

# THE EQUITY DEFICIT

The Hidden Cost of Urban  
Indigenous Health Disparities in St.  
John's, Newfoundland & Labrador

February 2026







# Summary

An estimated 1,300 Indigenous residents of St. John's experience unequal access to primary care due to longstanding health system inequities. This gap results in significant direct costs to the Newfoundland and Labrador health care system and additional indirect costs in areas such as emergency services, mental health and addictions care, and economic productivity. This briefing note estimates the annual direct health care cost impact at between \$1.5 million and \$4.4 million, not including substantial unquantified costs associated with lost productivity, avoidable suffering, and system strain. These findings underscore the urgency of funding sustainable, culturally safe, and community-led primary care services for urban Indigenous people in NL.





## Methodology

The following estimates combine population-level data from the 2021 Census with health service utilization rates drawn from national and regional sources. Specific health indicators – including primary care attachment rates, emergency department (ED) utilization, and hospitalizations for ambulatory care sensitive

conditions – are drawn from sources such as the Canadian Institute for Health Information (CIHI), Statistics Canada, and peer-reviewed studies focused on Indigenous health outcomes. Where province-specific data are not available, we apply conservative estimates based on national and regional data.



Per-person and per-case cost estimates reflect CIHI's most recent cost data for Newfoundland and Labrador, including ED visits, inpatient hospitalizations, and mental health and addictions interventions. Dollar-value cost estimates are based on a combination of publicly available data from the Canadian Institute for Health Information (CIHI) and peer-reviewed academic sources. In all cases, the low estimate uses the most conservative assumptions based on available published data and the high estimate uses realistic but still moderately conservative figures from available published data. All dollar figures used in this brief's subtotal and total estimates have been rounded to the nearest \$10.



**7,000+**

people living the  
St. John's CMA are  
Indigenous

(2021)

## ■ The Urban Indigenous Primary Care Gap

There is currently no available provincial data that directly quantifies how many urban Indigenous people in the St. John's CMA do not have access to a regular family doctor. This brief therefore uses national and regional health survey data to estimate the likely scale of the gap.

The 2021 Census identifies approximately 7,050 Indigenous people living in the St. John's Census Metropolitan Area (CMA), or 3.4% of the total population.<sup>1</sup>



The breakdown of population by Indigenous identity group is as follows:

- First Nations: 4,270 (60.6%)
- Métis: 1,370 (19.4%)
- Inuit: 920 (13.0%)

Based on national and regional health survey data, Indigenous people are significantly less likely than non-Indigenous people to have a regular primary care provider. These disparities persist across regions and contribute to greater reliance on emergency services and poorer health outcomes.<sup>2</sup>

The breakdown by Indigenous identity group, without a provider, is as follows:

- Off-reserve First Nations: 20.3%
- Métis: 17.9%
- Inuit\*: 24-25%

\*Living outside Inuit Nunangat

<sup>1</sup> Statistics Canada, "Census Profile, 2021 Census of Population."

<sup>2</sup> Kelsang Yangzom et al., Primary Health Care Access among First Nations People Living off Reserve, Métis and Inuit, 2017 to 2020 (Statistics Canada, 2023), <https://www150.statcan.gc.ca/n1/pub/41-20-0002/412000022023005-eng.pdf>.



estimate of

**1,310+**

community members  
without a family doctor  
in St. John's

Applying these rates to the St. John's CMA population yields the following estimates of individuals, grouped by Indigenous identity, without a family doctor:

- First Nations without family doctor: 850
- Métis without family doctor: 240-250
- Inuit without family doctor: 220-230

These numbers suggest an urban Indigenous population in St. John's without access to a primary-care doctor to be between 1,310 and 1,330 Indigenous people.

The proposed urban Indigenous health clinic will have the capacity to provide this number of individuals a family care provider of record in addition to walk-in services using a blended capitation model. The blended capitation model has a maximum recommended roster size of 2,400 patients.<sup>3</sup> Given the unique context of this clinic and the complex health care needs of many Indigenous individuals, we conservatively estimate that each physician working at the clinic will have a roster of no more than 1,000 patients. With 3 family care providers between medical doctors and nurse practitioners, this provides the basis for our confident assumption that we will be able to provide a family doctor of record for the Indigenous population of the St. John's CMA who are currently without one.





