EMS Public Advocacy Council EMSPAC

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Establishing the New York City Department of Emergency Medical Services

A White Paper on Restructuring Emergency Medical Services in New York City

EMS Public Advocacy Council (EMSPAC)

Steering Committee

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A note on data. Figures in this paper come primarily from public sources: the NYC Comptroller's October 16, 2026 report *A System Under Strain*, the Mayor's Management Report, the NYC Independent Budget Office, the Citizens Budget Commission, FDNY rulemaking records, and reporting by trade and local press. Where a figure comes from unpublished field estimates — including those of the EMS Public Advocacy Council (EMSPAC) — the text says so, and Appendix C lists them for verification. City fiscal years run July 1 to June 30 (FY 2026 = July 2025 – June 2026).

Executive Summary

New York City should establish an independent Department of Emergency Medical Services (NYC DEMS) — a third public safety service alongside the FDNY and NYPD — with its own commissioner, budget, workforce structure and systemwide authority over every ambulance that answers a 911 call. Thirty years after EMS was folded into the Fire Department, the system is failing on the measures that matter most to patients: how fast help arrives, how experienced the responders are, and whether there will be enough of them next year.

The problem in five numbers

Measure	Figure	Source
Increase in FDNY ambulance response time to life-threatening emergencies, FY 2015 – FY 2026	+3 min 50 sec (+41%)	NYC Comptroller, Oct. 2026
EMS share of all FDNY emergency responses	More than 75%	NYC Comptroller
EMS share of FDNY personnel	Less than one-third	NYC Comptroller
EMTs who left their title in FY 2026	More than 500 (19.5% of headcount)	NYC Comptroller
Base pay gap after 5.5 years, EMT vs. firefighter	$68,700 vs. $105,146	NYC Comptroller

In FY 2026, according to the Comptroller, response times to life-threatening emergencies took nearly as long as *non*-life-threatening emergencies did in FY 2015. On January 8, 2026, the FDNY had 360 ambulances in service against a daily target of 488 and a fleet roster of 651. The EMS workforce has been without a contract since July 29, 2022.

Why structure is the root cause

The symptoms — slow responses, attrition, low pay, a shrinking hospital-based fleet — share a common cause: EMS has no institution whose sole purpose is to advance it.

- **Within the FDNY, EMS is a pipeline, not a profession.** The promotional exam to firefighter is the main route to higher pay. In FY 2026, 58% of EMT departures were to the firefighter title. The median EMT stays 3.8 years in title; the median firefighter, 8.1.
- **EMS has no budget of its own.** EMS generated about $254 million in revenue in FY 2026 against roughly $434 million in costs, but that revenue flows into the general fund rather than an EMS account that can be planned, protected and reinvested.

- **The system is fragmented.** Roughly one-third of 911 ambulance tours are run by voluntary hospitals that can reduce or withdraw them for financial reasons, leaving the FDNY to backfill. More than 70 agencies deploy ambulances under a patchwork of standards.
- **Clinical governance sits outside government.** Protocols, paramedic credentialing and certificate-of-need decisions are made by a state-designated not-for-profit regional council rather than by an accountable city authority.

EMSPAC's proposal

1. **Create NYC DEMS** as a mayoral agency by local law, absorbing FDNY EMS personnel, ambulances, stations, the EMS Academy, EMS dispatch and EMS-specific budget lines, with full protection of seniority, pay, pensions and bargaining rights.
2. **Give EMS its own budget** that separates the cost of 24/7 readiness from per-patient reimbursement, dedicates EMS revenue to EMS, and adds diversified funding.
3. **Set one standard for every provider** — municipal, hospital, commercial and volunteer — on dispatch, staffing, equipment, uniforms, data reporting, safety and minimum compensation.
4. **Integrate the system on a defined timeline**: municipal operations first, then hospital-based 911 units, while regulating commercial providers and holding all volunteer agencies to the same standards.
5. **Build a real career.** Pay parity with uniformed services, uniformed status, a citywide EMS Academy linked to CUNY degrees from associate to master's level, and a clinical ladder that rewards staying in medicine.
6. **Consolidate clinical governance** under a DEMS Office of the Medical Director, working within New York State Public Health Law Article 30, and seek the state legislative changes needed to bring regional council functions under public accountability.

What it will take

The Comptroller estimates that bringing EMS pay to firefighter parity would cost about $289 million a year, net of raises already budgeted. City Hall's budget office has estimated that a standalone department would add about $25 million a year in administrative costs. Against this, EMS overtime has doubled since FY 2015 to $69.6 million, training costs have quadrupled to more than $62 million, and every departing EMT costs about $41,000 to replace and every paramedic about $130,000. A stable, experienced workforce is the cheapest EMS system New York can buy.

The ask

The City Council should pass legislation establishing the Department of Emergency Medical Services; the Mayor should sign it and settle a contract that recognizes EMS as a uniformed service; and the State should align Article 30 so a city EMS authority can govern the system it pays for. Vote YES for the Department of EMS.

Part I — The Crisis in New York City EMS

New York City's emergency medical system is getting slower, thinner and less experienced every year, and the trend has outlasted three mayors, four fire commissioners and a pandemic. This section lays out the evidence.

1.1 Demand: medicine is now the Fire Department's main job

The FDNY is the nation's largest fire department, but its daily work is overwhelmingly medical. EMS responses account for more than 75% of all FDNY emergency responses, according to the NYC Comptroller. The Citizens Budget Commission found the same pattern a decade ago: of 1.2 million FDNY incidents in 2014, 75% were medical and only 5% were fire-related.

The mix keeps shifting toward medicine. Between FY 2015 and FY 2026:

- FDNY ambulance-handled medical responses rose 11%, from 1.03 million to 1.14 million.
- Life-threatening medical emergencies (Segments 1–3) rose 22.9%; non-life-threatening rose 2.5%.
- Fire company responses to life-threatening medical calls rose 28.4%, while responses to fires fell 11.1%.
- Life-threatening medical calls now make up 53.4% of all fire company responses.

The Mayor's Management Report, which counts incidents more broadly, recorded about 1.6 million total medical incidents in FY 2026. By any measure, the City's emergency response system is a medical system that happens to be administered by a fire department.

1.2 Response times: a decade of decline

Response times have risen at nearly every stage of the 911 process. The Comptroller's analysis of NYC Open Data found:

Measure, FY 2015 → FY 2026	Change
FDNY ambulance response, life-threatening emergencies	+3 min 50 sec (+41%)
FDNY ambulance response, non-life-threatening emergencies	+14 min 49 sec (+107%)
Fire company response to structural fires	4:52 → 5:06 (under +5%)
Fire company response to medical emergencies	+70.3%
Average end-to-end response, life-threatening, FY 2026 (ambulance and fire company alike)	13 min 9 sec

The contrast in that table is the heart of the argument. Fire response, which the Department was built to deliver, has held almost steady. Medical response, which is now most of its work, has deteriorated sharply. The largest contributors are the **dispatch** and **travel** segments — the time it takes to find a free ambulance and get it there. Both are functions of how many staffed units are on the street.

The NYC Independent Budget Office reached the same conclusion in March 2026 in its decade review of medical response times, which covers both FDNY and non-FDNY ambulances.

These are not abstractions. In December 2023, 24-year-old Nick Costello died of cardiac arrest in the Bronx after waiting 19 minutes for an ambulance, a case reporting attributed to a combination of outdated dispatch, staffing shortages and too few ambulances. Every minute of delay in a cardiac arrest reduces the chance of survival.

1.3 Supply: not enough ambulances on the street

The City cannot respond faster than its staffed ambulance count allows. The Comptroller reports:

- On **January 8, 2026**, the FDNY had **360** ambulances in service — more than 100 below its daily target of 488 and nearly 300 below its fleet roster of 651.
- From July 2021 through January 2026, the Department averaged **372** ambulances in service per day.
- In spring 2026, the daily target was cut from 488 to **332** — a reduction of more than 150 ambulances, for reasons the Comptroller describes as unclear.
- By September 14, 2026, 416 ambulances were in service: above the lowered target, still well below the original.

The binding constraint is people. An ambulance without two certified crew members is a parked vehicle. Paramedic headcount is roughly where it was in FY 2015, even though life-threatening calls — the calls that require paramedics — have risen by more than 20%.

1.4 The workforce is leaving

Indicator	EMTs	Paramedics	Firefighters
Headcount, end of FY 2026	2,540	900	8,170
Average annual departure rate from title, FY 2019–26	15.4%	12.3%	6.6%
Median years in title, June 2026	3.8	5.4	8.1

Indicator	EMTs	Paramedics	Firefighters
Share with under five years in title	62%	54%	—

From FY 2019 to FY 2026, about 4,300 EMTs and paramedics left their titles — roughly the same number of firefighters who left, even though firefighters outnumber EMS clinicians more than two to one. In FY 2026 more than 500 EMTs departed, 19.5% of the year's average headcount, the highest rate on record. EMS Local 2507 told the City Council in 2026 that as many as 1,500 members were projected to quit, and that some members were living in homeless shelters (Firehouse).

Experience matters clinically. Studies cited by the Comptroller found survival improves once EMTs have more than four years of experience, and that each additional year of experience for the lead medic in ventricular fibrillation cases was associated with about a 2% increase in the likelihood of survival. New York is systematically replacing experienced clinicians with new ones.

1.5 Pay: the lowest-paid first responders in the city

Title	Starting salary	Base after 5.5 years	Growth, hire to year 5
EMT	$43,932	$68,700	56%
Paramedic	$58,088	$86,348	49%
Sanitation worker	$47,752	~$95,300	100%
Firefighter	$54,122	$105,146	94%
Police officer	$55,942	over $100,000	95%
Correction officer	$56,838	over $100,000	92%

Source: NYC Comptroller, salaries as of October 15, 2026. EMS figures reflect 2022 wage levels because Local 2507 has been without a contract since July 29, 2022.

EMTs have the lowest starting salary of any City-employed first responder or uniformed worker, and the gap widens with experience. A paramedic — a clinician with 1,200 to 1,800 hours of advanced training who intubates, administers medications and reads cardiac rhythms — earns less after five years than a sanitation worker.

1.6 The private and hospital safety net is fraying

Roughly one-third of 911 ambulance tours are staffed by voluntary hospitals and other non-FDNY providers that operate without City funding. When their finances tighten, they cut tours, and the FDNY must backfill.

- In June 2019, the FDNY reported 1,266 daily EMS tours: 844 FDNY and 422 non-FDNY.

- In 2026, Richmond University Medical Center on Staten Island announced it would take two 911 ambulances out of service entirely for financial reasons, following an earlier cut to an overnight tour (EMS1).
- Northwell's Lenox Hill Hospital has cut 911 ambulances and EMS staff; Staten Island University Hospital now runs four 911 ambulances versus five a decade ago.
- Field reports from EMS advocates, including EMSPAC, indicate further reductions: five Northwell-affiliated units cut in the past year (one in Staten Island, one in Queens, three in Manhattan), six NewYork-Presbyterian night tours cut in July 2026, and uncertainty over the long-term status of Maimonides' 19 units following its integration into the public hospital system.

