ZURICH

The Value of Mental Health

Strengthening personal resilience across people, productivity, and protection systems

Contents

Foreword

The value of mental health is felt every day – in the resilience that keeps people connected to work, family, and community.

Mental health shapes everyday life in ways that are often invisible – until a decline makes its influence impossible to ignore. It affects how people feel, how they cope with change and pressure, and whether they stay connected to work, family, and community.

Across the countries examined in this report – **Australia, Chile, Germany, Malaysia, the UAE, and the UK** – mental health has moved firmly onto the public agenda. Awareness has risen and more people are coming forward for diagnosis and support. This represents an important shift. Earlier recognition can reduce suffering and help individuals and families manage distress before conditions escalate.

It also reveals a broader set of realities. As mental health conditions surface at scale, needs that were once managed informally reach formal systems. When capacity does not keep pace, this burden falls back on individuals, through self-management, out-of-pocket spending, and informal care. Employers meanwhile face pressure to respond earlier, while services navigate difficult trade-offs to sustain timely, high-quality care for those with more severe or complex needs.

This points to a shared challenge across national contexts: how to strengthen the dynamic relationship between supportive protection systems and personal resilience. Disruption is part of life, but it is increasingly disconnecting people from daily routines, work, and social life. Support systems – including the mental health care services that insurers can provide – need to continue evolving toward prevention, early engagement, continuity of care, and sustained participation. But personal resilience – the ability to adapt to adversity, recover from setbacks, and maintain financial and social stability – also remains critical.

1 in 3

working-age adults in Australia (30%) and the UK (32%) are projected to be living with a mental health condition by 2030.

Drawing on original analysis across a diverse set of economies, *The Value of Mental Health* examines what mental health conditions mean for people, productivity, and protection systems. The countries included illustrate the full spectrum of challenges and opportunities – for public budgets, for people's ability to live healthy and productive lives, for employers trying to sustain their workforces, for families caring for those affected, and for systems already under strain.

A common pattern emerges across very different systems: significant costs are carried not just by governments, but by individuals, households, and employers, through wellbeing and productivity losses that dwarf public budgets.

As the first report in Zurich's *The Value of Health & Wellbeing* research series, we use these quantified costs to showcase the value that can be preserved through approaches to mental health that help support wellbeing, strengthen organizational performance, and maintain resilient protection systems.

Alison Martin
CEO, Life, Health & Bank Distribution

Key findings

This report brings together the latest data, modeling, and policy analysis to understand the scale, drivers, and implications of mental health conditions across six markets: Australia, Chile, Germany, Malaysia, the UAE, and the UK.

We focus on three pillars: people (the human impact), productivity (economic consequences), and protection systems (system pressures and policy landscape), that are shaping prevention, early intervention, access to support, and long-term recovery.

The goal is to offer a clear, evidence-based view of each country's mental health outlook and highlight select opportunities for strategic action to strengthen wellbeing, resilience, and inclusion in the years ahead.

By 2030, across the six countries examined, an average person living with a mental health condition is projected to face...[1]

Days of healthy life lost

60 to 67 days
of healthy life lost per year

Average employment gap

8% to 29%
employment gap compared to those without a mental health condition

Average sick days

0.2 to 5.6 days
of excess sick leave for mental health reasons per year[2]

Out-of-pocket expenditure

3% to 43%
of treatment costs covered by out-of-pocket expenditure

Annual hours of informal care

35 to 1,275 hours
of informal care received per year

Australia Chile Germany Malaysia UAE UK

1. Care should be taken in cross-country comparisons, particularly absenteeism and informal care, given differences in national reporting practices and methodological approaches.

2. Per worker in all countries excluding Australia, which is the average per worker with a mental health condition. Variances in recorded sick leave likely reflect both reporting regimes (for example, self-certification versus day-one medical certification), as well as labor-market incentives and constraints that shape whether distress appears as absence, long-term leave, or exit from work.

The five facets of mental health

Across six very different country contexts, a consistent pattern emerges:

High prevalence signals visibility – not just crisis

Mental health conditions are increasing, especially among young people. While this may partly reflect a real rise in cases, higher recorded prevalence can also point to better detection and systems uncovering previously unmet needs.

Early and widespread recognition can reveal hidden distress and bring a broader range of moderate and milder conditions into view sooner.

See 1. Prevalence

The greatest costs are lived, not budgeted

The biggest impact of mental health conditions is the loss of healthy, functional life – the ability to think clearly, participate, and stay connected.

This personal burden far exceeds what is captured in health care, social protection, and employer budgets, with wellbeing losses reaching up to 49 times formal spend.

See 2. People

Participation loss is the dominant productivity challenge

Mental illnesses are a key driver of productivity loss, with employment impacts projected to reach up to 5% of GDP by 2030 in some countries.

Sick leave is visible, but only accounts for a small share of economic loss. The main factor is long-term disengagement: leaving work, struggling to return, or never establishing attachment at all.

See 3. Productivity

Private and informal costs remain significant

Individuals, families, and employers shoulder much of the mental health burden.

Out-of-pocket payments, employer losses, and the value of unpaid informal care often exceed public spending – revealing gaps that formal systems alone cannot close.

See 4. Protection systems

As policy shifts upstream, employers are on the front line of early intervention and resilience

Employers are increasingly the first to recognize and support mental health needs – often before people access formal care.

Through early adjustments and coordinated support, workplaces can reinforce both system pathways and the personal resilience that keeps people connected, and reduces the risk of longer-term inactivity.

See 5. From awareness to action: Where the next opportunity lies

Collectively, these findings underline a shared imperative: strong protection systems must work alongside personal resilience – the ability to adapt to adversity, recover from setbacks, and maintain social and financial stability – so that everyday pressures do not become long-term disengagement.

How to read this report

The Value of Mental Health quantifies the current and projected prevalence of mental health conditions and related impact from 2025 to 2030, across six countries: Australia, Chile, Germany, Malaysia, the UAE, and the UK.

What do we mean by mental health?

Individuals may experience poor mental health without meeting the clinical definition of a mental health condition.

In this report, mental health conditions are clinically defined[3] mental and behavioral disorders captured in the Global Burden of Disease (GBD) study.[4] These include:

- **Anxiety, depressive and mood disorders:** Anxiety disorders (anxiety), bipolar disorder, major depressive disorder (depression), and dysthymia.
- **Eating disorders:** Anorexia and bulimia nervosa.
- **Neurodevelopmental and conduct disorders:** Attention deficit hyperactivity disorder (ADHD), autism spectrum disorders (autism), conduct disorder, and idiopathic developmental intellectual disability (IDID).
- **Psychotic disorders:** Schizophrenia.
- **'Other'** captures additional mental health conditions included within the GBD framework.