## ■ Direct Cost Impacts to the Health Care System



### **Increased Emergency Department (ED) Use**

*Estimate*

Given the cultural context of the urban Indigenous population, our clinic will offer same-day walk-in primary care visits, with priority to those who are on the roster of our family care providers. This model is built on our understanding of the community and how best to provide accessible and culturally-relevant care. concluded that Indigenous people frequently use emergency care as a substitute for unavailable or inaccessible primary care.

We estimate our clinic capacity for these walk-in visits (those on and off the roster) to be between 5,930 and 20,750 visits per year. This accounts for our clinic infrastructure including space for 2-4 exam rooms, for visit length between 20-30 minutes, and 6-7 clinic hours per day, with 247 clinic days per year. Previous research has estimated the emergency department diversion rate of day-time walk-in clinics to be 49%.<sup>4</sup> This estimate should be considered conservative, however, considering that previous research has found that Indigenous patients had a two<sup>5</sup> and three times<sup>6</sup> higher rate of use of emergency departments than non-Indigenous patients. These findings reconfirmed a previous review which concluded that Indigenous people frequently use emergency care as a substitute for unavailable or inaccessible primary care.<sup>7</sup>



estimate of

**49%**

emergency department  
diversion rate of day-time  
walk-in clinics

The calculations below do not include estimations of benefits from the effects of emergency department diversion on system capacity. For instance, a study in Alberta found that patients at an emergency department who were First Nations were nearly twice as likely as non-First Nations patients to leave against medical advice or before being seen. This difference was consistent regardless of the condition being seen, including with urgent conditions such as long bone fractures. A survey done with the patients as they were leaving found that the most common reasons that the First Nations patients decided to leave were experiences of racism (e.g. staff using derogatory terms) and stereotyping (e.g. staff assuming drug and alcohol use where it was not warranted). 19.9% of these patients returned to the emergency department within 72 hours.<sup>8</sup> A walk-in clinic which provides culturally safe care can support Indigenous patients in their continuity of care while also reducing repeat visits to emergency departments. A walk-in clinic which provides

4 [Alexandra Bicki et al., "A Nurse-Run Walk-In Clinic: Cost-Effective Alternative to Non-Urgent Emergency Department Use by the Uninsured," Journal of Community Health 38, no. 6 \(2013\): 1042-49, <https://doi.org/10.1007/s10900-013-9712-y>.](#)

5 [Marlene Leung, "Emergency Department Visits and Hospitalization Higher among Indigenous Adults in Toronto Compared to General Population: Study," May 25, 2023, <https://unityhealth.to/2023/05/emergency-visits-indigenous-adults/>.](#)

6 [Patrick McLane et al., "First Nations Emergency Care in Alberta: Descriptive Results of a Retrospective Cohort Study," BMC Health Services Research 21, no. 1 \(2021\): 423, <https://doi.org/10.1186/s12913-021-06415-2>.](#)

7 [Billie Allan and Janet Smylie, "First Peoples, Second Class Treatment: The Role of Racism in the Health and Well-Being of Indigenous Peoples in Canada," the Wellesley Institute, 2015, <https://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Summary-First-Peoples-Second-Class-Treatment-Final.pdf>.](#)

8 [Patrick McLane et al., "Leaving Emergency Departments without Completing Treatment among First Nations and Non-First Nations Patients in Alberta: A Mixed-Methods Study," Canadian Medical Association Journal 196, no. 15 \(2024\): E510-23, <https://doi.org/10.1503/cmaj.231019>.](#)



between  
**\$883k – \$3 M**  
saved in diverted ED visits  
annually

culturally safe care can support Indigenous patients in their continuity of care while also reducing repeat visits to emergency departments.

The Canadian Institute for Health Information (CIHI) estimates the cost of an ED visit in Newfoundland and Labrador to be \$304.<sup>9</sup> For 5,930 to 20,750 people accessing a walk-in appointment, 49% to 80% of which would otherwise have gone to the emergency department, this translates to annual costs of between **\$883,030** and **\$3,090,620**.