The outlook is worse. The Greater New York Hospital Association and the Healthcare Association of New York State estimate that federal cuts under H.R. 1 (the One Big Beautiful Bill Act) will remove about $8 billion a year from New York hospitals when fully implemented — about 7% of their operating revenue (GNYHA testimony). Hospitals facing cuts of that size will look hard at money-losing services, and 911 ambulances are an obvious target.

1.7 What the evidence adds up to

Demand is rising and shifting toward the most serious calls. Supply is constrained by a workforce that leaves faster than it can be trained. The private third of the system is shrinking. Every one of these trends lands on the same unit — the ambulance — and none of them is managed by an institution whose first job is EMS. The rest of this paper explains why that is the root problem, and how to fix it.

Part II — How We Got Here: Thirty Years Inside the Fire Department

New York did not arrive at its current EMS structure by design. It arrived through a sequence of administrative decisions — each defensible on its own terms — that left the profession without a home of its own. Understanding that history matters because it shows that the current arrangement is a choice, and choices can be revisited.

2.1 A hospital-based origin (1869–1969)

New York was a pioneer in emergency medical care. One of the nation's first municipal ambulance services began at Bellevue Hospital in 1869, using horse-drawn wagons stocked with tourniquets, bandages and splints. The two original Bellevue ambulances answered more than 1,400 calls in their first year, before the telephone existed, according to the Comptroller's history. After the 1898 consolidation of the five boroughs, public hospital services were unified under the Department of Hospitals in 1929.

For its first century, New York's ambulance service was understood as an extension of the hospital — medicine that traveled to the patient.

2.2 The professional era under Health and Hospitals (1969–1996)

The New York City Health and Hospitals Corporation (HHC) was created in 1969 and took over municipal ambulance operations. Over the next quarter century, the field professionalized nationally: the federal EMS Systems Act of 1973, standardized EMT and paramedic curricula, centralized dispatch and the shift from transport to pre-hospital treatment. NYC EMS, operating under HHC, dispatched both its own ambulances and voluntary hospital units in a coordinated 911 system.

In 1976, the State designated the Regional Emergency Medical Services Council of New York City (REMSCO) under Article 30 of the Public Health Law to coordinate regional EMS, with its Regional Emergency Medical Advisory Committee (REMAC) setting protocols (NYC REMSCO).

During this period, NYC EMS had its own identity: its own uniforms (green and white), its own leadership and a mission defined entirely by medicine. Veterans of that era recall that its members carried badges and were treated as a uniformed service.

2.3 The 1996 merger

On March 17, 1996, Mayor Rudolph Giuliani's administration transferred NYC EMS from HHC to the FDNY. The stated goals were better coordination between ambulances and the growing number of fire units responding to medical calls, faster response times

and administrative efficiency (NYC IBO). The merger made the FDNY the largest fire-based EMS provider in the country.

Many EMS members experienced it differently. Current FDNY Commissioner Lillian Bonsignore — the first former EMS member to lead the Department — has described the merger as viewed at the time as a hostile takeover, and later as "less of a merger and more of a fold in" (EMS1). The green and white uniforms were replaced with FDNY blue. Ambulance markings changed from NYC EMS to FDNY.

Critically, **EMS members retained civilian status** and stayed in the NYC Employees' Retirement System rather than joining the uniformed fire pension and union structure. That classification decision, made in 1996, still drives the pay gap today.

2.4 Thirty years of partial fixes

Since the merger, the City has responded to EMS problems with incremental measures rather than structural change:

Year	Measure	Effect
2001	Local Law 19 lets EMS unions bargain wages, overtime and leave like uniformed workers	EMS still receives mostly civilian-pattern raises
2016	Fly-car pilot in the Bronx: paramedic SUVs instead of fire engines on some calls	Limited scope
2018	CBC's *Reviving EMS* calls for fewer fire engine medical responses and more ambulances	Recommendations largely unadopted
2020	City Council unanimously passes a resolution supporting EMS pay parity	Non-binding
2021	B-HEARD mental health teams launched	Useful, narrow
2024	Intro 521 to create a Department of EMS introduced	Not passed before the Council term ended
2026	Ambulance billing rates raised up to 42%; daily ambulance target cut to 332	Revenue up, service target down

None of these addressed the underlying arrangement: an EMS workforce that is the majority of the Department's work, a minority of its people and a small share of its budget, managed by an institution whose culture, leadership and career ladder are built around firefighting.

2.5 The promotional exam: an exit built into the system

The single most telling feature of the post-merger structure is the Promotion to Firefighter exam. Offered roughly every four years to EMTs, paramedics, fire inspectors and dispatchers with at least four years of service, it is the primary path to higher pay within the FDNY.

The exam serves real goals. It has been an important pipeline for diversifying the firefighter ranks, which as of October 2025 were 68% white and 2% women, while EMS was 64% people of color and 26% women. But for EMS as a clinical service, it is a built-in exit:

- After the 2016 and 2023 exams (lists of 1,483 and 1,813 candidates), transfers from EMS to firefighter spiked in FY 2019, FY 2025 and FY 2026.
- In FY 2026, 58% of EMT departures and 45% of paramedic departures went to the firefighter title.
- Once promoted, a former paramedic need only maintain a Certified First Responder credential. The City's investment of $41,000 per EMT and $130,000 per paramedic in training is, in the Comptroller's word, underutilized.

The concern is clear: the exam attracts people into EMS who do not want a career in health care, and it guarantees a steady loss of experienced clinicians. An agency that wanted to build a medical profession would not design its best career incentive as a way out of medicine.

2.6 The lesson

The merger was justified by coordination. Coordination between ambulances and engines matters, and it can be achieved through joint dispatch, mutual aid and shared incident command — as it is in every city with a separate EMS agency. What the merger could not do is give EMS an institution of its own. Thirty years on, the results are clear enough to reconsider the choice.

Part III — EMS as a Public Good

Emergency medical services should be recognized, funded and governed as an essential public service — like police and fire protection — rather than judged mainly by the revenue each ambulance transport produces. This is not only a moral claim. It follows from basic public-finance economics.

3.1 The economics of a public good

Economists define a *pure public good* by two properties:

- **Non-excludability**: once the service exists, it is impractical or unacceptable to exclude people from it based on ability to pay.
- **Non-rivalry**: one person's benefit does not reduce what is available to others.

EMS readiness fits both. When someone calls 911, access to an ambulance does not depend on insurance, income or immigration status. And the main thing a city buys when it funds EMS is not a ride — it is *availability*: a staffed, equipped unit positioned to reach anyone within minutes, 24 hours a day. Every resident benefits from that availability whether or not they ever call, in the same way every resident benefits from a firehouse down the street.

Individual ambulance responses can, of course, become rival at the margin: when every unit is busy, the next caller waits. That is precisely why readiness must be funded as a public good. A market that paid only per transport would systematically under-provide spare capacity — which is the capacity that matters in a cardiac arrest, a mass-casualty event or a pandemic surge.

3.2 Why markets under-provide EMS

Three features of emergency care make private provision fall short of what society wants:

1. **Patients cannot shop.** An unconscious stroke patient cannot compare prices or decline service. Normal market discipline does not apply.
2. **Benefits spill over.** Fast EMS reduces death and disability, preserves workforce productivity, prevents more expensive downstream hospital care and protects the whole community's confidence that help will come. Those benefits accrue to society, not to whoever pays the bill.
3. **Costs are fixed; revenue is variable.** Personnel, vehicles, communications, training, medical oversight and geographic coverage must be maintained around the clock regardless of how many patients are transported. Revenue arrives only when a patient is treated or transported, at rates set largely by Medicare and Medicaid.

The result is predictable: a provider that depends on transport revenue will chase high-reimbursement transports and shed low-margin coverage. That is exactly what New York sees as voluntary hospitals withdraw 911 tours when their finances tighten.

3.3 "There is no money in 911" — and why that framing misleads

It is often said that 911 ambulance work loses money. Measured narrowly, against reimbursement alone, it does: FDNY EMS cost about $434 million in FY 2026 and generated about $254 million in revenue, according to the Comptroller. Medicare pays $517 and Medicaid $250 for a basic life support transport that the FDNY bills at $1,793.

But the framing misses where the value goes. The ambulance is the front door to the hospital. For hospitals, the financial benefit of running 911 ambulances flows mainly from the patients those units bring to their emergency departments and admit — patients who might otherwise go elsewhere, as the IBO has noted. An emergency department visit can generate bills of several thousand dollars; a high-acuity admission for a stroke or heart attack can run to tens of thousands. Here, the revenue generated downstream from a single high-acuity patient can rival the monthly operating cost of an ambulance unit.

This is also why roughly 70 agencies deploy ambulances in New York City. If there were truly no money in emergency medicine, there would be no competition to provide it. The money is real; it is simply captured by the hospital and insurer side of the system, while the cost of readiness falls on the public side.

3.4 Measuring EMS by the value it creates

If EMS is a public good, its performance should be measured the way other public safety services are measured — by outcomes, equity and readiness, not only by transports billed. A DEMS should report on:

- **Clinical outcomes**: survival from out-of-hospital cardiac arrest, stroke and STEMI time-to-treatment, trauma outcomes.
- **Equity**: response times and outcomes by neighborhood, borough and income.
- **Readiness**: unit-hours available against demand, by hour and geography.
- **System value**: avoided emergency department visits through treatment-in-place and alternative destinations, and downstream health care costs avoided.
- **Workforce stability**: retention, experience mix and training investment preserved.

Response times and transport volume remain important. But they cannot by themselves tell the City whether it is getting good medicine for its money.

3.5 What follows for structure

Police and fire protection are housed in dedicated departments with dedicated budgets because government has accepted responsibility for their availability. EMS meets the same test. Recognizing it as an essential public service means giving it the same institutional standing: a department, a budget line, leadership accountable for its outcomes, and a workforce classified as what it is — uniformed public safety.

Part IV — The Structural Problem: A Fragmented System

New York's emergency medical response is not one system but several, stitched together by a shared dispatch center. Authority over EMS is split among the FDNY, voluntary hospitals, commercial operators, volunteer agencies, a state-designated not-for-profit council and the State Department of Health. No one entity is responsible for the whole, and no one entity exists to advance EMS as a profession.