What do we mean by projected prevalence?

Prevalence refers to both the number of affected individuals and the number of diagnosed conditions.

Individuals may experience more than one mental health condition (comorbidity) – figures therefore include more recorded conditions than affected individuals. Overall prevalence estimates (by population, age, and gender) account for comorbidities.

Figures are based on the GBD's latest meta-analysis of country studies, from structured clinical interviews to administrative data sources, published in 2025 using data to 2023. This means recorded prevalence reflects national practices: it may be overstated where diagnoses are made in primary care without applying strict clinical thresholds, and understated where diagnosis is constrained by stigma, cultural norms, or limited access to specialist services.

Projections are based on historical trends in mental health prevalence by condition and population profile, combined with anticipated population growth for each market. Although the COVID-19 period influenced recent prevalence, projections are based on a 10-year historical window, reducing the impact of temporary shocks.

3. Aligned to the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).
4. Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2023 (GBD 2023). Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2025.

What do we mean by impact?

Impacts are assessed at both an individual and market level across three dimensions:

1. People (personal wellbeing)

The impact of living with mental health conditions is measured in years of healthy life lost using Disability Adjusted Life Years (DALYs). This includes morbidity (Years Lived with Disability, YLDs) and mortality (Years of Life Lost, YLLs). One DALY represents the loss of the equivalent of one year of full health.

The GBD presumes a consistent distribution of severity within conditions across countries. Differences in DALYs and YLDs between countries therefore reflect variation in condition mix and age profile.

Suicide is attributed to self-harm in the GBD, rather than mental health conditions. We have included self-harm in morbidity and mortality estimates; however, not all people who self-harm have a diagnosed mental health condition. This means we have captured part of the undiagnosed population that is not otherwise included in prevalence.

Years of healthy life lost are translated into monetary values based on a single estimate and market exchange rates to ensure comparability across countries, and it may differ to other in-market valuations. The valuation of healthy life years – an estimate of the value society places on a year of healthy life – provides an evidence-based way to compare mental health impacts with other national priorities.

Where data allows, additional financial and social impacts are included.

2. Productivity (economic impacts)

The effects of mental health conditions on employment are measured through reduced workforce participation and absenteeism.

Each country varies in measurement approach, labor market institutions, and data quality. Due to data limitations, these relationships are associative rather than causal. For example, an observed employment gap may reflect mental health conditions leading to unemployment, unemployment contributing to mental health conditions, or both.

Employment gaps are conservative: Estimates exclude informal unemployment, while those in employment are more likely to receive a diagnosis due to health care access.

Absenteeism is expressed as average excess sick days attributable to mental health per worker, except for Australia, where it represents average excess sick days attributable to mental health per worker with a mental health condition. It is calculated through four different methods, each with different limitations: certified sick leave systems (Chile, Germany); self-reported attribution (UK); OECD-modelled estimates (UAE, Malaysia); and a microdata-based approach (Australia).

Employment gaps and sick day estimates are held constant over the projection period. Presenteeism is not evaluated due to data gaps, and therefore these figures are conservative estimates of overall employment-related impacts.

3. Protection systems (public and private)

Expenditure associated with supporting individuals living with mental health conditions includes public and private health care expenditure and disability and social protection payments. Higher spending in this category may reflect more accessible or comprehensive systems, rather than poorer outcomes.

The value of informal (unpaid) care is also calculated for each market.

Data sources and limitations

The analysis predominantly relies on publicly available data to support transparency and replicability. Parameters are drawn from international datasets and peer-reviewed literature, where available.

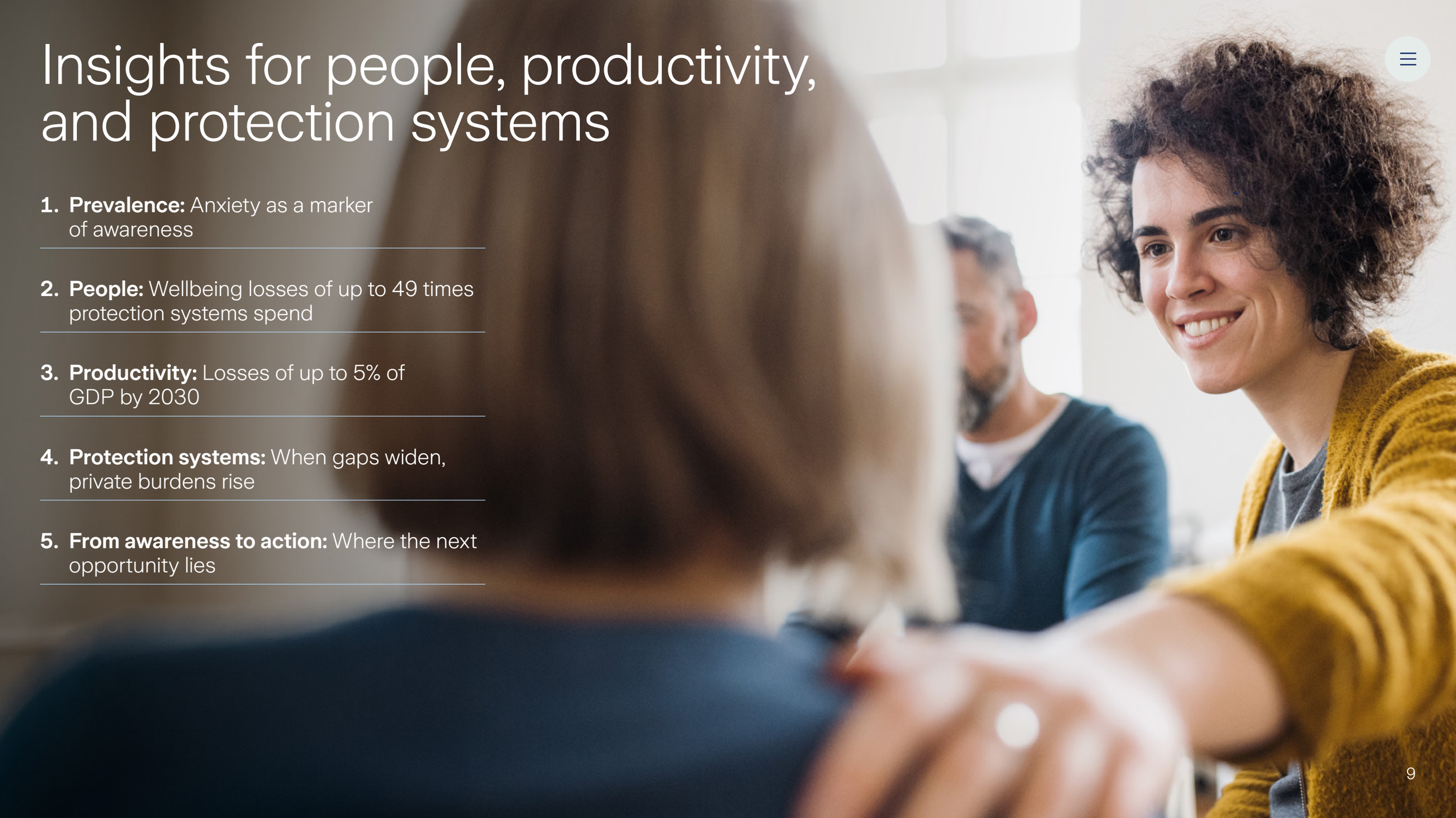
Where comparable data is not consistently available across countries, estimates are derived using an Australian micro dataset to support cross-market comparability. Zurich claims and underwriting data have been selectively analyzed to stress-test estimates where material data gaps exist.

