Taking Stock of the 2017-2027 Federal Mental Health Transfer

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CONVERGE Research Power Hour

August 27 2026

McGill | MAX BELL SCHOOL of PUBLIC POLICY

Acknowledgements

- Research Assistants: Mahnoor Zaman, MPP, Courtney White, MPP
- Funding: J. W. McConnell Visiting Scholar Fellowship
- Ethics: McGill Research Ethics Board approval April 30 2026

What is this all about and why is it important?

- In 2017, federal government launched targeted mental health transfer to address shared health priority.
- A big deal! Gaps and inequities in public funding for mental health and substance use health (MHSUH) since temperance movement, since mental hospitals excluded from Medicare in 1957 and Canada Health Act back in 1984.

$5B

over 10 years

Why 2017?

- Mental Health Strategy for Canada target, backed by strong case for investment
- Innovations in UK and Australia
- Shift to collaborative federalism, more active federal role in health policy

7% →  **9%**

Mental health's share of spending on health (MHCC 2012)

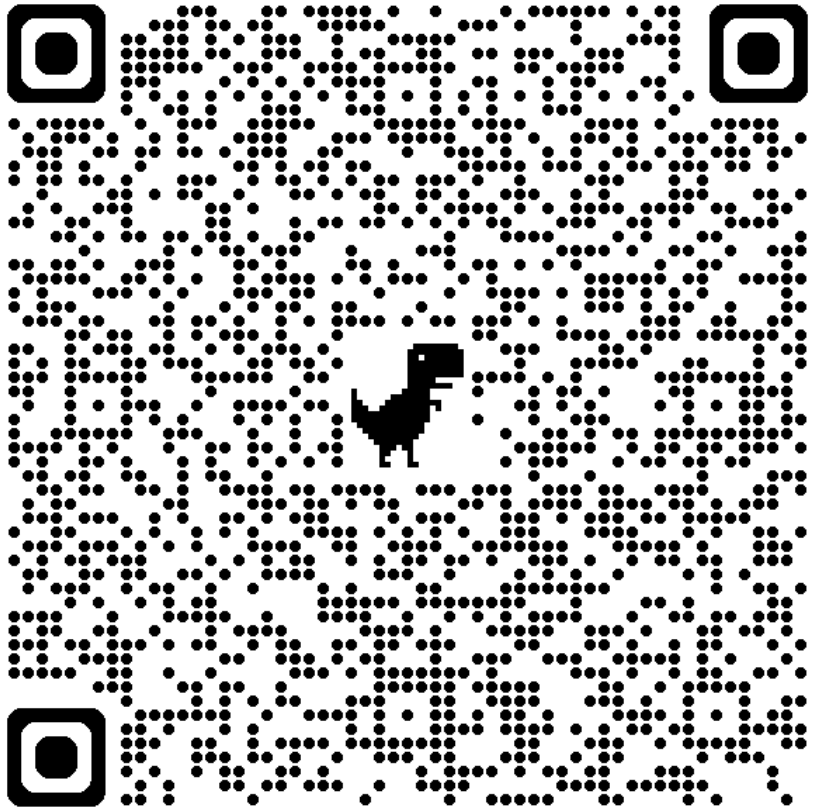
What role do health transfers play in Canada?

- Radically decentralized healthcare system
- Provinces and territories have jurisdiction over health care
- BUT vertical fiscal imbalance
- Federal government collects more taxes, and uses federal spending power for areas of national priority
  - ✓TRANSFERS: Canada Health Transfer (22%), equalization, targeted transfers
  - ✓HEALTH SYSTEM INFRASTRUCTURE: public health, research, pan-Canadian health organizations, etc.

What did the mental health transfers look like?

- Series of bilateral agreements between each province or territory and the federal government, with detailed action plans
- Required sign off by chief financial officer
- Funding split between PTs according to population size
- 2017-2027 MH Transfers integrated into 2023-2026 bilateral agreements Working Together Transfers
- Supported by
  a. CIHI-led indicators initiative (2019-present)
  b. Standards Council of Canada Standards MHSUH Collaborative Roadmap (2023-2025)

You can see the agreements for yourself!



▾ Home and Community Care, and Mental Health and Addictions Services funding agreements and news releases

- ▸ Alberta
- ▸ British Columbia
- ▸ Manitoba
- ▸ New Brunswick
- ▸ Newfoundland and Labrador
- ▸ Northwest Territories
- ▸ Nova Scotia
- ▸ Nunavut
- ▸ Ontario
- ▸ Prince Edward Island
- ▸ Quebec
- ▸ Saskatchewan
- ▸ Yukon

Why study the transfers now?