4.1 Who answers a 911 medical call today

Sector	Role in the 911 system	Funding	Who sets its standards
FDNY EMS	About two-thirds of 911 ambulance tours; runs EMS dispatch for the whole city	City tax levy plus billing revenue	FDNY, REMAC protocols, NYS DOH
Voluntary hospital EMS	About one-third of 911 tours, under agreements with the FDNY	Hospital budgets; no City funding	Each hospital, REMAC, NYS DOH
Commercial ambulance companies	Subcontracted 911 tours for some hospitals; interfacility transport; events and construction sites	Contracts and billing	Each company, REMSCO certificate of need, NYS DOH
Volunteer ambulance corps	Neighborhood and community response, mostly outside 911 dispatch	Donations	Each corps, REMSCO, NYS DOH
FDNY fire companies	First response to many life-threatening calls (CFR level)	City tax levy	FDNY

Sources: NYC Comptroller; NYC REMSCO. EMS advocates at EMSPAC estimate that the current split of 911 calls is about 60% FDNY, 30% hospital-based and 10% commercial providers subcontracted to hospitals, and that hospital, private and volunteer units together handle 5,500 to 6,000 calls a day — more than 35% of daily volume — plus several hundred more outside the 911 system.

4.2 Seventy agencies, many rulebooks

By EMSPAC's count, about 70 EMS deploying agencies operate in the city across the municipal, hospital, commercial and volunteer sectors. They wear different uniforms, carry different equipment, pay different wages and operate under different employment and safety rules. The only things they reliably share are the REMAC protocols and the FDNY dispatch system.

That fragmentation has costs that fall on patients and workers alike:

- **Wages are held down.** When the same work is done by many employers, no one employer sets the market, and bargaining power is spread across many small units.
- **Quality varies.** Turnover in the lowest-paying sectors produces an inexperienced, transient workforce.
- **Accountability is diffuse.** When response times rise, each sector can point at the others.
- **Capacity is fragile.** When a private operator fails, the system loses capacity overnight. In 2016, when the commercial operator TransCare filed for bankruptcy, the City lost 27 ambulances and 81 daily tours in the Bronx and Manhattan at once and had to activate an emergency contingency plan (FDNY).

4.3 The voluntary hospital dependency

Hospital participation in 911 is voluntary. Hospitals join because the units bring patients to their emergency departments, and they leave when the numbers stop working. When they leave, the FDNY must fill the gap.

FDNY EMS Chief Michael Fields told the City Council in November 2024 that private hospital partners had removed “a handful or even up to a dozen” daily ambulance tours at a time, and that each withdrawal strains the rest of the system (City Council testimony). The FY 2025 budget added 25 daily FDNY tours, at $9.4 million a year, partly to cover such gaps.

This means that a core public safety function — whether an ambulance is available in a given neighborhood tonight — depends in part on the financial decisions of private institutions. The availability of emergency care should not depend on whether a hospital finds ambulances profitable this quarter.

4.4 Clinical governance outside government

Under Article 30 of the New York State Public Health Law, the Regional Emergency Medical Services Council of New York City — a 501(c)(3) not-for-profit — coordinates EMS in the five boroughs. Its Regional Emergency Medical Advisory Committee develops treatment and transport protocols and credentials every paramedic in the city. The council also makes determinations of public need for new ambulance services — the certificate-of-need process (NYS DOH).

These are important functions, and REMSCO and REMAC are staffed by dedicated clinicians. The structural concern is accountability. Decisions that shape what care New Yorkers receive, who may practice and who may operate ambulances are made by a private, membership-based body whose stakeholders include the hospitals and agencies it regulates, rather than by a public authority answerable to the Mayor, the Council and voters.

4.5 Dispatch and the over-use of fire companies

New York's dispatch system up-triages many calls and sends fire companies to a large share of life-threatening medical emergencies. In FY 2026, fire companies responded to 38.7% of life-threatening medical calls, and those calls made up 53.4% of all fire company runs.

Fire companies arrive quickly from 218 firehouses, and early CPR and defibrillation save lives in cardiac arrest. But firefighters in New York need only a Certified First Responder credential — 50 to 60 hours of training outside the FDNY, versus 480 for an EMT and 1,200 to 1,800 for a paramedic. They cannot start an IV, administer most medications, interpret a cardiac monitor or transport a patient.

The Citizens Budget Commission estimated in 2018 that a fire engine response to a medical incident cost about $1,970, compared with $486 for an ambulance run, and that staffing one engine costs about $7.2 million a year. It recommended dispatching engines to medical calls only when they are likely to arrive first and add clinical value. Those recommendations remain largely unadopted. Meanwhile, the Comptroller notes that in FY 2026 average fire company response times to medical emergencies were no faster than ambulance times.

4.6 The FDNY's own model is unusual

Among the largest U.S. cities, the FDNY is unique. According to the Comptroller, the eight most populous cities after New York all require firefighters to remain EMT-certified so they can respond fully to medical calls. New York has neither a cross-trained fire-medic model nor an independent EMS agency. It has two separately credentialed workforces, unequally paid, inside one department organized around the smaller of its two missions.

This paper argues for the independent-agency model (Part VII). But the larger point is that New York's status quo is not a recognized best practice. It is an accident of history.

4.7 Summary of structural failures

1. EMS has no institution whose sole mission is EMS.
2. EMS has no budget it controls or revenue it keeps.
3. A third of 911 capacity depends on voluntary private participation.
4. Standards, pay and safety vary across about 70 agencies.
5. Clinical governance rests with a not-for-profit rather than an accountable public authority.
6. Dispatch relies on costly fire units with limited medical capability.
7. The main career incentive for EMS clinicians leads out of medicine.

Part V — Financing an Essential Service

EMS needs its own budget, its own revenue and a financing model built around the true cost of being ready, not just the price of a ride. Today EMS is a line inside a $2.7 billion fire department budget, its billing revenue goes to the general fund, and its funding rises and falls with decisions made for the Department as a whole.

5.1 Where the money goes today

Item	FY 2015	FY 2026	Change
FDNY EMS expenses	$258M	~$435M	+68%
— Personnel services	$230M	$395M	+70%
— Overtime	$34.5M	$69.6M	+102%
— Training for new EMTs	$15M	$62M+	+300%
FDNY EMS revenue	$160M	$254M	+59%
City tax levy needed to cover the gap	~$98M	~$180M	—

Source: NYC Comptroller. FY 2026 figures are preliminary.

The FDNY's FY 2027 adopted budget is $2.72 billion, of which fire extinguishment and emergency response takes 70%. EMS — more than 75% of the Department's emergency responses — accounts for roughly 16% of spending. Put simply: three-quarters of the calls, about one-sixth of the money. The Citizens Budget Commission found the same imbalance in 2015, when EMS was 13% of the budget.

Two features of the EMS budget stand out. First, the fastest-growing costs are the costs of churn: overtime and training. Second, those costs rose even as headcount grew, which means the City is spending more to stand still.

5.2 Billing: rates up, reimbursement flat

The FDNY raised its ambulance charges effective July 1, 2026 (FDNY rule 3 RCNY §8400-02):

Service	Before (May 2023)	From July 1, 2026	2026 Medicare	2026 Medicaid
BLS transport	$1,385	$1,793	$517	$250
BLS treatment in place	$630	$896	—	—
ALS Level 1 transport	$1,680	$2,196	$614	$296
ALS Level 2 transport	$1,692	$2,212	$889	$429

Service	Before (May 2023)	From July 1, 2026	2026 Medicare	2026 Medicaid
ALS treatment in place	$1,050	$1,098	—	—
Mileage, per mile	$20	$20	$9	$3
Oxygen	$66	$66	—	—

Medicare and Medicaid cover more than half of EMS patients and pay a fraction of the charge. Private insurance (about 25% of patients in FY 2019) and self-pay (about 20%) are billed at FDNY rates, so rate increases fall mostly on commercial insurers and on uninsured patients, subject to the FDNY's charitable care policy. The BLS charge has risen 155% since 2012.

EMS Local 2507 President Oren Barzilay warned when the increase was proposed that the new revenue would go to the FDNY budget rather than to EMS (ABC7). Under the current structure he is right: nothing requires EMS revenue to be spent on EMS.

5.3 The unrealized Medicaid supplement

In FY 2021, New York State asked federal regulators to allow public EMS agencies to receive supplemental Medicaid payments based on the actual cost of service, through a Certified Public Expenditure (CPE) program. The City booked $128 million a year in anticipated federal revenue. The application is still pending. Each year since, the City's budget office has replaced the missing revenue with City tax dollars — $210 million in FY 2022, $190 million in FY 2023, $150 million in FY 2024, $144 million in FY 2025 and $146 million in FY 2026 — before finally removing the assumption in May 2026.

A dedicated EMS agency with a dedicated finance office would have a single mission in pursuing this money, and a clear stake in the result.

5.4 The core design principle: separate readiness from encounters

The central weakness of transport-based financing is that it pays for encounters while the main cost is readiness. An ambulance staffed for a 24-hour day costs nearly the same whether it carries one patient or twelve. A sustainable model should split the budget into two parts:

1. **Readiness budget (public appropriation).** The fixed cost of maintaining coverage — unit-hours, stations, dispatch, training, medical direction, preparedness and reserve capacity for surges — funded by City appropriation as a public good, with a multiyear commitment.
2. **Encounter revenue (billing).** Reimbursement for treatment and transport, collected from insurers and dedicated by law to an EMS revenue fund for capital replacement, workforce investment and clinical programs.

This mirrors how many third-service and public-utility EMS systems are financed and makes the City's choices transparent: the Council would vote on how much readiness it wants to buy, and residents could see what that buys in response times and outcomes.

5.5 Revenue diversification

A department that depends mainly on reimbursement is exposed to changes in Medicare and Medicaid policy, payer mix and transport volume. Those risks are growing: the Commonwealth Fund found the uninsured rate among working-age adults rose from 8.9% in 2024 to 11.2% in 2026 (EMS1), and H.R. 1 is expected to remove coverage from hundreds of thousands of New York City residents. The City should evaluate a portfolio of legally authorized sources:

Source	Mechanism	Notes
Dedicated EMS revenue fund	Local law requiring all EMS billing revenue to fund EMS	Highest priority; no new tax
Medicaid CPE or intergovernmental transfer	Pursue pending federal approval; explore alternatives	Potentially $100M+ a year
Treat-in-place and alternate destination reimbursement	Bill for care that avoids unnecessary ED visits	Rates now in the FDNY schedule
Community paramedicine contracts	Payments from health plans and hospitals for post-discharge visits and chronic care	Common in third-service systems
Event and facility standby fees	Charge large venues and events for dedicated EMS coverage	Removes subsidy of private events
Alcohol-related public health assessment	A modest levy on alcohol distribution or licensed sales, dedicated to EMS	See 5.6
Health system contribution	Contributions from hospitals that benefit from 911 patient flow but do not staff units	Requires negotiation or state action

5.6 An alcohol-related public health assessment

EMSPAC estimates that at least 1,000 of the roughly 5,500 daily calls handled by non-FDNY providers relate to excessive alcohol consumption. That figure is an advocate estimate rather than a published statistic, and a DEMS research bureau should measure it rigorously. But the principle is sound and widely used in public health: activities that impose predictable costs on public services can be asked to help pay for them.