Results should be interpreted with caution, particularly between countries, given differences in data quality, assumptions, methodology, and national reporting practices.

Refer to Data and methodology for a full overview of data sources, assumptions and calculations.

Insights for people, productivity, and protection systems

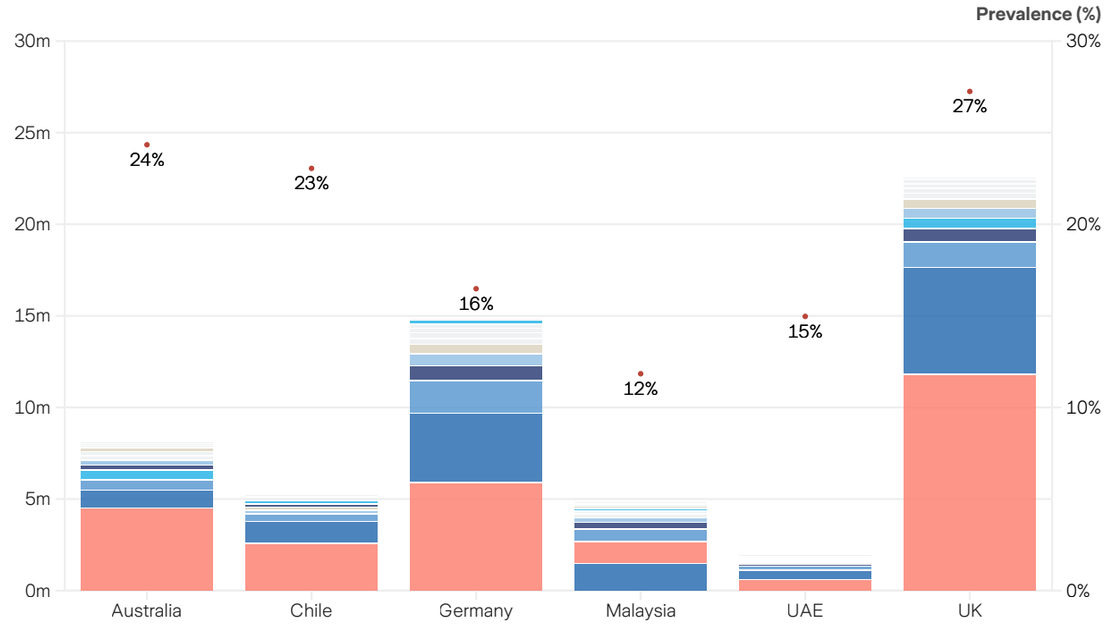
1. **Prevalence:** Anxiety as a marker of awareness
2. **People:** Wellbeing losses of up to 49 times protection systems spend
3. **Productivity:** Losses of up to 5% of GDP by 2030
4. **Protection systems:** When gaps widen, private burdens rise
5. **From awareness to action:** Where the next opportunity lies



1. **Prevalence:** Anxiety as a marker of awareness

Prevalence of mental health conditions (2030)

Projected number of mental health conditions (m) and total prevalence rate (%), by country



Prevalence (%) Anorexia nervosa Anxiety disorders
Attention deficit hyperactivity disorder Autism spectrum disorders Bipolar disorder
Bulimia nervosa Conduct disorder Dysthymia
Idiopathic developmental intellectual disability Major depressive disorder
Schizophrenia Other mental disorders

Primary sources: IHME (2025), World Bank (2025).

Individuals may experience more than one mental health condition (comorbidity) - therefore there are more recorded conditions than affected individuals. Prevalence estimates account for comorbidities.

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Mental health conditions affect a large and growing share of the population across all six countries, with recorded prevalence varying widely (projected 12% to 27% by 2030).

But prevalence should be interpreted with caution – high figures can also reflect widespread awareness and support. Low figures, on the other hand, may point to strong social and personal resilience – or a hidden burden of mental illnesses carried by family networks.

While the data cannot disentangle genuine increases in mental health conditions from the uncovering of previously unmet need – with observed prevalence likely a blend of both – patterns across markets suggest that variations in prevalence are strongly shaped by awareness, access, and thresholds for formal recognition.

In particular, the prominence of anxiety disorders emerges as a useful marker of how early and how widely mental health care needs are identified. Across markets, higher recorded prevalence is consistently associated with a greater share of anxiety disorders, indicating systems that capture a broad spectrum of distress – including milder, episodic, or situational symptoms that might otherwise be managed informally or by individuals. Conversely, where anxiety disorders account for a smaller share of recorded cases, formal diagnosis tends to occur selectively or late, once symptoms are more impairing.