Important to build evidence to inform future federal role especially with fiscal pressure building on many fronts…

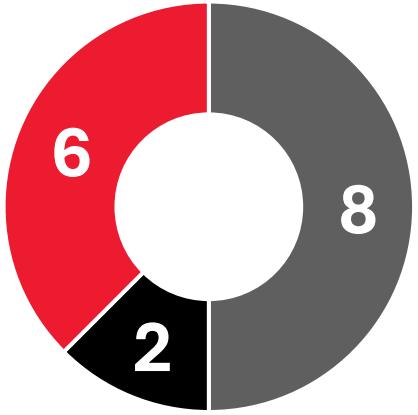
- ✓Transfers are set to sunset, per federal Spring Economic Update.
- ✓Uneven uptake of mental health as a priority in 2023-2033 Working Together transfers.
- ✓Planned reduction Canada Health Transfer (from 5% to 3% annual increase per year).
- ✓Policy context shifting – economic turn, infrastructure turn.

What was the research question we were trying to answer and how did we go about it?

- Simply put, the research question was what are the strengths and limitations of the 2017-2027 targeted federal mental health transfer?
- We did what is called a policy case study (Yin, 2014) with two kinds of evidence:
  - analysis of publicly-available policy documents
  - interviews with political, public service, and service system leaders
- We used purposive sampling to identify people with a strong line of sight on the strengths and limitations of the transfer

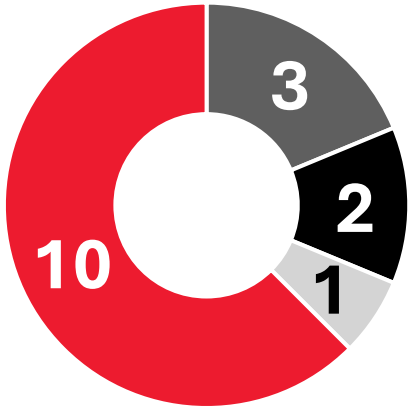
Who participated in the interviews? (N=16)

Leadership Role



- Service system
- Political
- Public service

Region



- West
- Central
- North
- Pan-Canadian

Key themes: STRENGTHS

Strength #1: Created fiscal room for innovation

The [provincial] government has a list of 31 initiatives that were funded through the first shared health priorities agreements that range from…supportive recovery housing to hospital-based services to expanding rapid access to addictions medicine clinics to youth programs…. A lot of them were community driven, community based. (P14&P15)

The mental health and addictions area has had budget lines and support from the government to engage in some pretty serious system transformation work. Things like for the first time ever, bringing in e-mental health initiatives to improve access, really shifting the way community counselling programming has been delivered. (P11)

Strength #2: Signalled MHSUH as priority

What was most important was to … make sure that … the federal government recognized the challenges around mental health and addressed both the perception and the reality of a lower level of funding… The actual mechanism, the directing of some of the envelope to that area, was at the highest level a signaling effort… so that those challenges were going to be more addressed in each of our provincial health care systems. (P4)

The money created focus, and the money created people demanding it to be focused. … It allowed the advocacy and sector organizations … to say, and here's why this is important. And some of those organizations became watchdogs over this, and they didn't take their foot off the gas. (P13)

Strength #3: Strengthened indicators and data

[The community mental health wait times indicator has] … been a really important data point … in terms of talking about system transformation and how is this working and is the [government] sustaining it… I think any data, [the North] is hungry for it. (P11)

By strengthening data infrastructure, expanding coverage, and improving data quality, the transfers have created lasting capacity that will continue to support evidence-informed decision-making and adaptation to future health system priorities. (P12)

Strength #4: Ringfenced but flexible

We were able to hold the line on the idea of ring fence funding back in 2017, despite the fact that the premiers were extremely unhappy with the federal unilateral decision to keep with the Harper Canada Health Transfer formula [3% annual increase] and to do these bilateral agreements on the side. (P1&P2)

While it's targeted for mental health and also for addictions, there is flexibility....Giving the provinces all the flexibility that they need to implement or invest those dollars in a way that hopefully meets the needs of their residents. (P14&P15)

Key themes: LIMITATIONS

Limitation #1: Indigenous policy gaps

If at least we could get recognition, provinces and territories are financially responsible under the Canada Health Act for ensuring .... [h]ealth transfers reflect the needs of the whole population, meaning including First Nations people. That's number one, because if they think they still have a choice about that, then the federal government has a responsibility to ... show accountability for the transfer of dollars. If you're giving this money, then how are you monitoring how it's allocated, how it's meeting the needs? (P16)

It's like, no more jurisdictional confusion, because First Nations have been in that space for too long. It's outright racism. (P16)

Limitation #2: Hard to track investments

I don't know where the money was coming from. So maybe in mental health it was coming from the federal program, but you know that part is completely opaque. (P5)