New York already taxes alcohol at the state level, and any new levy would require state authorization. A narrow assessment on distributors or licensed sales, dedicated to EMS readiness and alcohol-related intervention programs, is worth serious study. Opponents

will argue it burdens hospitality businesses that are still recovering, and that cost should be weighed against the scale of the public burden.

5.7 What parity and an independent department cost

Item	Estimate	Source
Firefighter pay parity plus uniformed raise pattern, net of budgeted raises	~$289M a year (FY 2027); $1.23B for FY 2023–27	Comptroller
Private-hospital wage benchmark, net	~$98M a year (FY 2027); $352M for FY 2023–27	Comptroller
22.5-year retirement for EMS (S7916)	~$31M a year	NYC Office of the Actuary, via Comptroller
Additional administrative cost of a standalone department	~$25M a year	Mayor's Office of Management and Budget, per Crain's

The City Council's fiscal impact statement for the 2024 bill estimated negligible new cost, because funding would transfer from the FDNY; the budget office disagreed. The truth depends on design. A department that duplicates every FDNY support office will cost more. One that shares back-office services with other City agencies during transition and draws its leadership from the existing EMS command can keep the added cost modest.

5.8 The cost of doing nothing

The status quo has its own price. Overtime has doubled. Training costs have quadrupled. Each EMT who leaves costs about $41,000 to replace and each paramedic about $130,000. The Comptroller notes that some parity costs could be offset by lower overtime and training needs. And every minute of added response time has a cost measured in lives and lasting disability that never appears in the budget. A financially responsible EMS system treats workforce stability as an investment that pays for itself.

Part VI — The Workforce: Retention as Infrastructure

The most important asset in any EMS system is an experienced clinician who stays. New York's current structure is built to lose them. A Department of EMS must treat workforce stability as infrastructure — something to be built, maintained and measured — rather than accepting turnover as a cost of doing business.

6.1 The economics of turnover

Every EMT or paramedic who leaves takes with them institutional knowledge, clinical judgment and public money. The Comptroller reports that it costs about $41,000 to train a new EMT and $130,000 to train a paramedic. At FY 2026 attrition levels — more than 500 EMTs alone — replacement training for departing EMTs represents more than $20 million a year before counting paramedics, recruitment, overtime to cover vacancies or the slower, less experienced care that results.

High turnover creates a self-reinforcing cycle:

1. Low pay and heavy workload drive departures.
2. Vacancies are covered with overtime, which increases fatigue and burnout.
3. Burnout drives more departures.
4. New hires require training and supervision, pulling experienced staff off the street.
5. Fewer staffed ambulances raise response times and workload, and the cycle repeats.

Breaking the cycle requires changing the incentives at the start, which is pay, status and career.

6.2 Compensation parity

DEMS should adopt the principle that EMS clinicians are uniformed public safety employees and should be paid accordingly. Specifically:

- **Uniformed status.** Reclassify EMTs, paramedics and EMS officers as uniformed employees, with access to the uniformed bargaining pattern. This requires agreement through the City's Office of Labor Relations and, for pensions, state legislation.
- **Wage floor pegged to peer services.** Set EMS salary schedules with reference to police, fire and sanitation, with paramedic pay recognizing their clinical training. The Comptroller's parity model starts EMTs on the firefighter scale and paramedics at the firefighter year-three rate, rising to about $123,000 after five years.
- **Retirement.** Support state legislation for an EMS retirement plan comparable to other first responders. A 22.5-year plan (S7916) is estimated to cost about $31 million a year.

- **Settle the contract.** Local 2507 has been without a contract since July 2022. No restructuring will succeed unless the City first resolves this.

Pay parity is also a matter of equity. The EMS workforce is 64% people of color and 26% women; the fire service is 68% white and 2% women. A federal court certified a class of 4,500 to 5,000 FDNY EMS workers in September 2024 in litigation alleging discriminatory pay practices. Closing the pay gap is the most direct way to address the disparity.

6.3 A career ladder that stays in medicine

Today, the best-paid path for an FDNY EMT leads to firefighting. DEMS should build a clinical career ladder in which advancement rewards deeper medical skill:

Level	Role	Indicative requirements
1	EMT	NYS EMT certification; DEMS Academy
2	Senior EMT / Field Training Officer	Experience, preceptor training
3	Paramedic	NYS paramedic certification; associate degree pathway
4	Critical Care / Specialty Paramedic	Rescue, HazTac, tactical, critical care transport
5	Community Paramedic	Mobile integrated health training
6	Paramedic Practitioner	Bachelor's or master's degree; advanced scope under medical direction
Leadership track	Lieutenant, Captain, Division Chief, Chief	Supervisory exams; MS in EMS administration encouraged

The Paramedic Practitioner role already exists in the United Kingdom, Australia and elsewhere, and Austin-Travis County EMS hires directly into a Paramedic Practitioner position (ATCEMS). Advanced practice paramedics can manage low-acuity patients at home, reduce unnecessary transports and extend physician reach.

6.4 One citywide EMS Academy

DEMS should operate a single citywide EMS Academy, building on the existing FDNY EMS Academy at Fort Totten, with satellite training sites in all five boroughs. The Academy should:

- Train all municipal recruits and offer training to hospital, commercial and volunteer agencies on a cost-recovery basis.
- Partner with the City University of New York (CUNY) on a degree ladder: an associate degree in paramedicine, a bachelor of science in paramedicine and, over

time, a master of science in EMS administration and leadership.
- Offer tuition support tied to a service commitment, so the City recovers its investment.
- Run continuing medical education, call review and recredentialing for the whole system.

An education-backed career ladder does two things: it makes EMS a profession people choose for life, and it builds a local pipeline of clinicians who already know the city.

6.5 Safety and violence prevention

EMS providers face violence at work at rates far above most occupations. The City Council has required the FDNY to supply body armor and self-defense training to EMS members, after reporting that attacks on EMS had doubled over five years (CBS News). DEMS should go further and apply the standard citywide:

- A workplace violence prevention program with incident reporting, data analysis and follow-up for every provider in the 911 system.
- Standard personal protective equipment, including ballistic protection, for every unit.
- Coordinated response protocols with NYPD for scenes with known risk.
- Peer support, critical incident stress management and access to mental health care, consolidated from current regional programs.
- Post-assault leave, legal support and prosecution coordination.

6.6 Morale, identity and respect

Pay is necessary but not sufficient. EMS workers repeatedly describe themselves as second-class members of the FDNY. Local 2507's president told the Council in November 2025 that EMS members are treated as second-class employees (Crain's). An independent department restores something money alone cannot: a leadership that comes from EMS, speaks for EMS and measures success by EMS outcomes. DEMS should restore a distinct EMS uniform and identity, recognize meritorious and life-saving performance, and give clinicians a real voice in protocol and policy.

6.7 Workforce targets

DEMS should publish annual targets and report against them:

Metric	Current (FY 2026)	Five-year target
EMT annual departure rate	19.5%	Under 10%
Median EMT years in title	3.8	6+
Share of paramedics with 5+ years	46%	60%+

Metric	Current (FY 2026)	Five-year target
Overtime as share of EMS personnel costs	~18%	Under 10%
Daily staffed ambulances vs. need	416 (Sept. 2026)	Meet a published, demand-based target

Targets are indicative and should be set formally by the DEMS Bureau of Research and Performance.

Part VII — The Proposed Department of Emergency Medical Services

The New York City Department of Emergency Medical Services would be a mayoral agency and the City's third public safety service, coequal with the FDNY and NYPD. It would operate municipal ambulances directly, govern every provider in the 911 system, and own the full EMS mission from dispatch to clinical quality to workforce.

7.1 Mission

To preserve human life and alleviate human suffering by delivering timely, high-quality emergency and mobile medical care to everyone in New York City, and to build the profession that delivers it.

The department's scope would include emergency medical assessment and treatment; basic and advanced life support; prehospital emergency medicine; trauma, cardiac and respiratory emergencies; mass-casualty medical operations; emergency medical transportation; behavioral health response; community paramedicine; and preventive and mobile integrated health care.

7.2 Three coordinated public safety departments

Department	Core mission
FDNY	Fire suppression, rescue, fire prevention and related emergency operations
NYPD	Law enforcement and public safety
DEMS	Emergency medical response, prehospital medicine, ambulance operations and systemwide EMS administration

Firefighters would remain in the FDNY. Fire companies would continue to provide first response to appropriate medical calls under DEMS dispatch criteria, and the three departments would operate under unified incident command at major emergencies, as they do in every city with a separate EMS agency.

7.3 Organization

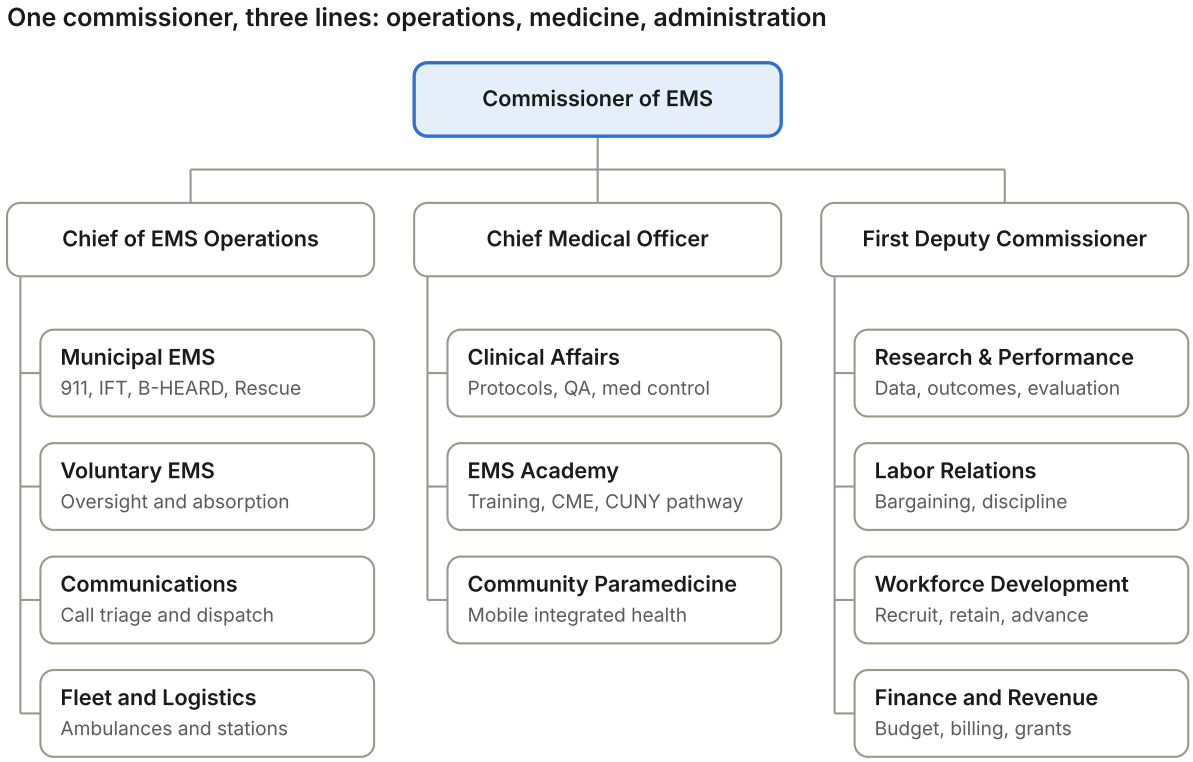


Figure 1. Proposed NYC DEMS organization · 11 bureaus under 3 lines

The Commissioner oversees three lines: field operations under a Chief of EMS Operations, medicine under a Chief Medical Officer who is independent of the operations chain, and administration under a First Deputy Commissioner.