From stigma to system access

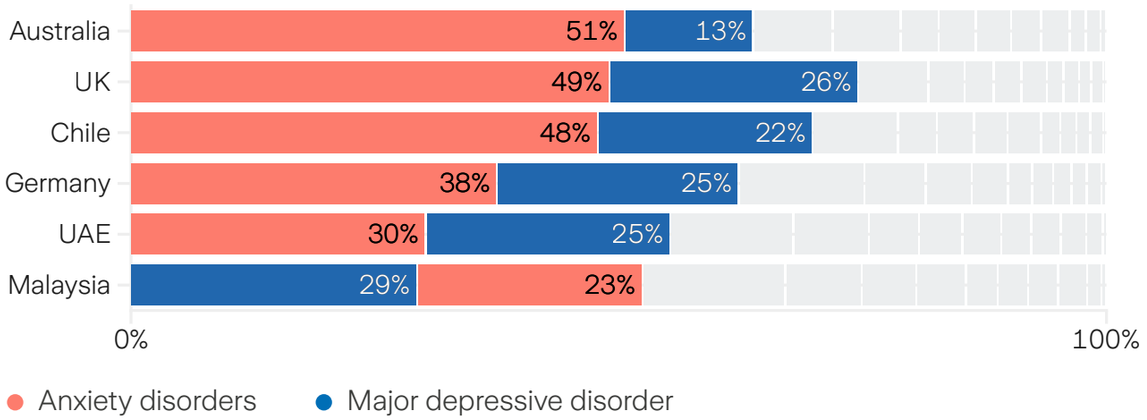
The UAE and Malaysia record the lowest official prevalence (estimated 14% and 11% of the population in 2026).

Continued efforts are expanding openness around mental health, empowering more individuals to seek support both within their communities and through professional channels. However, formal diagnosis thresholds remain high, and a material share of mental illness is still managed privately, through family support and community networks.

For example, in Malaysia in particular, major depressive disorder – a more highly impairing condition than anxiety – accounts for the largest share of recorded burden (estimated 29% versus 23% in 2026). The comparatively smaller presence of anxiety suggests that earlier or milder distress remains uncaptured, even as awareness continues to rise.

Higher prevalence conditions (2026)

Projected share of total mental health conditions (%), by country



Primary sources: IHME (2025), World Bank (2025).

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Both markets appear to be in transition, though at different stages. Slower prevalence growth in the UAE (2.2% a year) could reflect the ongoing success of sustained wellbeing policies in uncovering mental health conditions, while faster growth in Malaysia (2.8% a year) points to more rapidly rising awareness beginning to draw informal distress into formal care.

These dynamics shape downstream impacts. Higher barriers to identification mean that help may only be sought when resilience has already been eroded, narrowing the window for preventative or stabilizing support.

From early identification to early disengagement

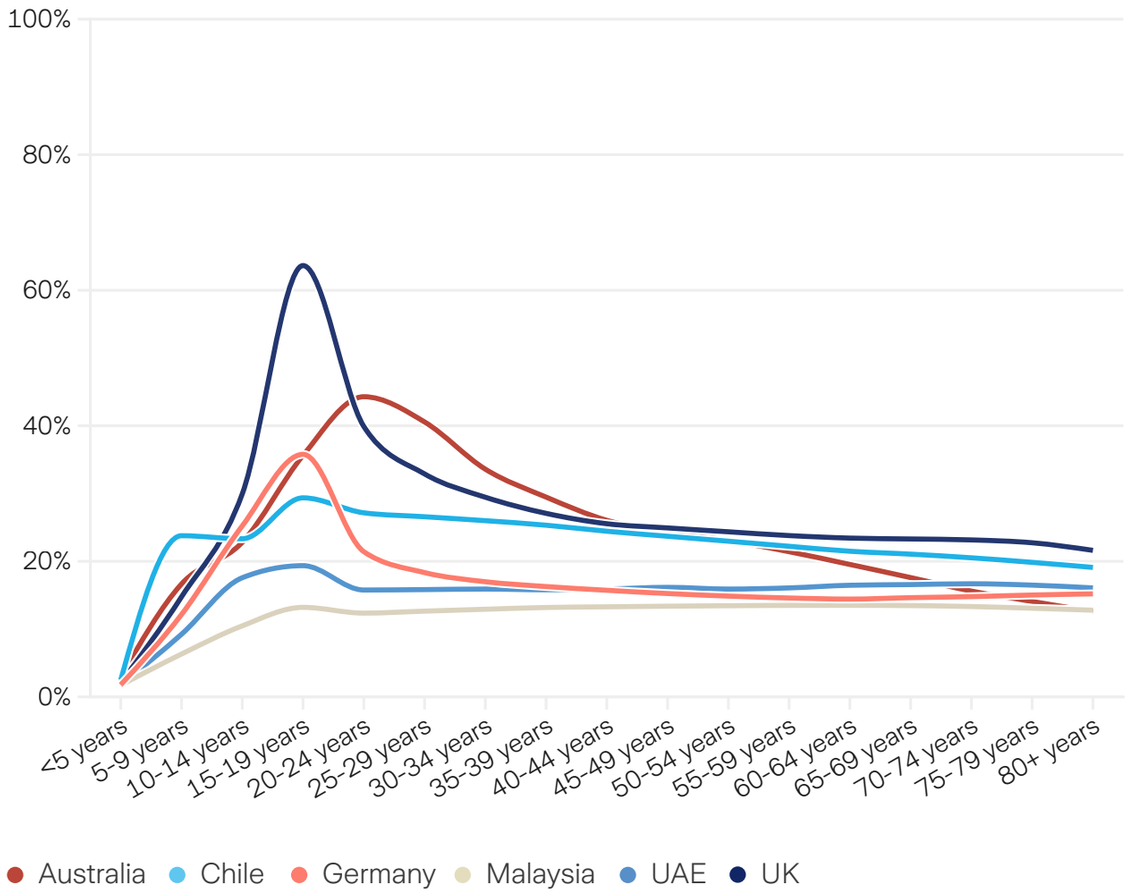
In contrast, Australia and the UK show the highest prevalence of mental health conditions in this study (23% to 24% in 2026), along with some of the fastest growth rates (2.5% and 3.6% a year). Prevalence peaks among younger cohorts (15 to 19 years in the UK and 20 to 24 years for Australia), and anxiety disorders dominate the prevalence profile: estimated 49% to 51% in 2026, rising to up to 56% of cases by 2030, if current trends continue unchecked. These patterns signal lower barriers to recognition and earlier entry into formal care. Primary care, education systems, and workplaces act as common points of contact, bringing a wider spectrum of mental illness into view – including lower severity and episodic distress that might remain informal elsewhere.

1 in 3

working-age adults in Australia (30%) and the UK (32%) are projected to be living with a mental health condition by 2030.

Prevalence of mental health conditions by age (2030)

Projected prevalence rates of mental health conditions by age group (%), by country



Primary sources: IHME (2025), World Bank (2025).