I think I could say it's a wave of funding. I think I can see it. I'm assuming the money's coming from somewhere, so there's been a lot of new services. There's been a lot of investment. (P3)

Limitation #3: Hard to measure impact

It was a large sum of money, but I don't think outcomes or impact or goals ...[were] very clearly set ...[or] communicated with the sector. So I think when you're trying to measure the impact of this very significant investment, the feds didn't tell the province and the province didn't tell their service providers. (P9)

I think there needs to be an agreed set upon metrics – access, confidence, effectiveness... And let's put an infrastructure in place to do that... The basic premise is we cannot manage what we can't measure. We seem to be able to measure other very complex things in healthcare. (P13)

Limitation #4: Time limited

We're feeling a little bit at odds because that's a revenue source that we've been very dependent on... Either way, either the health system is going to feel it, or the mental health system is going to feel it... Am I hoping that there's going to be a new revenue source provided for mental health and addiction specifically? Yes, I sure am. (P14&P15)

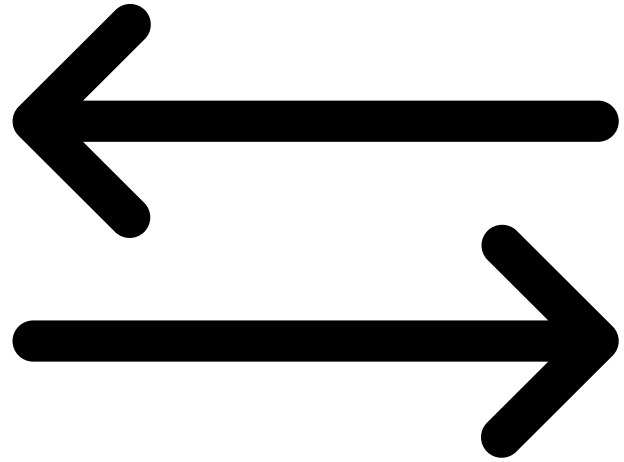
I think this [the transfers sunsetting] would leave a huge gap, not only in our community, in our city, but across the province now. (P7)

Limitation #5: Need for stronger standards

Standardization gradually builds awareness of the value of standards… I think that's where the Mental Health and Substance Use Health Standardization Collaborative Roadmap had its greatest impact—subtly, almost like a whisper. The long-term goal should be on equitable use and proof of standardization in the mental health and substance use health care system, and linking and making that a condition of the transfers. (P8)

I think we've ended up with a very long document [the Standards Collaborative Roadmap], that hasn't resulted in any change. (P13)

Key themes:
CROSS-CUTTING



Cross-cutting #1: Stigma and exclusion

There's nobody who pays [out-of-pocket] for the core service basket of cancer care. Most people pay for their core service basket of mental healthcare. When you have to pay for something it's a nice-to-have. It is not part of healthcare and I think ultimately it comes down to a lot of that. (P13)

When it comes to the mental health and addiction sector … it is not part of the billing code systems of each province and territory… which means that the province again sets priorities based on if the debate is polarized, stigmatized, where they land politically. Mental health is a contentious issue and I think we need to be clear about that. (P6)

Cross-cutting #2: Influence of federalism

Is there an ability to co-opt or coax provinces to a degree of transparency... of saying, okay, you've alleviated these costs for us and the billions of dollars of buildings and infrastructure. Therefore, we are free now to invest more in the mental health services that we know are priorities for our citizens. (P6)

This is the age-old problem the provinces have, is you start giving them money and they start expanding into a space and then the feds turn off the tap and leave the PTs holding the proverbial bag. (P10)

What are the key take-aways?

- Created fiscal room for expanding access to services, strengthening system infrastructure that would otherwise not have been possible
- Accountability and data far from perfect, but big leap forward given catch up needed after decades of underfunding, Medicare exclusion
- Policy clarity needed to address Indigenous inequities
- Anxiety in face of scarcity – people twisting themselves into knots a bit to avoid any criticism out of fear of losing funding

Where to from here?

Ideally renewed targeted funding will be able to build on lessons learned, further strengthen system capacity, catch up from legacies of exclusion.

BUT… policy outcomes shaped by IDEAS INTERESTS and INSTITUTIONS…

- IDEAS: Evidence of impact moderate, evidence of on-going need high, societal value on MHSUH mixed
- INTERESTS: Economy is priority one, risk of political fall out from taking $600M out of system moderate, advocacy underway across the country
- INSTITUTIONS: Strong influence of fiscal federalism - health transfer discussion heating up, so far PTs are calling for BOTH sustained 5% CHT and renewal of targeted transfers but could be crowded out

Thank you!

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