Office of the Commissioner. Appointed by the Mayor, with a statutory qualification requirement of substantial EMS clinical and management experience. Houses legal, intergovernmental affairs, public information and the inspector function.

Bureau of Municipal EMS. Direct operation of City-funded staff and fleet: 911 ambulances; NYC Health + Hospitals interfacility transport; B-HEARD behavioral health teams; EMS hazardous materials (HazTac) and rescue units; special events and tactical EMS.

Bureau of Voluntary EMS. Oversight, integration and eventual absorption of non-municipal units in or adjacent to the 911 system. Manages operating agreements, monitors performance, authorizes qualified hospital and private-sector personnel to cover shifts on municipal units during transition, and schedules voluntary units for absorption.

Bureau of Emergency Communications. Medical call-taking and dispatch for the whole city, with improved triage, the ability to divert low-acuity calls out of 911 to nurse triage, telemedicine or alternative transport, and coordination with NYPD and FDNY dispatch.

Bureau of Fleet and Logistics. Ambulances, equipment, stations, supply and maintenance, with published vehicle availability targets.

Bureau of Clinical Affairs (Office of the Medical Director). Online medical control, protocols, quality assurance, call review, credentialing and recredentialing, and continuing medical education, working within the state framework described in Part XII.

EMS Academy. Initial and advanced training for all levels, satellite sites in five boroughs and the CUNY degree pathway (Part VI).

Community Paramedicine. Mobile integrated health, post-discharge visits, high-utilizer programs and treat-in-place care.

Bureau of Research and Performance. Data, response times and system evaluation, with a mandate to measure clinical outcomes, geographic equity, workforce stability, unit-hour utilization, readiness and the cost-effectiveness of alternative care models — evaluating EMS as an integrated public health and safety system rather than a fleet of vehicles. It would also administer performance recognition, including rewarding high-quality and life-saving performance.

Bureau of Labor and Employee Relations. Workforce policy and labor relations, and investigation of disciplinary complaints now handled by the FDNY's Bureau of Investigations and Trials, with a process designed for clinical practice.

Bureau of Workforce Development. Recruitment, retention, morale, wellness and career advancement, with an explicit mandate to value education and clinical growth.

Bureau of Finance and Revenue. EMS budget, billing and collections, grants and federal reimbursement programs including Medicaid supplemental payments, and the EMS revenue fund.

7.4 Formal relationships

DEMS would maintain written operating agreements with the FDNY (joint response, incident command, shared facilities during transition), NYPD (scene safety, 911 call transfer, violence response), NYC Emergency Management (disaster planning), NYC Health + Hospitals and the Department of Health and Mental Hygiene (public health surveillance, overdose and behavioral health programs, interfacility transport), private and voluntary hospitals (receiving protocols and hospital turnaround times), and the New York State Department of Health.

7.5 What DEMS is not

- **It is not another ambulance employer competing with hospitals.** It is the City's central EMS authority, operating the municipal service and setting the rules for everyone else.
- **It is not a rejection of firefighters.** Joint response remains where it adds clinical value, and practical configurations that include fire personnel — including dual-certified firefighter/EMT units — can be part of the design.
- **It is not an instant upheaval.** Integration happens on a published timeline with full protection for every employee (Part IX).

7.6 Governance and transparency

DEMS should be subject to annual reporting in the Mayor's Management Report, quarterly public dashboards on response times, staffed units, workforce and finances, and an EMS Advisory Board including clinicians, labor, hospitals, community members and public health experts. The department's budget should appear as its own agency in the City's financial plan, with readiness and encounter costs reported separately (Part V).

Part VIII — One Set of Standards for Every Provider

Every ambulance that serves New Yorkers should meet the same standards for care, staffing, equipment, safety, pay and reporting, set and enforced by one accountable public authority. The objective is not necessarily to eliminate different employers. It is to eliminate unnecessary differences in the quality, accountability and operational expectations of the emergency medical response system.

8.1 Why one standard

Today a patient's experience can depend on which of roughly 70 agencies happens to answer. Crews differ in experience, equipment differs by operator, data reporting varies and some workers are paid far less than others for the same work. Fragmented standards also weaken the workforce: spreading EMS workers across many employers and sectors holds down wages and dilutes bargaining strength, and a transient, inexperienced workforce lowers the quality of care.

Uniform standards fix the floor without requiring every provider to be the same organization overnight.

8.2 The standards framework

Domain	Standard DEMS would set and enforce
Dispatch and triage	A rebuilt, evidence-based medical triage system; reduced up-triage; fire company response only where it is likely to arrive first and add clinical value; capacity to divert low-acuity calls to nurse triage, telemedicine or non-ambulance transport
Unit types and staffing	Defined unit types: BLS (EMT/EMT), ALS (paramedic/paramedic), mixed ALS (EMT/paramedic), dual-medic rescue, EMT/social worker behavioral health teams (B-HEARD), paramedic response units, and firefighter/EMT units where appropriate; minimum staffing aligned with national standards
Compensation	Minimum wage and benefit floors for EMS workers in every sector operating in the 911 system, pegged to municipal uniformed pay for DEMS employees
Uniform and identification	One citywide EMS uniform and identification standard, so the public can recognize a medical responder
Equipment	A standard ambulance equipment and medication list; standard cardiac monitors and data systems where practicable
Vehicles	Strict maintenance and inspection requirements; published availability targets

Domain	Standard DEMS would set and enforce
Clinical protocols	One set of advanced, consistently updated protocols for all providers; expanded scope where evidence supports it
Training and competency	Common continuing education, competency testing and recredentialing
Performance	Measurable standards for response times, clinical outcomes and hospital turnaround; recognition for meritorious and life-saving performance
Safety	Standard PPE including ballistic protection; workplace violence prevention program; post-incident support
Labor standards	Minimum employment and workplace protections; no employer may compel use of lights and sirens for non-emergency calls
Reporting	Standardized operational, clinical and financial reporting by every provider; confidential employee reporting channels
Coverage	Geographic coverage requirements and reduced reliance on fire companies for medical-only responses
Education and hiring	Centralized education and credentialing through the DEMS Academy, with hiring standards for all 911 participants

8.3 Dispatch reform: the highest-leverage standard

The Comptroller found that dispatch and travel time drive most of the rise in response times. Reforming triage is therefore the fastest way to put ambulances where they are needed.

- **Re-triage the call mix.** Many calls currently classified as high priority do not need lights-and-sirens response. A DEMS communications bureau should adopt an evidence-based emergency medical dispatch system with continuous clinical audit.
- **Right-size fire company response.** Fire companies should be dispatched to medical calls when they are likely to arrive first and their presence improves outcomes — cardiac arrest, choking, major trauma — consistent with the Citizens Budget Commission's recommendation. Each avoided engine response saves money and keeps engines available for fires.
- **Divert low-acuity calls.** Build a clinical call center that can resolve appropriate calls by nurse or physician telemedicine, arrange non-emergency transport including ride services, or schedule a community paramedic visit.
- **Expand treat-in-place.** The July 2026 FDNY rate schedule already prices treatment in place. DEMS should build the protocols and medical oversight to use it safely.

- **Fix hospital turnaround.** Set and publish hospital offload standards and expand the Hospital Liaison Unit model so ambulances return to service faster.

8.4 Ending lights-and-sirens abuse

Providers and advocates, including EMSPAC members, report that some commercial operators pressure employees to use lights and sirens to speed non-emergency transports, and that some volunteer agencies routinely run with lights and sirens while transporting stable patients between boroughs. Unnecessary emergency driving endangers crews, patients and the public, and it is a well-documented source of ambulance crashes nationally. DEMS should set a single citywide standard for emergency vehicle operation, require providers to log and report lights-and-sirens use, and enforce it through the authorization process.

8.5 Non-discrimination

Every provider that operates under City authorization must serve every patient without regard to race, religion, ethnicity, national origin, sex, gender identity, sexual orientation, immigration status or ability to pay — including in its decisions about whether to transport a patient or to call another service to do so. This standard should apply equally to municipal, hospital, commercial and volunteer agencies, with complaint, audit and enforcement mechanisms under DEMS. Agencies that serve particular communities, and that provide valuable rapid response in their neighborhoods, can continue to do so within this standard.

8.6 How standards are enforced

Standards matter only if they can be enforced. DEMS should use three tools:

1. **City authorization.** Any provider that wishes to operate in the 911 system, or to hold itself out as an emergency ambulance service within the city, must hold a DEMS operating authorization, renewed periodically, in addition to state certification.
2. **Inspection and audit.** DEMS inspectors conduct vehicle, equipment and records inspections and clinical audits.
3. **Graduated sanctions.** Corrective action plans, fines, suspension from 911 dispatch and, for repeated or serious violations, revocation of City authorization.

The scope of City authority over state-certified providers depends on New York State law; Part XII addresses the legal pathway.

Part IX — The Integration Pathway

Integration should happen in deliberate stages: move municipal EMS out of the FDNY first, bring hospital-based 911 units in on a defined timeline, regulate commercial providers, and hold every volunteer agency to the same standards. This cannot happen overnight, but it must happen on a published schedule with protections for every worker.

9.1 Guiding principles

1. **No gap in coverage.** No unit leaves service until its replacement is staffed.
2. **No worker loses ground.** Every transferring employee keeps seniority, pay, benefits, pension credit, bargaining rights and promotional eligibility.
3. **Municipal first.** Stand up the department by moving what the City already owns.
4. **Standards before absorption.** Every sector meets common standards before any structural integration.
5. **Public milestones.** Each stage has published criteria, reported quarterly.

9.2 What transfers from the FDNY

On the effective date of the enabling law, DEMS would absorb:

- FDNY EMS EMTs, paramedics, EMS officers and EMS civilian and administrative personnel.
- Municipal ambulances and EMS support vehicles.
- The 39 EMS stations and deployment infrastructure.
- The EMS Academy and training facilities.
- EMS call-taking and dispatch functions, and the EMS share of the 911 system.
- EMS medical logistics, supply and operational support.
- B-HEARD EMS staffing, EMS HazTac and EMS rescue capabilities.
- All EMS-specific budget lines and EMS billing and revenue functions.

Firefighters remain in the FDNY. Shared assets — fleet maintenance shops, radio systems, headquarters space — would be governed by transition service agreements until permanently divided.