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

5. More than 60 days of healthy life lost.

As a result, recorded prevalence is elevated not only by higher demand, but by broad visibility and early engagement. This is most visible across the working-age population. A growing share of adults in both countries are interacting with mental health systems during periods of labor market entry, skill formation, and career progression, increasing the importance of pathways that both lower initial barriers to entry, and enable recovery without long-term disengagement from work.

Chile exhibits similar characteristics: comparatively high prevalence (21% in 2026), growing strongly (2.5% per year), and dominated by anxiety cases (48%). Prevalence is also higher among younger cohorts, but it does not exhibit the same sharp peak projected in Australia and the UK.

Charting a middle course?

While the data does not allow firm conclusions about severity, findings from Germany point to a more balanced model of high visibility and early identification, without broad prevalence inflation.

Recorded prevalence sits in the mid range of countries examined, at around 16% of the population in 2026, growing slowly at around 1.2% per year, with anxiety disorders making up 38% of cases and higher impairment conditions[5] accounting for a similar share (38%). This places Germany between lower-visibility markets like Malaysia and the UAE, where higher-impairment conditions dominate (41% to 43%), and higher-visibility markets like Australia and the UK, where anxiety-related distress makes up a larger share.

These patterns suggest a system that captures persistent or impairing need, while milder or situational distress is often still managed outside formal care. Higher prevalence among adolescents – peaking at 36% in 15- to 19-year-olds by 2030 – also points to early engagement, yet this has not translated into rapid overall prevalence growth. While these rates could also signal increasing need, Germany's youth profile indicates earlier routing of need through primary care, within a system that maintains selective thresholds for formal diagnosis.

Germany's experience may show that earlier and broader engagement can coexist with stable prevalence when capacity, thresholds, and care pathways are aligned to support both higher-impact need and personal resilience – the ability to adapt to adversity, recover from setbacks, and maintain financial and social stability.

Spotlight

Youth mental wellbeing

Higher prevalence among young people may reflect both a rise in recognition and a rise in mental illness. Risk factors such as social media exposure, academic pressure, economic uncertainty, and the stresses of major life transitions likely play a role, but what is clear is that awareness and need are rising fast, possibly outpacing the capacity of support pathways.

One common response across countries is to strengthen early, community-based prevention and promotion by creating low-barrier, trusted entry points – reaching young people before symptoms escalate and building the emotional literacy, coping skills, and social support that underpin resilience.

This is at the heart of the Z Zurich Foundation's youth mental wellbeing work, operating in 29 countries via 31 scaling initiatives. Programs like *Tackle Your Feelings* in Australia and Ireland use sporting clubs and educational environments as familiar settings to open conversations about stress and normalize help seeking. School-based models in Spain and Portugal, for example, integrate emotional regulation skills and stigma reduction into everyday curricula. In Hong Kong, Türkiye and Poland, digital programs are extending impact by offering prevention campaigns or moderated peer spaces for individuals less likely or able to seek in-person help.

These examples show how early visibility can be translated into early stability – when prevention and promotion are woven into the settings where young people already spend their time, long before crisis or disengagement takes hold.

2. People: Wellbeing losses of up to 49 times protection systems spend

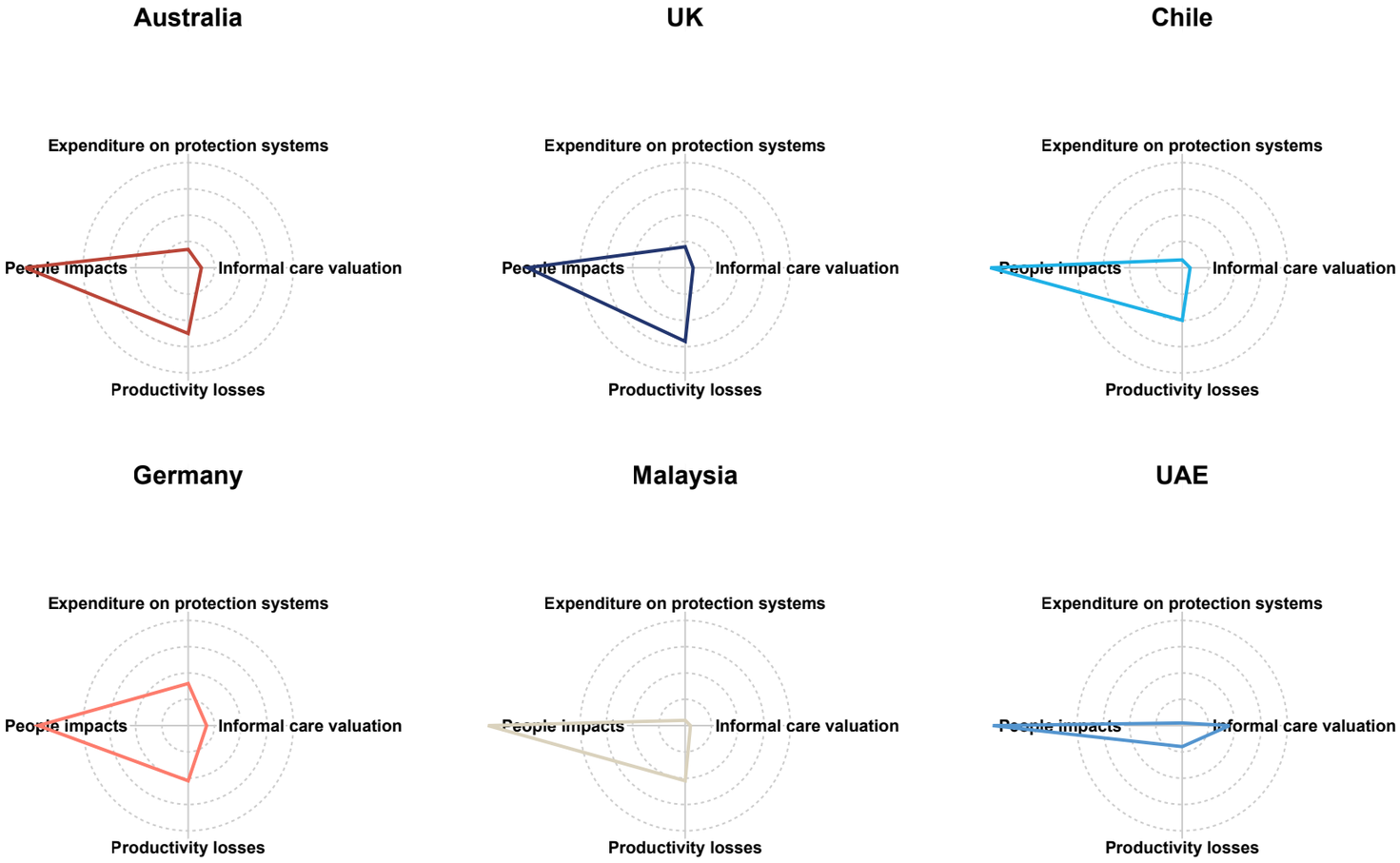
The people level impact of mental health captures something deeply human: the years of healthy life lost because of illness or premature death. These losses reflect the days when individuals cannot function at their usual capacity, the years spent managing persistent symptoms, and the moments when mental health challenges interrupt work, learning, relationships, and daily life.

