicle has a total social cost of $1.15. [41] This is especially relevant for the urban fleets that are often idling or under high-stress cold-started movement through high density urban corridors. Suppose there are 350 urban ambulances that cover 50,000km per year: under this calculation the government saves $20.1 million in social cost per year.

Rising fuel volatility highlights the direct operating cost exposure faced by ambulance providers, and the savings from electrification can be readily calculated at the level of Hato Hone St John or Wellington Free Ambulance. However these latter calculations indicate that the largest benefits of decarbonisation accrue to the public. Reduced emissions lower the Crown's long-term fiscal liability under carbon pricing, while reductions in air pollution generate substantial public health benefits and avoid social costs that sit outside any charitable balance sheet.

These are national gains, captured through improved population health, lower hospitalisation rates, and reduced climate and environmental liabilities.

Electrification therefore exposes a misalignment between who bears the cost of investment and who receives the bulk of the benefit. Bringing ambulance services into public ownership resolves this mismatch by allowing the Crown to finance decarbonisation upfront while internalising the long-term fiscal, health, and environmental returns—further strengthening the case for treating emergency ambulances as core state infrastructure rather than charitable operations.

5. National health infrastructure

Our emergency ambulance services are the frontline - and often the front door - of our public health system. They are the primary point of clinical contact for hundreds of thousands of patients each year and act as the critical gateways to our public emergency departments, hospital admissions, and urgent care pathways. The standard of care they are able to provide with the resources they are allocated directly shapes patient outcomes, hospital congestion, workforce pressures, and system wide costs.

Ambulance officer remuneration is an obvious starting point for return on investment throughout the health system, but the challenges facing the sector – rising demand, workforce attrition, funding instability, and delivery resilience – cannot be addressed in isolation because they are symptoms of a deeper structural misalignment between the service's national importance and its current governance and funding model. Reframing emergency ambulance services as core national health infrastructure is essential to resolving these pressures in a durable and cost-effective way.

Public ownership allows benefits to flow through the system.

Because ambulance services sit at the front door of the health system, decisions made at the point of dispatch and on scene – whether to treat, transport, or escalate – have downstream consequences for emergency departments, hospital admissions, and system congestion. Integrating ambulance services into the public health system enables demand to be better managed coherently across silos. Shared protocols, data integration, and aligned incentives allow for more effective triage and better utilisation of urgent and primary care pathways. These efficiencies lower system wide costs, even

where ambulance operating costs appear unchanged in isolation.

Integration doesn't eliminate the workforce pressures facing health services more broadly, but it does allow these challenges to be confronted in a coordinated, whole-of-system way rather than in isolation. Workforce planning, remuneration structures, and career pathways can be better aligned across the sector, supported by integrated forecasting across the health system. This reduces competition between services, limits labour churn, and allows experience and clinical capability to be retained where it delivers the greatest system-wide value. In a context of rising clinical complexity and constrained labour supply, retaining and deploying experience efficiently becomes a core cost containment strategy.

"I love this job, I love learning, helping people and teaching others. I saw myself doing this forever but despite everything I've put into it, it's not going to be my last career anymore. You put so much effort in reassuring people, reducing their pain, explaining their complex health conditions, convincing them that hospital is where they need to be, only for them to die in the waiting room…"

Importantly, public ownership allows us to consider system-wide challenges more coherently.

The fuel crisis and challenge of electrification highlight the constraint of the charity model to make large long-lived investments, even when those investment decrease costs over the long-term. Emergency ambulance services already require substantial ongoing capital investment just to maintain their existing facilities and assets, not to mention the cost of financing new vehicles, depots, charging infrastructure, ICT systems, and medical equipment.

Public ownership enables the Crown to finance these assets at significantly lower cost, coordinate national procurement, and standardise systems; reducing duplication, lowering unit costs, and accelerating the transitions that would otherwise be delayed or foregone due to balance sheet constraints. Electrification is just one challenge, and future challenges could include the application of new mobile medical and surgical technologies that further embed our national health system within the emergency ambulance service. As with hospitals, roads, and energy networks, the scale and risk profile of ambulance infrastructure strongly favours public financing.