9.3 Employee protections

The enabling law should guarantee, for every employee who transfers:

- Continuity of seniority, civil service status and time in title.
- No reduction in pay, differentials or benefits.

- Full pension service credit and continued membership in their retirement system, with the option to move to any improved EMS plan created by state law.
- Continuation of current collective bargaining agreements and union representation until successor agreements are negotiated.
- Eligibility for the FDNY promotional exam lists already established at transfer, so no one loses an earned opportunity, with the expectation that DEMS's own career ladder will make that path less necessary over time.

9.4 Sector-by-sector pathway

Sector	Stage 1: Regulate	Stage 2: Coordinate	Stage 3: Integrate
FDNY EMS	—	—	Transfers to DEMS on day one
Voluntary hospital 911 units	DEMS operating agreements and standards	Joint scheduling; cross-authorized staff cover shifts on any 911 unit	Absorbed on a defined timeline, starting with units at risk of withdrawal; employees offered DEMS positions with protections
Commercial 911 subcontractors	Standards and authorization	Contracts not renewed as DEMS capacity grows	Commercial subcontracting removed from the 911 system
Commercial interfacility, event and construction-site EMS	Standards, minimum pay and authorization	Reporting and inspection	Remain private under DEMS regulation; H+H interfacility transport moves to DEMS
Volunteer ambulance corps	Same clinical, safety, driving and non-discrimination standards	Formal mutual aid roles defined by DEMS	Gradual transition of emergency response to the integrated system, as this paper proposes; members offered pathways into DEMS

9.5 Hospital-based EMS: from dependency to partnership

Hospitals participate in 911 because ambulances bring patients. As H.R. 1 cuts hit, many will want to reduce or exit that role. DEMS turns that risk into an orderly transition:

- **Right of first absorption.** Any hospital that wishes to withdraw 911 units must give DEMS advance notice, and DEMS may absorb the units, staff and equipment rather than leaving a gap.
- **Workforce transfer.** Hospital EMS employees are offered DEMS positions at equal or better pay and benefits, with credit for experience.
- **Destination neutrality.** Once units are municipal, patient destination is determined by clinical protocol and capacity, ending any incentive for patient steering.

- **Hospital contribution.** During transition, hospitals that benefit from 911 patient flow but no longer staff units contribute to the cost of readiness, by agreement or under state authorization.

9.6 Joint deployment during transition

Until integration is complete, DEMS should authorize qualified personnel from any sector who meet the common standards to staff shifts across the 911 system. Personnel cleared this way are called "VAX'd" and are authorized to work across all EMS work sites. This approach lets the City put more units on the street immediately by using staff where they are needed, regardless of employer, and gives private-sector workers a route into public service.

9.7 Volunteers

Volunteer ambulance corps in New York City have a long tradition of neighborhood service, and many respond quickly in areas they know well. EMSPAC favors volunteer agencies should be regulated first and phased down over time as the public system grows, because a unified, accountable and professionally staffed system is the safest standard. Those agencies that engage in practices such as routine lights-and-sirens transport of stable patients, or that apply different service decisions to different communities, should be held to account immediately under the standards in Part VIII.

A phase-down will be contested, and the City should approach it carefully: by setting the same standards for everyone, defining clear mutual aid roles, measuring results and offering volunteer members a route into DEMS. The decision on any eventual phase-out should rest on that evidence.

9.8 Absorbing regional council functions

Over time, DEMS should assume the operational functions now performed for New York City by REMSCO and REMAC, to the extent state law permits:

- Medical director credentialing.
- Protocol development and paramedic credentialing.
- Certificate-of-need determinations for ambulance services in the city.
- Peer support programs.
- Continuing medical education and committee functions.

Part XII explains why this requires state legislation and how it can be achieved while keeping clinical governance consistent with the State Department of Health.

Part X — Lessons from Other Jurisdictions

Independent, third-service EMS is a proven model in the United States and the dominant model in much of the developed world. New York would not be experimenting; it would be joining a well-established tradition.

10.1 The three organizational models

The NYC Comptroller identifies three main U.S. models:

Model	How it works	Examples
Fire-based, dual deployment	Separate fire and EMS workforces in one fire department; firefighters at a basic first-responder level	New York City (FDNY)
Fire-based, cross-trained (fire-medic)	Firefighters required to be EMTs or paramedics; engines and ambulances staffed from one workforce	Most large U.S. cities, including the eight largest after New York
Third service	A separate public EMS agency alongside police and fire	Boston, Austin-Travis County, Pittsburgh

New York's model is the outlier: it has neither the integrated workforce of the fire-medic model nor the institutional focus of a third service.

The Comptroller cites a 2022 peer-reviewed study by Cheng Hua and Arthur J. Swersey modeling St. Paul, Minnesota, which found that a system with separate engines and ambulances, like New York's, needs about 33% more personnel to match the response times of a cross-trained system. That finding cuts two ways. It shows New York's current arrangement is inefficient. It also shows that whichever direction New York chooses, the status quo is the least efficient option.

10.2 U.S. third-service systems

Boston EMS. Boston's municipal EMS traces its origin to the Boston City Hospital Ambulance Service, formed in 1892. In 1996 — the same year New York merged EMS into the FDNY — Boston made EMS a bureau of the newly created Boston Public Health Commission (Boston EMS). The city describes it as one of three public safety agencies that respond to 911 calls. Its uniformed EMTs and paramedics are hired by competitive examination, paramedics are promoted from within after an internship, and it pairs EMTs with behavioral health clinicians on a dedicated unit. Boston EMS was the primary medical response agency at the 2013 Boston Marathon bombing. Boston's choice illustrates the public health identity this paper recommends: EMS as the place where public safety meets public health.

Austin-Travis County EMS. Austin built the nation's first stand-alone EMS station in 1982, and Austin-Travis County EMS is described as the largest stand-alone EMS agency in the country, serving more than 1,300 square miles (Austin American-Statesman via AOL). It is a City of Austin department separate from both police and fire (City of Austin). Its medics practice under clinical guidelines issued by an independent Office of the Chief Medical Officer; it began giving whole blood transfusions in the field in 2022; and it hires directly into a Paramedic Practitioner role. Austin shows what clinical ambition looks like when EMS is not competing with another mission for attention.

Pittsburgh EMS. Pittsburgh operates EMS as a separate bureau within its Department of Public Safety, alongside the police and fire bureaus — a structure that keeps EMS distinct while sharing public safety administration. That model is one option New York could study for administrative efficiency.

Other examples include Cleveland, Ohio; Fayetteville, North Carolina; Baton Rouge, Louisiana; Minneapolis, Minnesota; and New Castle County, Delaware as jurisdictions that operate EMS separately from their fire departments, each with its own governance arrangement. Several, like Minneapolis, use a hospital-affiliated public model rather than a city department; the common thread is that EMS has an institution of its own.

Here, these systems show notable differences from fire-based models in retention, compensation and the clinical sophistication of their protocols. A DEMS Bureau of Research and Performance should benchmark New York against them formally.

10.3 International models

Most peer nations operate EMS as an independent service separate from police and fire, including the United Kingdom, Ireland, Canada, Australia, New Zealand, Israel, South Africa, Norway, Finland, the Netherlands, Poland, the Czech Republic, Croatia and Latvia. Arrangements vary — some are national health service trusts, some are state or provincial agencies, some are municipal — and several continental European countries, including France, integrate physicians into prehospital care. Common features include:

- **Degree-level education.** In the United Kingdom, Australia and elsewhere, paramedicine is a university-degree profession, and master's-level advanced practice is common.
- **Advanced practice roles.** The *paramedic practitioner* or advanced paramedic manages low-acuity patients in the community, reducing hospital transports.
- **Integration with health systems.** EMS is governed as part of the health system, not as a subsidiary of firefighting, which supports community paramedicine, mobile integrated health and coordinated interfacility transport.

10.4 Lessons for New York

1. **Institutional identity drives clinical development.** Where EMS has its own institution, it develops its own career ladder, education and clinical scope.
2. **Separation does not mean isolation.** Third-service systems work alongside fire and police through joint dispatch, mutual aid and unified command.
3. **Financing must recognize readiness.** Successful systems combine public appropriation with billing revenue rather than relying on transport income alone.
4. **Scale is not a barrier.** New York's size argues for, not against, a dedicated department: its EMS system alone is larger than most American cities' entire public safety apparatus.
5. **The choice is New York's to make.** The current arrangement was imposed by administrative decision in 1996. It can be changed the same way, by law.

Part XI — Anticipated Objections and Responses

The strongest objections to an independent department deserve direct answers. Several were raised by then-Fire Commissioner Robert Tucker at the City Council's November 13, 2025 oversight hearing on Intro 521, where his testimony led some co-sponsors to reconsider (Crain's New York Business). These objections matter.

Objection 1: "A new department duplicates what the FDNY already has and adds cost."

Commissioner Tucker argued that a new agency would need its own commissioner, human resources, compliance officers, analysts and lawyers, imposing redundant costs. The Mayor's Office of Management and Budget estimated about $25 million a year in added administrative cost.

Response. Some added administrative cost is real, and this paper does not pretend otherwise. But $25 million is under 6% of current EMS spending — less than the $35 million increase in EMS overtime since FY 2015, and only about half the $47 million increase in new-EMT training costs over the same period. If an EMS-focused department reduced attrition even modestly, the savings in overtime and training could offset the administrative cost. The cost can also be limited by design: shared back-office services during transition, leadership drawn from the existing EMS command, and a lean commissioner's office.

Objection 2: "A new department won't raise pay — pay is set by the Office of Labor Relations."

Tucker correctly noted that EMS pay is negotiated by the City's Office of Labor Relations, not the FDNY. Council Member Joann Ariola questioned whether a freestanding agency would succeed if the Mayor was not willing to fund higher pay.

Response. Structure alone does not raise pay — but structure determines who advocates for it, how it is classified and how its value is measured. Inside the FDNY, EMS pay competes with firefighter pay in the same department budget, and EMS's best-paid career path is to leave EMS. A department whose entire budget, leadership and performance depend on EMS has every incentive to fight for competitive pay and to show the return in retention and response times. That is why this paper pairs the new department with uniformed status and pay parity. Each makes the other more achievable. As Council Member Justin Brannan put it at the hearing, if the City granted parity and uniformed status he would withdraw his bill — the structural proposal exists because those things have not happened in thirty years.

Objection 3: "EMS and fire belong together; the merger improved coordination."

Response. Coordination is essential, and it does not require a single department. Police and fire coordinate every day without being one agency. Every third-service system in the country coordinates with its fire department through joint dispatch, automatic response agreements and unified incident command. DEMS would keep all of these. What separation adds is focus: leadership, budget and career development devoted to medicine. Thirty years of outcomes under the merged model are the best evidence on whether the merger delivered on its promise.

Objection 4: "The City should cross-train firefighters instead."