## Preventable Hospitalizations

Research in comparable settings in BC have found higher rates of hospitalization for ACSCs in Indigenous compared to non-Indigenous populations, and a high correlation of hospitalization for ACSCs to premature mortality. These figures place the estimated difference in hospitalizations for ACSCs between 1.26 and 2.74 times when comparing non-isolated Indigenous communities to the rest of the province.<sup>10</sup> Another study found that urban Métis individuals face hospitalization rates for ACSCs at double or more compared to the national average, underscoring the urgent need for preventive care.<sup>11</sup> Research in the USA found that preventable hospitalizations among the lowest quartile of socioeconomic status were 1.3 higher than the second lowest quartile and 1.8 times higher compared to the highest quartile.<sup>12</sup> Research has also found that the rate of hospitalizations and the rate of ACSCs is higher in NL than in the rest of Canada.<sup>13</sup>



## Estimate

Research has found that the rate of hospitalizations for ACSCs in urban areas of NL between 2001–2009 was approximately 14 per 1000 population, with no statistically significant changes in this rate over the years of study.<sup>14</sup>

Considering that previous research has found rates of hospitalization for ACSCs to be 1.26–2.74 times higher among Indigenous individuals in non-isolated areas of BC compared to other non-reserve settings in that province,<sup>15</sup> and using the most recent Census estimates of the population of Indigenous and non-Indigenous residents of St. John's,<sup>16</sup> we can estimate the rate of hospitalization for ACSCs in St. John's as being between 18 per 1000 Indigenous residents and 14 per 1000 non-Indigenous residents. Assuming that a population of 1,310–1,330 urban Indigenous people receive a family doctor because of the First Light Urban Indigenous Health Clinic, 24–48 of them would avoid an unnecessary hospitalization because of the routine primary care they

<sup>9</sup> Canadian Institute for Health Information (CIHI), "Hospital Spending: Focus on the Emergency Department," Ottawa, ON, October 2020, <https://www.cihi.ca/sites/default/files/document/hospital-spending-highlights-2020-en.pdf>.

<sup>10</sup> Josée G. Lavoie et al., "Underutilized and Undertheorized: The Use of Hospitalization for Ambulatory Care Sensitive Conditions for Assessing the Extent to Which Primary Healthcare Services Are Meeting Needs in British Columbia First Nation Communities," *BMC Health Services Research* 19, no. 1 (2019): 50, <https://doi.org/10.1186/s12913-018-3850-y>.

<sup>11</sup> Gisèle Carrière et al., "Hospitalization for Ambulatory Care Sensitive Conditions among Urban Métis Adults," *28, no. 12 (2017): 3–11*.

<sup>12</sup> Ernest Moy et al., "Potentially Preventable Hospitalizations — United States, 2001–2009," *62, no. 03 (2013): 139–43*, [https://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a23.htm?s\\_cid%3Dsu6203a2#Fig2](https://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a23.htm?s_cid%3Dsu6203a2#Fig2).

<sup>13</sup> Quality of Care NL, "Evidence and Strategies to Inform a 10-Year Health Accord in Newfoundland & Labrador," November 2020, [https://www.healthaccordnl.ca/wp-content/uploads/2022/06/Practice\\_Points\\_SE\\_interactive.pdf](https://www.healthaccordnl.ca/wp-content/uploads/2022/06/Practice_Points_SE_interactive.pdf).

<sup>14</sup> John Knight et al., "Effect of Primary Health Care Reforms in the Province of Newfoundland and Labrador: Interrupted Time-Series Analysis," *65 (July 2019)*.

<sup>15</sup> Lavoie et al., "Underutilized and Undertheorized."

<sup>16</sup> Statistics Canada, "St. John's, CMA [Census Metropolitan Area], Newfoundland and Labrador (Table). Indigenous Population Profile. 2021 Census of Population," Government of Canada, 2023, <https://www12.statcan.gc.ca/census-recensement/2021/dp-pp/index.cfm?Lang=E>.



receive. CIHI reports an average inpatient cost in Newfoundland and Labrador to be \$7,596.<sup>17</sup>

Based on the above data and assumptions, we conservatively estimate that the annual cost savings for prevented hospitalizations would be between **\$182,400 and \$364,800.**