Across the six countries examined, mental health conditions in 2026 are projected to result in:

- Around 60 to 67 days of healthy life lost per person with a mental health condition, per year.[6]
- At a market-level, this equates to between 0.3 and 2.9 million years of healthy life lost in each country – about 7 to 14% of overall wellbeing losses, close to the burden of all cancers (6 to 19%) in most countries.[7]
- Converted to monetary terms, these figures represent a total wellbeing cost of USD 1 trillion – ranging from USD 24 billion to USD 403 billion per year per market – far exceeding formal spend.

6. This is not a measure of how many hours a condition is present, but rather how many days of full, healthy life people miss out on, on average, due to mental health conditions – based on the total impact of symptoms, impairment and early mortality expressed as a single number. Functional impairment varies widely within and across conditions – this score is based on the typical level of impairment.
7. Based on comparative DALYs in 2023.

Projected impact of mental health conditions on people, productivity and protection systems (2026)
Monetary values as a proportion of the total (%), by country



Refer to ⮑ Data and methodology for a full set of data sources, assumptions and calculations.

Two months of healthy life lost per year

Across all countries, more than 85% of total wellbeing impact is driven by morbidity, not mortality. This reflects people living day-to-day with impaired concentration, energy, emotional regulation, and social functioning.

Countries face this burden through two distinct but parallel challenges:

- **Higher-prevalence conditions:** In these markets, many people experience more moderate but widespread impairment. Anxiety disorders are typically associated with lower average impairment per person (around 42 to 43 days lived with disability per year), but their overall contribution to wellbeing loss varies widely across countries depending on how broadly distress is recognized and recorded – 18% to 45% of total years lived with disability (YLDs).

- **Higher-severity conditions:** In lower-prevalence markets, a greater share of wellbeing losses are attributable to conditions that exhibit higher average impairment per case.

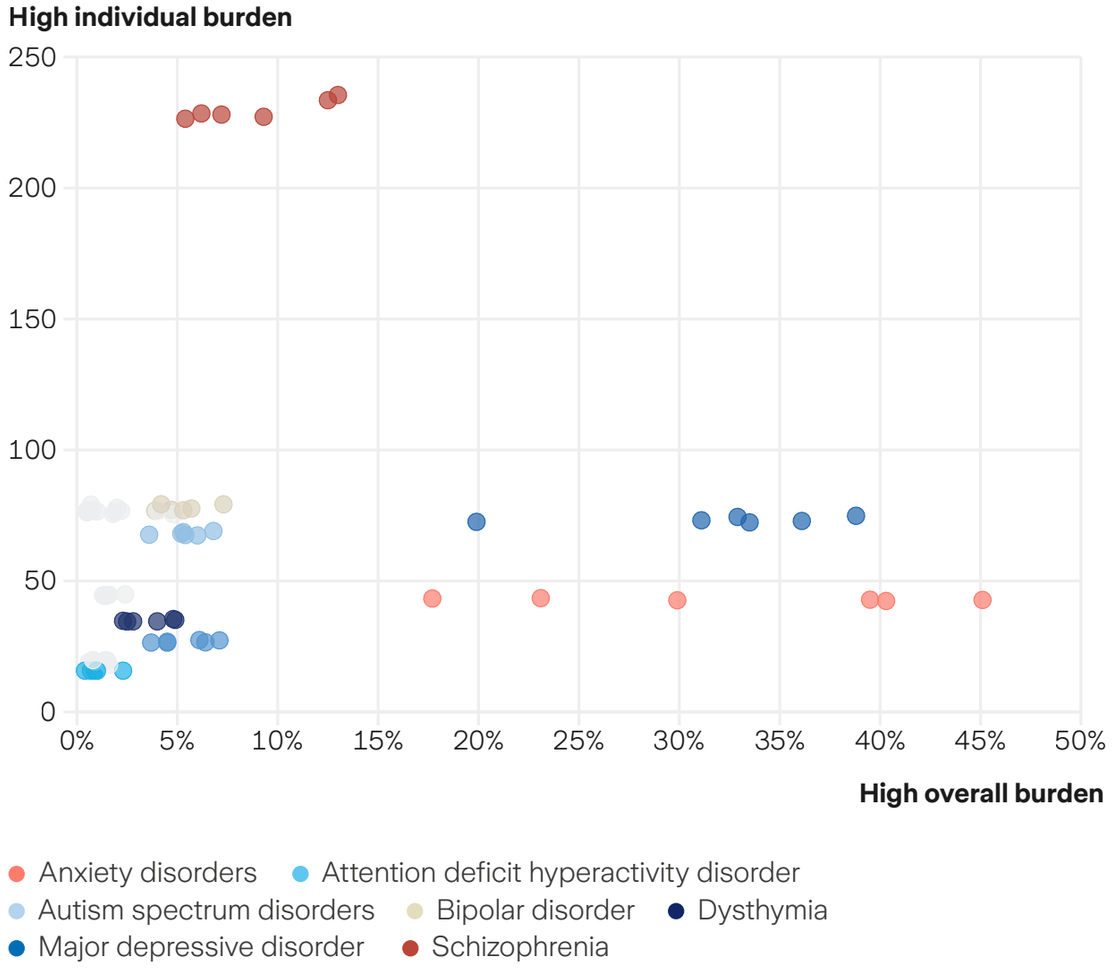
  For example, schizophrenia, while affecting less than 1% of people, generates outsized wellbeing impacts (5% to 13% of total YLDs) due to its chronic and highly impairing nature (226 to 236 days lived with disability per year).

  Autism accounts for the largest share of impact (4% to 7%) among neurodevelopmental conditions, despite a lower prevalence rate compared to ADHD in most markets. This reflects the comparative extent to which early-life conditions shape wellbeing across the life course (67 to 69 days lived with disability per year, compared with 16 days for ADHD).

These patterns show that very different prevalence profiles can produce similarly large wellbeing losses, depending on whether burden accumulates through scale, high-impairment conditions, or a combination of both.