Most large cities use a fire-medic model, and the Hua–Swersey study suggests cross-training can be efficient.

Response. Cross-training is a legitimate alternative, and a DEMS can incorporate firefighter/EMT units where they add value. But converting New York's 8,000-plus firefighters into EMTs or paramedics would be a long, expensive and contested undertaking, and it would not address the EMS workforce that already exists, the fragmentation of the 911 system or clinical governance. It would also deepen the pattern in which medicine is a secondary skill attached to a firefighting career. New York already has a dedicated medical workforce; the better investment is to keep it.

Objection 5: "Separation will disrupt service during the transition."

Response. Disruption is a real risk, which is why Part IX requires that no unit leave service until its replacement is staffed, that dispatch transfer happen only after parallel testing, and that every milestone be public. The largest disruption today is the one already underway: hundreds of clinicians leaving each year and hospitals withdrawing units.

Objection 6: "Hospitals will resist losing their 911 role."

Response. Some will; many are already leaving voluntarily under financial pressure. Integration on a defined timeline gives hospitals predictability, offers their EMS workers secure public jobs, and replaces a voluntary, financially fragile arrangement with a stable public service. Hospitals continue to receive patients by clinical protocol.

Objection 7: "The City can't regulate state-certified providers or replace REMSCO."

Response. This is a genuine legal constraint. Article 30 gives regional councils and the State Department of Health defined roles. Part XII sets out a two-track approach: the City acts now within its existing powers over its own agencies, its 911 system, its contracts and its local licensing authority; and it seeks state legislation to bring regional functions for New York City under public accountability.

Objection 8: "Volunteer and community ambulance services provide value and should not be phased out."

Response. Many volunteer corps provide fast, valued service in their neighborhoods. This paper's first step is not elimination but common standards — on clinical care, safe driving and non-discrimination — that every provider must meet. Any longer-term phase-down should follow evidence from those standards and include a route for volunteers into DEMS.

Objection 9: "This is the wrong time; the City faces a fiscal crisis."

Response. Fiscal pressure is the reason to act, not to wait. The City is already paying for the status quo in doubled overtime, quadrupled training costs and lost federal revenue. Federal cuts will push more hospitals out of 911, and the City will bear the cost of backfilling either way. A department designed for EMS gives the City the tools to manage those pressures deliberately rather than reactively.

Part XII — The Legal and Legislative Pathway

The City can create the Department of Emergency Medical Services by local law, but full systemwide authority will also require action in Albany. This section sets out what the City can do on its own, what needs the State, and how the bill history informs the next attempt. It is a policy roadmap, not legal advice; the enabling legislation should be drafted with the Council's legislative counsel and the Law Department.

12.1 Legislative history

Date	Action
May 2020	City Council unanimously passes a resolution supporting EMS pay parity with firefighters and police
March 7, 2024	Council Member Justin Brannan introduces **Intro 521-2024**, establishing a Department of Emergency Medical Services headed by a Commissioner of EMS (intro.nyc)
November 13, 2025	Council oversight hearing; FDNY Commissioner Robert Tucker opposes the bill; EMS Local 2507 supports it; the bill has about 21 sponsors, less than half the Council (Crain's)
December 2025	Council term ends; Intro 521 lapses without a vote
January 2026	New Council and Mayor Zohran Mamdani take office; Lillian Bonsignore, a former EMS chief and supporter of pay parity, becomes Fire Commissioner
October 16, 2026	Comptroller Mark Levine's *A System Under Strain* recommends a contract that substantially raises EMS pay and urges the City to begin considering broader structural changes to EMS service delivery
2026–27 session	According to EMSPAC, Council Member Susan Zhuang intends to reintroduce Department of EMS legislation in response to the current crisis

The next bill should learn from Intro 521's reception: lead with a credible cost estimate, pair structure with a compensation plan, and answer the coordination objection with concrete operating agreements.

12.2 What the City can do by local law

The New York City Charter allows the Council, with the Mayor's signature, to establish and organize City agencies. A local law can:

- Create DEMS as a mayoral agency, define its commissioner's qualifications, powers and duties, and add a new Charter chapter.
- Transfer the functions, personnel, property, records, appropriations and contracts of the FDNY Bureau of EMS to DEMS, with employee protections (Part IX).

- Make DEMS responsible for medical call-taking and dispatch within the City's 911 system, which the City already controls.
- Require all EMS billing revenue to be deposited in a dedicated EMS revenue account and reported separately in the financial plan.
- Set conditions for participation in the City's 911 system: any hospital or other provider that receives City dispatches must meet DEMS standards, report data and give advance notice before withdrawing units.
- Use the City's contracting and licensing powers to set standards for providers that contract with the City or operate on City property and events.
- Establish public reporting requirements, an EMS Advisory Board and performance targets.

A charter amendment by referendum is another route, and could give the department a firmer footing. The local law route is faster.

12.3 What requires the State

Several changes depend on state law:

Change	Why state action is needed	Approach
Regional council functions for NYC (protocols, credentialing, certificate of need)	Public Health Law Article 30 assigns these to the regional EMS council and REMAC, under the State Department of Health (NYS DOH)	Amend Article 30 so that, for a city of one million or more, a municipal EMS department may serve as or host the regional council and REMAC, keeping state clinical oversight
Certificate of need for municipal operations	Article 30 governs ambulance operating certificates; state law already eases municipal entry (NY courts)	Confirm DEMS's authority to operate citywide and to approve or condition non-municipal ambulance services within the city
EMS pension improvements	Pension benefits are set by state law	Support pending legislation, including a 22.5-year retirement plan (S7916) and contribution caps
Uniformed status for pension purposes	Uniformed pension systems are defined in state law	Legislation to recognize EMS as a uniformed public safety service for pension purposes
New dedicated revenue sources (such as an alcohol-related assessment)	Taxing authority derives from the State	Seek enabling legislation if the City pursues it
Medicaid supplemental payments	Requires State Medicaid plan action and federal approval	Joint City–State push to resolve the pending CPE application or an alternative mechanism

12.4 Clinical governance under state law

Clinical governance must remain consistent with New York State Department of Health requirements and the statutory roles of the regional council and its medical advisory committee. The goal is not to remove state oversight but to place New York City's regional functions inside an accountable public body. Under the proposed amendment:

- The DEMS Chief Medical Officer would chair a reconstituted NYC Regional Emergency Medical Advisory Committee that includes hospital, academic and field representation.
- Protocols would continue to meet State Medical Advisory Committee standards.
- Credentialing, CME and peer review would be run by DEMS's Bureau of Clinical Affairs, open to all providers.
- Certificate-of-need determinations for the city would be made by a public body subject to open meetings and administrative review.

12.5 Labor law

Transfer of FDNY EMS employees to a new agency must comply with the Civil Service Law and the City's collective bargaining agreements. The enabling law should require the City to bargain transition terms with the affected unions — Local 2507, Local 3621 and others — and to preserve existing agreements until successor terms are reached. Reclassification to uniformed status for bargaining purposes would build on Local Law 19 of 2001, which already extended uniformed-style bargaining over wages, overtime and leave to EMS unions.

12.6 A model bill outline

1. **Findings.** EMS as an essential public service; the crisis data; the purpose of the department.
2. **Establishment.** DEMS created; commissioner appointed by the Mayor; qualifications.
3. **Powers and duties.** Operation of municipal EMS; medical dispatch; systemwide standards; authorization of providers in the 911 system; data and reporting.
4. **Transfer of functions.** From the FDNY Bureau of EMS, with an effective date and transition period.
5. **Employee protections.** Seniority, pay, benefits, pensions, bargaining rights and promotional eligibility.
6. **Finance.** Dedicated EMS revenue account; separate readiness and encounter reporting.
7. **Standards and authorization.** Participation conditions for the 911 system; notice before withdrawal; inspection and enforcement.

8. **Coordination.** Required operating agreements with FDNY, NYPD, NYCEM, H+H and DOHMH.
9. **Advisory board and reporting.** Membership, quarterly dashboards, annual report.
0. **Implementation plan.** Deadlines for a transition plan, dispatch transfer, standards issuance and integration milestones.
1. **State legislative program.** A statement of the City’s request for Article 30, pension and revenue changes.

Part XIII — Implementation Roadmap, Metrics and Risks

DEMS can be operating within 18 months of enactment and can bring every 911 ambulance under its operation or governance within five years, if each phase clears a public gate before the next begins.

13.1 Roadmap

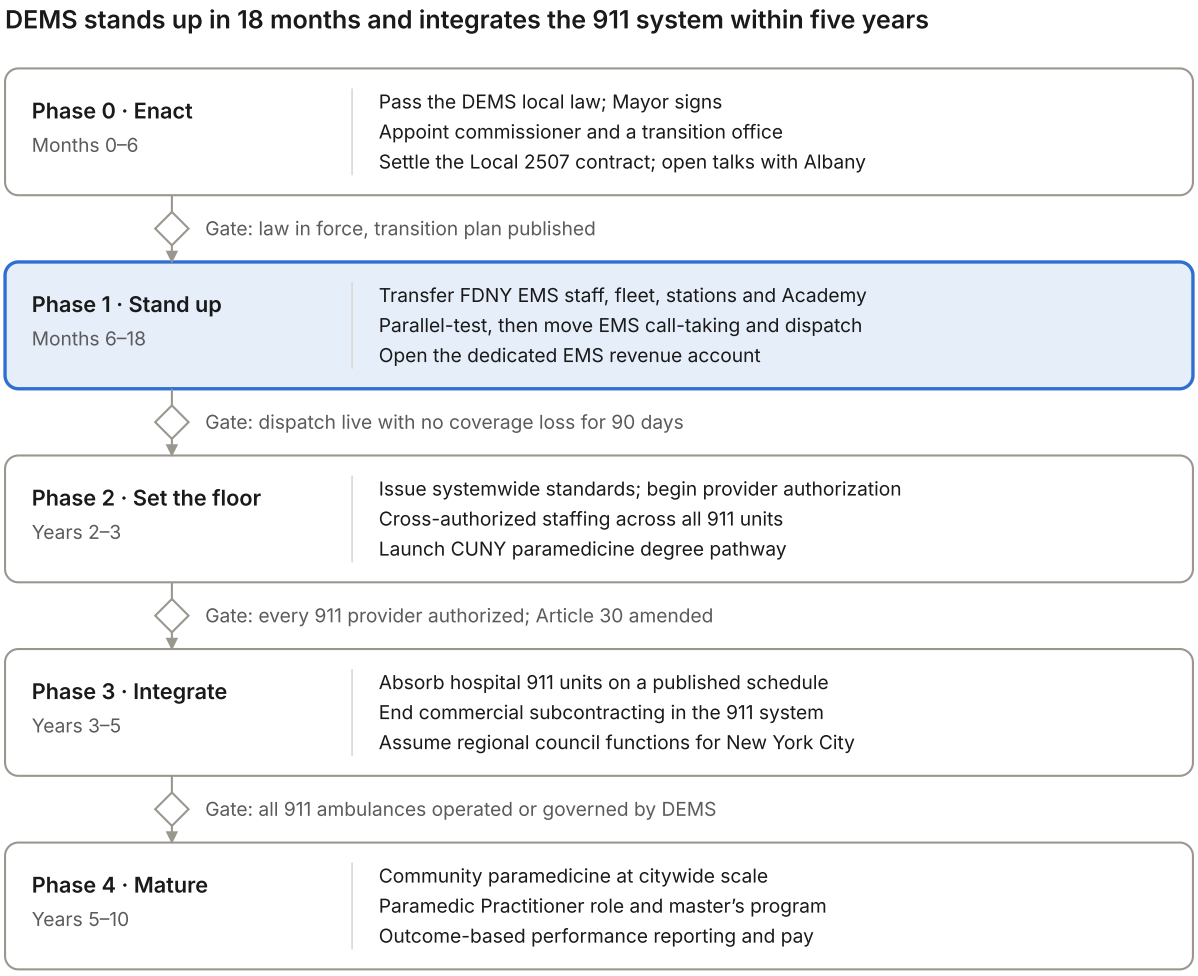


Figure 2. Proposed DEMS implementation roadmap · 5 phases, 4 gates (not to scale)

Phase durations are planning targets. Phase 3 depends on state legislation and on hospital agreements, and could move faster where hospitals choose to exit early.