## Mental Health and Addictions

Indigenous people experience significantly higher rates of crisis-related service use, including hospitalizations for mental illness, substance use, and suicide risk. According to the Newfoundland and Labrador Centre for Health Information, approximately 70% of hospitalizations in the province's mental health and addictions system are for mental illness only, while around 6% are for addiction alone. The remainder involve overlapping conditions.<sup>18</sup>

A national 2024 survey by Statistics Canada found that 32% of First Nations people living off reserve, 30% of Métis, and 29% of Inuit reported unmet mental health needs in the past year, further elevating the risk of crisis-level episodes.<sup>19</sup>

### **Estimate**

To estimate the cost of mental health and addictions emergency care, this brief uses the following dollar-values:

- **Psychiatric Inpatient Care:** A range of \$5,800 to \$27,700 per stay, depending on the conditions involved and length of treatment. This brief assumes the low estimate of psychiatric inpatient care to be at the lower bound number (\$5,800) and the high estimate to be an average cost of \$12,000 per stay.<sup>20</sup>



- **Detoxification Care:** A range of \$3,625 to \$7,250 per day to deliver inpatient care, based on Canadian peer-reviewed research. This brief assumes the high estimate would be no greater than an average of \$5,000.<sup>21</sup>
- **Emergency Overdose Response:** \$1,622 per case, also based on Canadian peer-reviewed research.<sup>22</sup>

This brief supposes that 100 out of 1,300 members of the St. John's urban Indigenous community – approximately 7.7% – might experience an episode requiring crisis-level intervention in the course of a typical year. Based on the data presented above, the breakdown of interventions and associated aggregate costs would be as follows:

- 70 individuals admitted for inpatient psychiatric care costing between \$5,800 and \$12,000 per stay = **\$406,000 to \$840,000**

17 Canadian Institute for Health Information (CIHI), "Cost of a Standard Hospital Stay | CIHI," Ottawa, ON, May 2023, <https://www.cihi.ca/en/indicators/cost-of-a-standard-hospital-stay>.

18 Newfoundland and Labrador Centre for Health Information, "Mental Health and Addictions Programs Performance Indicators," Newfoundland and Labrador, April 2017, [https://www.nlchi.nl.ca/images/Mental\\_Health\\_and\\_Addictions\\_Programs\\_Performance\\_Indicators\\_2017-04-17.pdf](https://www.nlchi.nl.ca/images/Mental_Health_and_Addictions_Programs_Performance_Indicators_2017-04-17.pdf).

19 Statistics Canada, "The Daily: Health Care Access and Experiences among Indigenous People, 2024."

20 Canadian Institute for Health Information (CIHI), "Health System Resources for Mental Health and Addictions Care in Canada, Chartbook," Ottawa, ON, July 2019, <https://www.cihi.ca/sites/default/files/document/mental-health-chartbook-report-2019-en-web.pdf>.

21 Abreham Molla Mekonnen, "Predictors of Detoxification Services Use in Alberta: A Provincial Socio-Demographic and Utilization Analysis" (Doctoral Dissertation, University of Lethbridge, 2025), <https://opus.uleth.ca/server/api/core/bitstreams/1e7c8587-88b3-42b4-888d-cbe697512e1e/content>.

22 Shahreen Khair et al., "Supervised Consumption Site Enables Cost Savings by Avoiding Emergency Services: A Cost Analysis Study," *Harm Reduction Journal* 19, no. 1 (2022): 32, <https://doi.org/10.1186/s12954-022-00609-5>.



- 6 individuals requiring addiction-only detoxification or stabilization services costing between \$3,625 and \$5,000 per stay = **\$21,750 to \$30,000**
- 24 individuals treated for mixed or acute episodes, including overdose, costing \$1,622 per episode = **\$38,928**

**This yields an estimate of between \$466,680 and \$908,930** annually for crisis-level mental health and addictions care. The figure leans toward the conservative, as it does not account for repeat admissions, transportation, outpatient follow-up, or community-based supports.

### **Total Estimate of Direct Cost**

Based on the above, the following is the total breakdown of direct costs to the provincial health care system resulting from the primary care equity gap affecting urban Indigenous people in St. John's.