Annex I

Calculating the Trans-Tasman wage gap

Hato Hone St John (NZ) rate					Australian award rate				*Difference*		South Australia rate			*Difference*	
NZ role	**Level**	**Base rate**	**Avg loading**	**After-tax**	**AU role**	**Base rate**	**Avg loading**	**After-tax**	**$**	**%**	**Base rate**	**Avg loading**	**After-tax**	**$**	**%**
EMA/PTO*	Entry	63,934	70,327	56,001	Patient	74,800	88,264	67,820	*11,819*	*21*	83,120	98,082	74,484	*18,483*	*33*
	Ceiling	69,688	76,657	60,432	Transp. Officer	81,532	96,208	73,212	*12,780*	*21*	90,650	106,967	80,503	*20,071*	*33*
Emergency	Entry	69,245	76,170	60,091	Amb. Transport	81,200	95,816	72,946	*12,855*	*21*	91,400	107,852	81,104	*21,013*	*35*
Medical Tech	Ceiling	76,417	84,059	65,372	Attendant	88,835	104,825	79,052	*13,680*	*21*	99,230	117,091	86,983	*21,611*	*33*
Paramedic	Entry	91,436	100,580	76,013	Qualified	101,200	119,416	88,561	*12,548*	*17*	112,850	133,163	97,117	*21,104*	*28*
	Ceiling	100,906	110,997	83,047	Paramedic	112,663	132,942	96,938	*13,891*	*17*	126,420	149,176	106,535	*23,488*	*28*
ECP/CCP**	Entry	121,670	133,837	97,019	Intensive care/	138,700	163,666	115,134	*18,115*	*19*	155,100	183,018	126,628	*29,609*	*31*
	Ceiling	134,272	147,699	105,744	MICA Paramedic	154,800	182,664	126,410	*20,666*	*20*	174,150	205,497	140,240	*34,496*	*33*
Dispatcher	Entry	71,715	78,887	61,993	Communications	78,500	92,630	70,782	*87,89*	*14*	88,100	103,958	78,464	*16,471*	*27*
	Ceiling	86,907	95,598	73,016	Officer	94,721	111,771	83,493	*10,477*	*14*	107,350	126,673	92,729	*19,713*	*27*

All rates in NZD

The base rate comparison is presented in New Zealand Dollars and assumes a current (May 2026) exchange rate in which NZ$1 buys AU$0.82.

*EMA/PTS = Emergency Medical Assistant / Patient Transfer Officer

**ECP/CCP = Extended Care Paramedic / Critical Care Paramedic

Annex I

Calculating the Trans-Tasman wage gap, cont.

The Australian award rate sets legal minima that all employers throughout Australia must comply with. This is the lowest an ambulance officer can get paid in the country. The highest enterprise rates are in the South Australia ambulance enterprise agreement. [38]

The loading calculations presumes 40% of shifts are at penal rates. In NZ, all loading is at 25%. In Australia, afternoon/evening loading is calculated at 15%, with Saturdays at 50% and Sundays and public holidays at 100%.

After-tax income is calculated using the relevant income tax rates in New Zealand and Australia, as well as ACC at 1.6% in New Zealand and Medicare at 2% in Australia.

The following table estimates current employer annual superannuation contributions. These figures are net of tax.

NZ role	Level	NZ KiwiSaver	AU Award	SA EA	*Difference*
EMA/PTO	Entry	2,557	8,976	9,762	*7,205*
	Ceiling	2,788	9,784	10,673	*7,885*
Emergency	Entry	2,770	9,744	10,584	*7,814*
Medical Tech	Ceiling	3,057	10,660	11,622	*8,565*
Paramedic	Entry	3,657	12,144	13,250	*9,593*
	Ceiling	4,036	13,520	14,652	*10,616*
ECP/CCP	Entry	4,867	16,644	18,054	*13,187*
	Ceiling	5,371	18,576	20,188	*14,817*
Dispatcher	Entry	2,869	9,420	10,250	*7,381*
	Ceiling	3,476	11,367	12,343	*8,867*

All rates in NZD

Annex 2 Estimating the cost of a national rollout

The below tables estimate the cost of a nationwide rollout of electric ambulances (1) and charging infrastructure (2). These estimates assume that ambulance officers are happy with the E-Transit, which likely relies on the air conditioning issues being sorted. A rollout of only E-Sprinters would require greater investment in charging infrastructure as well as larger solar arrays and batteries.

1. Vehicle capex

Vehicle	Role	Estimated unit cost	Quantity	*Total capex*
Ford E-Transit	Metropolitan/High-intensity	$290,000 (based on ASB trial)	350	$101.5 million
Mercedes eSprinter	Regional/Long-range	$385,000 (estimated)	350	$134.7 million
All costs in NZD			700	*$236.2 million*

2. Charging infrastructure

Infrastructure	Role	Unit/site cost	Quantity	*Total capex*
Depot network	Every HHSJ and WFA base station	$85,000	215	$18.3 million
Hospital network	Health NZ Emergency Departments	$120,000	40	$4.8 million
All costs in NZD			255	*$23.1 million*

Annex 2 Estimating the cost of a national rollout cont.

At (3) we estimate the cost of adding rooftop solar and battery storage to depots. This would not be required but would ensure sovereign resilience in the case of disruption. These estimates assume that no roof strengthening is required, however given the age of a lot of depots it is not clear that this would be the case.

Additionally, a full-eSprinter rollout would mean much larger batteries to charge and therefore would likely require larger solar arrays. These would put substantially greater strain on depot roofs, which themselves may not be large enough. These questions would have to be addressed on a case-by-case basis, but may be better addressed through the construction of solar carport structures.