However, the prominence of morbidity-driven wellbeing loss also clarifies where the greatest returns lie: reducing duration, recurrence, and cumulative impairment.

Morbidity impacts of mental health conditions (2026)
Estimated individual impairment (days living with a disability) and share of overall disease burden (% of total YLDs), by condition and by country

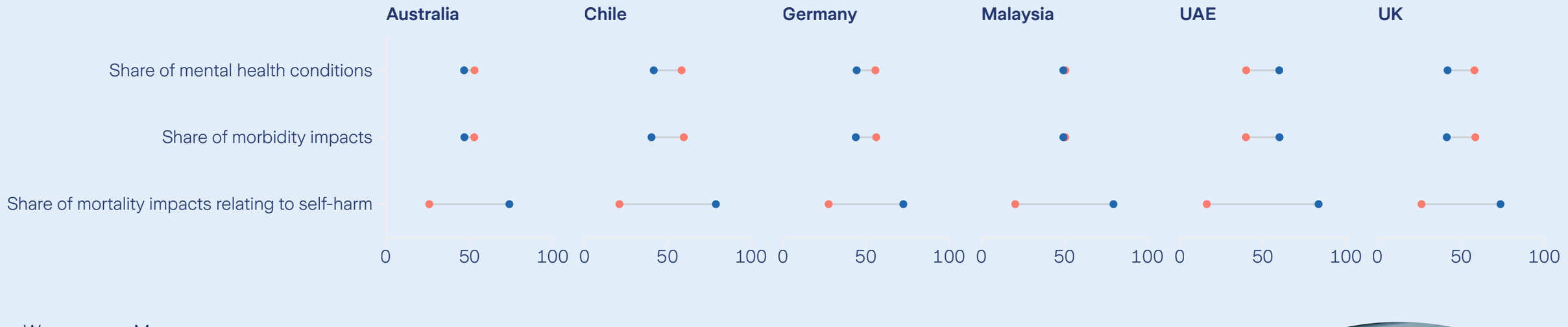


Primary sources: IHME (2025), World Bank (2025).

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Gender divides

Projected impacts of mental health conditions by gender (2026)
% of total cases, YLDs and YLLs, by gender



Primary sources: IHME (2025), World Bank (2025).
Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Across all six countries, patterns are consistent. Mental health conditions are more common and faster-growing among women.

With the exception of the UAE, this translates to women bearing a higher share of mental health conditions, as well as a higher morbidity burden. However, men are more vulnerable to suicide when distress goes unaddressed.

Enduring disadvantage

The personal cost of mental health conditions is not confined to symptoms or episodes of care. Australia-specific wellbeing indicators show that, alongside reduced quality of life, individuals with mental health conditions experience:

Greater financial stress, reflecting both reduced capacity to work and greater exposure to unexpected costs.

Lower financial resilience.

Lower overall life satisfaction – with gaps of around 10 to 11 percentage points – and are less likely to feel safe or part of their local community.

Stronger wellbeing and financial security underpin resilience, while financial vulnerability and reduced wellbeing erode it over time leaving individuals less able to absorb shocks, adapt to change, and recover quickly from disruption.

And because mental health conditions are widespread, these individual effects accumulate across the population and intersect with constrained system capacity, shaping downstream impacts on productivity, participation, and reliance on both formal and informal support systems.

Spotlight

Financial resilience

Financial resilience is a critical complement to mental health care. It helps people remain stable through periods of illness – especially when work participation is disrupted or support is delayed. Across markets, income and savings tools can provide short-term stability at times individuals are more exposed to income volatility or unexpected expenses.

Common approaches include individual and employer-based income protection plans, as well as programs that encourage regular saving habits, employer-linked savings schemes, and automatic micro-contributions that build modest financial buffers over time. In the UAE, for example, national financial literacy and savings initiatives aim to strengthen day-to-day resilience among younger workers.

Income smoothing and budgeting support – offered through employers, unions, or community organizations – also help people manage variable earnings during periods of reduced capacity. In Australia and the UK, employer-linked savings schemes and earned-wage access models (salary advance) offer alternatives to high-cost credit. In Chile, community cooperatives and rotating savings groups remain widely used to manage financial strain.

This stability can preserve agency, reduce pressure on family networks, and create space for individuals to engage with treatment and recover without slipping into deeper financial insecurity.

3. Productivity: Losses of up to 5% of GDP by 2030

Mental health conditions represent one of the most serious and sustained threats to productivity across the six markets examined, reducing economic potential through two main channels: lower workforce participation and higher absence.[8]

While the scale varies by market, the direction is consistent: productivity losses significantly outpace formal spend on care. Employment-related impacts of mental health are already projected to range from nearly USD 4 billion to USD 190 billion, the equivalent of nearly 0.7% of GDP in the UAE, to over 4% in the UK – reaching 5% by 2030.

Absence versus exit?

While sick leave is visible and often tracked, the largest and most persistent productivity losses across markets stem from reduced participation – people leaving, struggling to re-enter, or never entering the workforce to begin with.

Within this, however, the data points to two broad productivity profiles, reflecting how different labor markets and protection systems shape the relationship between symptoms, absence, and sustained participation.

In **exit-heavy markets,** mental health conditions are associated with larger employment gaps. The UK is the clearest example: employment rates among people living with a mental health condition are about 29 percentage points lower than among those without, and the overwhelming share of productivity loss is driven by people being out of work rather than by absence. This relationship runs both ways: disconnection from work can also drive poorer mental health outcomes, reinforcing the risks of long-term disengagement.[9]

This pattern is closely linked to where and when mental health conditions are surfacing. In higher-prevalence markets, diagnosis increasingly emerges before or during labor market entry, peaking among adolescents, students, and young adults. When early support is poorly connected to education-to-work transitions or first employment pathways, short-term distress is more likely to delay entry or lead to repeated withdrawal.

These pressures are likely to intensify as automation and AI reshape entry routes into work. Fewer routine or entry-level roles, faster shifting skill requirements, and more frequent job redesigns raise the bar for work readiness – increasing the importance of early support, adaptable pathways, and the personal resilience needed to navigate transitions.

These dynamics collectively risk creating a reinforcing cycle: higher barriers to first entry into work can erode confidence and financial stability, compounding underlying distress. In turn, emerging mental health challenges can make it harder to secure that first foothold in the labor market, deepening the risk of long-term disengagement.