Line Item	Low Estimate	High Estimate	Realistic Estimate
Diverted Emergency Department Visits	\$883,040	\$3,090,620	\$1,986,830
Preventable Hospitalizations	\$182,400	\$364,800	\$273,600
Psychiatric Inpatient Care	\$406,000	\$840,000	\$623,000
Detoxification Care	\$21,750	\$30,000	\$25,880
Emergency Overdose Response	\$38,930	\$38,930	\$38,930
<b>Total</b>	<b>\$1,532,120</b>	<b>\$4,364,350</b>	<b>\$2,948,240</b>

The estimate of all direct costs to the health care system resulting from the primary care equity gap is between \$1.5 and \$4.4 million. The realistic estimate of \$2.9 million remains a conservative one given indirect and systemic costs.



estimated

**\$2.9 Million**

cost of healthcare  
equity gap



## ■ Indirect and Systemic Costs

While harder to quantify, the broader social and economic impact of unmet health needs among urban Indigenous populations includes:

- Lost productivity due to unmanaged chronic illness and mental health conditions;
- Longer-term health deterioration, leading to more complex and costly interventions;
- Educational and employment impacts, especially for youth and young adults; and
- Increased pressure on social services, housing, and justice systems.

Research consistently links primary care access to reduced total system costs, improved employment outcomes, and higher quality of life.



In Newfoundland and Labrador, where physician shortages already strain emergency and acute care services, reducing avoidable demand through targeted investments in Indigenous-led clinics would yield system-wide benefits.

It is also likely that physician retention would be higher in an Indigenous-led clinic. Turnover of family physicians has been flagged as a concern in NL, even in urban areas like St. John's where the turnover rate has been found to be 26% annually.<sup>23</sup> Fulfilling and meaningful work supports physician retention in vulnerable population clinics.<sup>24</sup> Research has also found that physician burnout is strongly related to the ability of the clinic to meet the patients' needs.<sup>25</sup>

By establishing a clinic which is embedded in an organization already providing wrap-around supports (including housing, justice system navigation, and cultural supports), the potential to meet patient needs is high. This strength is likely to reduce the rate of physician burnout, supporting physician retention in the long term.<sup>26</sup>

**23** Health Accord NL, "Our Province. Our Health. Our Future. A 10-Year Health Transformation: The Report."

**24** Kara Odom Walker et al., "Recruiting and Retaining Primary Care Physicians in Urban Underserved Communities: The Importance of Having a Mission to Serve," *American Journal of Public Health* 100, no. 11 (2010): 2168–75, <https://doi.org/10.2105/AJPH.2009.181669>.

**25** Emilia De Marchis et al., "Physician Burnout and Higher Clinic Capacity to Address Patients' Social Needs," *Journal of the American Board of Family Medicine* 32, no. 1 (2019): 69–78, <https://doi.org/10.3122/jabfm.2019.01.180104>.

**26** Jasmine Lee and Evangelos Kontopantelis, *A Systematic Review Exploring the Factors That Contribute to Increased Primary Care Physician Turnover in Socio-Economically Deprived Areas*, pt. e0315433, 19, no. 12 (2024), <https://doi.org/10.1371/journal.pone.0315433>.



# Conclusion

The cost of maintaining inequity in health care is steep. When urban Indigenous people cannot access timely, culturally safe primary care, the resulting pressure on emergency departments, hospitals, and crisis services becomes both financially unsustainable and ethically problematic.

Redirecting even a portion of those resources toward prevention – through integrated, community-led models of care – offers a high return on investment. Evidence shows that culturally grounded primary care reduces unnecessary hospitalizations, improves chronic disease management, and strengthens trust in the health care system.<sup>27</sup>

Proactive investment in upstream care for the urban Indigenous community in St. John's is not only a matter of equal opportunity, human dignity, and reconciliation; it is also a practical, cost-effective, and system-sustaining solution.







First Light's mission is to deliver transformative programs and services that empower, uplift, and support Indigenous communities and nations in ways that promote good relations between all.

Through advocacy, research, and social entrepreneurship, we foster inclusive environments that unite Indigenous and non-Indigenous peoples, promote social well-being, and drive sustainable change.

Guided by principles of trust, respect, and friendship, we aim to build a brighter future where Indigenous Peoples thrive and flourish, leaving a profound and lasting legacy for generations to come.