3. Rooftop solar

Component	Role	Unit cost	Quantity	*Total capex*
Solar Array (50kW)	Daytime energy harvesting	$80,000	215	$17.2 million
BESS Battery (150kWh)	Night-time energy storage	$95,000	215	$20.4 million
Hybrid Inverters	Off-grid/Grid-tie Management	$12,000	215	$2.6 million
All costs in NZD				*$40.2 million*

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[14] Calculated used Infoshare dataset CPI009AA.

[15] See Note 15.

[16] These are average figures, and the 65-year-old cut-off is somewhat arbitrary. Of course, a 64-year-old likely has a more similar health profile to a 65-year-old than to a 25-year-old.

[17] "Monetary Policy Statement February 2026 data" (18 February 2026) *Reserve Bank of New Zealand. Te Putea Matua*. https://www.rbnz.govt.nz/-/media/project/sites/rbnz/files/publications/monetary-policy-statements/2026/feb-180226/mpsfeb26-data.xlsx

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[29] The 13,671km traveled over the one-year trial averages to 37.5km per day, which is probably quite a bit less than an average metropolitan ambulance

travels in a day, let alone in a rural region. It is unclear whether the $9 saving was calculated on the basis of the relatively limited daily travel or otherwise.

[30] Ibid., p17.

[31] This figure assumes daily usage of 120km per vehicle. Diesel is priced at $3.51 per litre, while electricity is priced $0.23 per kWh (this assumes that 80% of charging is on a night rate of $0.20 per kWh and 20% is at a day rate of $0.39 per kWh). Vehicle efficiency numbers are taken from the HHSJ trial report, which recorded 32.9kWh per 100km and a fleet standard of 11.1L per 100km. p23. Maintenance and the cost of road user-charges have been excluded from this calculation.

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[33] Note 31, p8.

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[35] Annual report 2024/25, pp 31 and 36. https://www.stjohn.org.nz/globalassets/documents/hato-hone-st-john-annual-report-2025_lq.pdf

[36] Impact report 2024/25, pp 25 and 26. https://issuu.com/wellingtonfreeambulance/docs/annual_impact_report_2024_-_2025?ff

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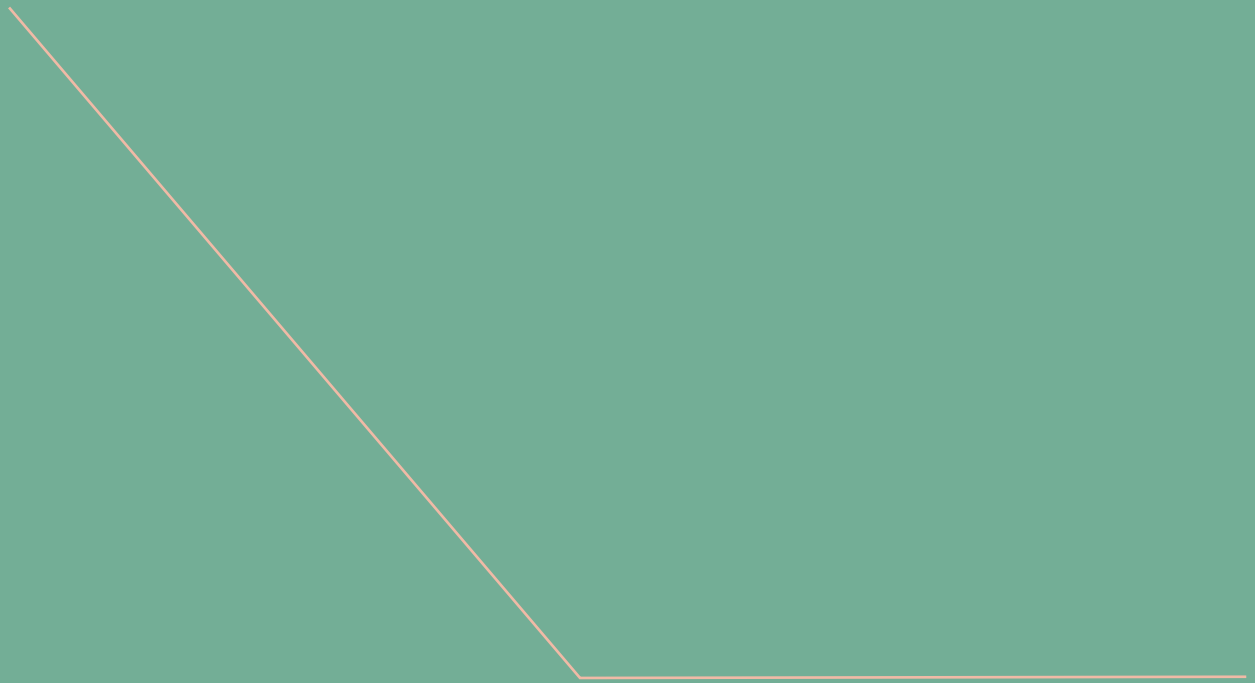

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