13.2 First 100 days after enactment

- ☐ Mayor appoints the Commissioner and Chief Medical Officer.

☐ Transition office staffed from the FDNY EMS command, OMB, the Office of Labor Relations and the Law Department.

☐ Transition service agreements with the FDNY signed for fleet maintenance, radio, IT and facilities.

☐ Baseline data published: staffed units by hour, response times by segment and borough, workforce, overtime and finances.

☐ Bargaining opened with EMS unions on transfer terms and a successor contract.

☐ EMS Advisory Board convened.

☐ State legislative package delivered to Albany.

13.3 Performance metrics

DEMS should report quarterly against a published scorecard. Indicative five-year targets:

Domain	Metric	Baseline	Five-year target
Response	End-to-end response, life-threatening (average)	13:09 (FY 2026)	Below 10:00 citywide, with no borough more than 60 seconds above the citywide figure
Response	Ambulances in service, daily	416 (Sept. 2026)	A published, demand-based target met 95% of days
Clinical	Survival to discharge from witnessed VF cardiac arrest	To be established	Top quartile of U.S. large-city systems
Clinical	Stroke and STEMI first-contact-to-hospital times	To be established	National guideline targets
System	Hospital offload time (90th percentile)	To be established	Under 30 minutes
System	Low-acuity calls resolved without ED transport	To be established	Measured growth with no safety signal
Workforce	EMT annual departure rate	19.5%	Under 10%
Workforce	Median EMT years in title	3.8	6+
Finance	Overtime as share of EMS personnel costs	~18%	Under 10%
Finance	Share of EMS billing revenue reinvested in EMS	0% dedicated	100%
Equity	Gap between fastest and slowest borough response	To be established	Halved

13.4 Risks and mitigations

Risk	Likelihood	Impact	Mitigation
Coverage gap during transfer	Medium	High	No unit leaves service until replaced; parallel dispatch testing; FDNY mutual aid agreements
Administrative cost overrun	Medium	Medium	Shared services during transition; cap on headquarters staffing; public cost reporting
Pay parity not funded	Medium	High	Pair the law with a contract settlement; phase parity over the contract; offset with overtime and training savings
State legislation delayed	High	Medium	Act first on City powers; build a coalition with unions, hospitals and the State DOH
Hospital resistance	Medium	Medium	Right of first absorption; workforce transfer guarantees; predictable timeline
Workforce uncertainty drives more departures	Medium	High	Early, written employee guarantees; retain promotional list eligibility; visible pay progress
Federal reimbursement cuts	High	Medium	Readiness funded by appropriation; diversified revenue; Medicaid supplemental program
Political turnover	Medium	High	Establish DEMS in law, not executive order; consider a charter amendment

13.5 Accountability

The Council should require a public implementation report every six months for the first five years, and an independent evaluation — by the Comptroller, the IBO or an academic partner — at the three- and five-year marks, measuring results against the baseline in this paper.

Conclusion and Call to Action

New York City needs an independent Department of Emergency Medical Services. The case rests on evidence the City itself has published: response times to life-threatening emergencies up 41% in a decade, ambulances in service far below target, an EMS workforce that turns over at more than twice the rate of firefighters, pay frozen at 2022 levels, and a hospital-based third of the system pulling back under financial pressure.

These are not separate problems with separate fixes. They are the predictable results of placing the City's largest emergency service inside an institution organized around a different mission, without its own leadership, budget, career ladder or authority over the system it is responsible for. Thirty years of incremental fixes have not changed the trajectory. Structure has to change.

This is not an indictment of the FDNY or its firefighters, whose history and courage New York rightly honors. It is a recognition that firefighting and emergency medicine are distinct professions with different operational requirements, workforce needs and institutional responsibilities — and that EMS deserves comparable standing, funding and respect as an essential, uniformed public health and safety discipline, distinct from fire and police but working alongside them.

The people who provide emergency medical care should have a department that exists to advance, protect, professionalize and improve EMS for the sake of both patients and providers. A Department of EMS would reduce response times, bring every provider under one accountable standard and improve patient care for all New Yorkers.

EMSPAC's request

Of the City Council

- Introduce and pass legislation establishing the New York City Department of Emergency Medical Services, built on the model in Part XII.
- Fund the transition and a dedicated EMS budget in the next financial plan.
- Hold oversight hearings on the Comptroller's findings and on hospital withdrawals from the 911 system.

Of the Mayor

- Sign the legislation and appoint a commissioner with deep EMS experience.
- Direct the Office of Labor Relations to settle a contract with EMS unions that moves toward parity and recognizes EMS as a uniformed service.
- Require that EMS billing revenue be reinvested in EMS.

Of the State of New York

- Amend Public Health Law Article 30 so a municipal EMS department in a city of one million or more can perform regional council functions under State oversight.
- Pass EMS retirement reform.
- Work with the City to secure Medicaid supplemental payments for public EMS.

Of hospitals, unions and the public

- Hospitals: partner on an orderly transition rather than unplanned withdrawals.
- Unions: help design the transfer, the career ladder and the standards.
- New Yorkers: tell your Council Member that emergency medical care is an essential public service.

Vote YES for the Department of EMS.

EMS Public Advocacy Council (EMSPAC)

Appendix A — Glossary

Term	Meaning
ALS	Advanced Life Support: care by paramedics, including medications, IV access, advanced airway and cardiac monitoring
B-HEARD	Behavioral Health Emergency Assistance Response Division: an EMT or paramedic paired with a mental health professional for crisis calls
BLS	Basic Life Support: care by EMTs, including CPR, oxygen, bleeding control and transport
CFR / CFR-D	Certified First Responder (with Defibrillation): the basic medical credential held by FDNY firefighters
CON	Certificate of need (determination of public need) required to operate a new ambulance service under PHL Article 30
CPE	Certified Public Expenditure: a Medicaid mechanism to reimburse public providers closer to actual cost
CTL	City tax levy: City-funded portion of an agency budget
DEMS	The proposed New York City Department of Emergency Medical Services
End-to-end response	Time from the 911 call entering the phone system to the first unit's arrival
IFT	Interfacility transport between health care facilities
Local 2507	Union representing FDNY EMTs, paramedics and fire inspectors
Local 3621	Union representing FDNY EMS officers
MMR	Mayor's Management Report, the City's annual agency performance report
Paramedic Practitioner	Advanced practice paramedic, typically degree-educated, who manages a wider range of patients in the community
PHL Article 30	The New York State Public Health Law article governing EMS
REMAC	Regional Emergency Medical Advisory Committee: sets NYC protocols and credentials paramedics
REMSCO	Regional Emergency Medical Services Council of New York City, a not-for-profit designated under Article 30
Segment 1–3 / 4–8	FDNY dispatch categories for life-threatening and non-life-threatening medical calls
Third service	An EMS agency separate from both police and fire

Term	Meaning
Tour	One ambulance shift, usually eight or twelve hours
Treat in place	Care provided on scene without transport to a hospital

Appendix B — Key Data Reference

Indicator	Value	Period	Source
FDNY total budget	$2.72 billion	FY 2027 adopted	Comptroller
FDNY EMS expenses	~$435 million	FY 2026 (prelim.)	Comptroller
FDNY EMS revenue	~$254 million	FY 2026 (prelim.)	Comptroller
EMS share of FDNY emergency responses	>75%	FY 2026	Comptroller
Ambulance-handled medical responses	1.14 million	FY 2026	Comptroller (Open Data)
Total medical incidents (MMR basis)	~1.6 million	FY 2026	Mayor's Management Report
Life-threatening response, end-to-end average	13:09	FY 2026	Comptroller
Change in ambulance response, life-threatening	+3:50 (+41%)	FY 2015–26	Comptroller
Ambulances in service	360 vs. target 488; fleet 651	Jan. 8, 2026	Comptroller
Revised daily ambulance target	332	Spring 2026	Comptroller
EMTs / paramedics / firefighters	2,540 / 900 / 8,170	End FY 2026	Comptroller
EMS stations / firehouses	39 / 218	2026	Comptroller
EMT departures	>500 (19.5%)	FY 2026	Comptroller
EMS overtime	$69.6 million	FY 2026	Comptroller
New-EMT training costs	>$62 million	FY 2026	Comptroller
Cost to train an EMT / paramedic	$41,000 / $130,000	2026	FDNY Commissioner, via Comptroller
Non-FDNY share of 911 ambulance tours	About one-third	2026	Comptroller
Pay parity net cost	~$289 million/yr; $1.23 billion FY 2023–27	FY 2027	Comptroller
Projected H.R. 1 cut to NY hospitals	~$8 billion/yr when fully implemented	2025 estimate	GNYHA/HANYS
Fire engine vs. ambulance cost per medical response	$1,970 vs. $486	2017	Citizens Budget Commission

Appendix C — Field Estimates Requiring Verification

The following figures come from EMS advocates' field estimates, principally EMSPAC's November 9, 2026 joint statement, rather than published data. A DEMS research bureau, or the Council through oversight, should verify them:

- Hospital, private and volunteer units handle 5,500–6,000 calls per day, more than 35% of daily volume, plus several hundred outside 911.
- Current 911 call split of roughly 60% FDNY, 30% hospital-based and 10% commercial subcontractors.
- At least 1,000 daily calls relate to excessive alcohol consumption.
- About 70 EMS deploying agencies operate in the city.
- Recent unit reductions: five Northwell-affiliated units, six NewYork-Presbyterian night tours, and the status of Maimonides' 19 units.
- Council Member Susan Zhuang's planned reintroduction of Department of EMS legislation.

Appendix D — Sources

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