In **absence-heavy markets**, employment gaps are smaller, but recorded sick leave is higher.[10] Chile illustrates this pattern: while the participation gap is more moderate (about 14 percentage points), a large share of productivity loss shows up through prolonged or repeated absence, with sick leave accounting for around 30% of total productivity costs. In these systems, people are more likely to remain formally attached to employment, even as recovery and return take longer.

8. Presenteeism, or reduced productivity while at work, is an additional channel, however was not quantified due to data limitations.

9. Sterud, et. al. Mental health effects of unemployment and re-employment: a systematic review and meta-analysis of longitudinal studies (2025).

10. Variances in recorded sick leave likely reflect both reporting regimes (for example, self-certification versus day-one medical certification), as well as labor-market incentives and constraints that shape whether distress appears as absence, long-term leave, or exit from work.

Balancing protection and participation

Both profiles are shaped by how systems balance income protection with incentives to remain in work. Strong public and employer safety nets play a critical role in enabling recovery, reducing financial stress, and preventing crisis-driven exits.

But the longer someone is disconnected from work because of a mental health condition, the harder it becomes to return. And when protection is not paired with early intervention and structured return-to-work support, time away from work can raise the risk of permanent detachment – a challenge most visible in higher-income markets.

The highest leverage actions therefore sit upstream of long-term exit: fast time to care, clear stay-at-work options, and return-to-work pathways that are supported and aligned with real-world utilization. Where these elements are in place, mental health conditions are more likely to cause temporary disruption rather than a lasting loss of economic potential.

Spotlight

Return-to-work pathways

Periods of mental illness do not always require stepping away from work altogether. For many people, remaining safely connected to routine, colleagues, and purpose can support recovery, helping maintain rhythm, confidence, and social contact. Employers are placing greater emphasis on both entry pathways and return-to-work approaches that can adapt to someone's capabilities. This includes clearer job design, flexible duties and hours, and maintaining early contact during absence. For example, Zurich UK uses adapted roles, predictable environments, and coached transitions to strengthen job fit for neurodiverse employees.

These targeted approaches are complemented by a broader set of wellbeing and prevention tools. Insurers are now early intervention partners – helping organizations identify risks sooner, supporting employees before conditions escalate, and preventing avoidable absences. Group risk arrangements such as life insurance and income protection commonly include mental health helplines, early psychological support, virtual GP access, crisis counselling and employee assistance programs. Mental health coaches, for example, offer confidential guidance to help individuals navigate early symptoms and plan gradual reintegration. Early notification insights can also help employers identify emerging patterns before long-term absence develops.

However, people need to be able to find, trust, and use these tools. Utilization is often lowest among those most affected, particularly when services require self-navigation or sit outside workplace processes. Targeted, guided pathways – including proactive outreach and clear signposting – can help connect available support to earlier recovery. Staying connected to work – with the right support – can be a strong predictor of long-term participation. But it requires clear coordination and trust between employees, employers, and the wider ecosystem of clinical, workplace, and insurer support.

4. Protection systems: When gaps widen, private burdens rise

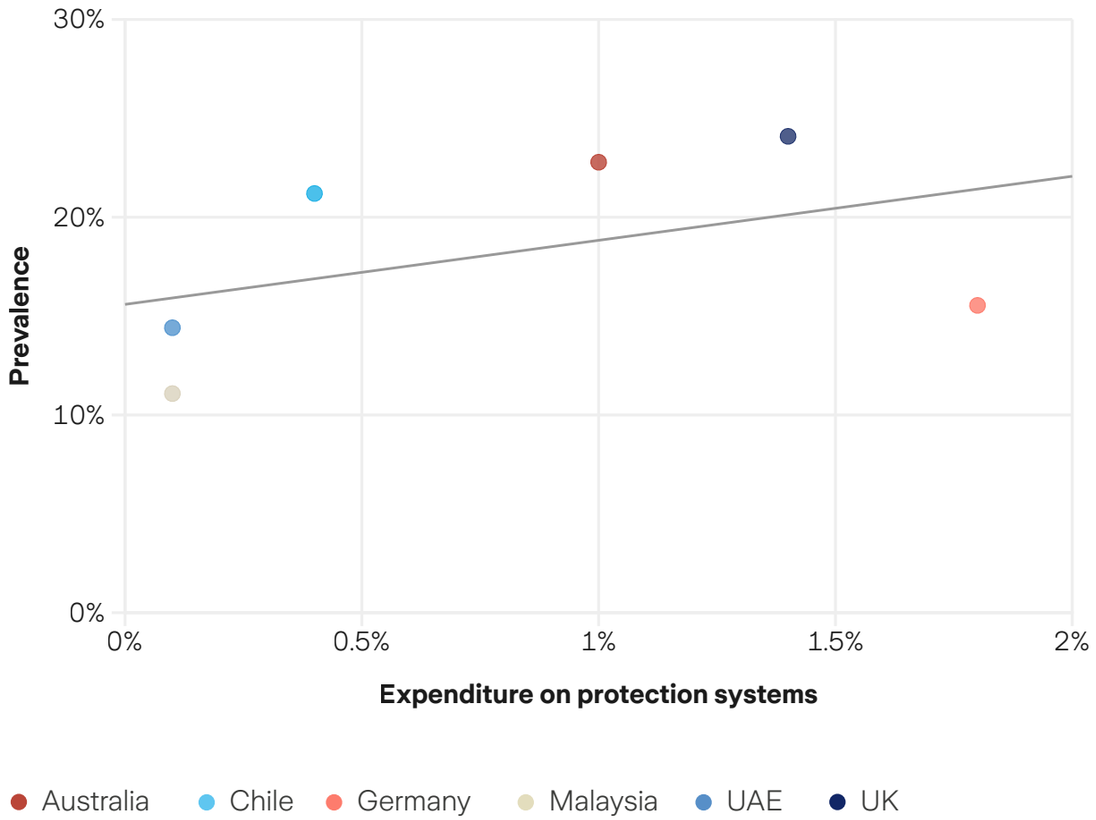
Across all six markets, protection systems play a central role in shaping how mental health conditions are identified, funded, and managed.

Public expenditure varies widely. There is a broad correlation between higher prevalence and higher formal spend – from around 0.1% of GDP in the UAE and Malaysia, to 1.0% in Australia and 1.4% in the UK in 2026 – with two notable exceptions.

Germany stands out as a lower-prevalence but higher-spend market (USD 96 billion, or 1.8% of GDP in 2026). Paired with its slow growth rates and moderate employment gap, this points to a market that has achieved a balance of broad access, early access, and strong social protection – without prevalence inflation.

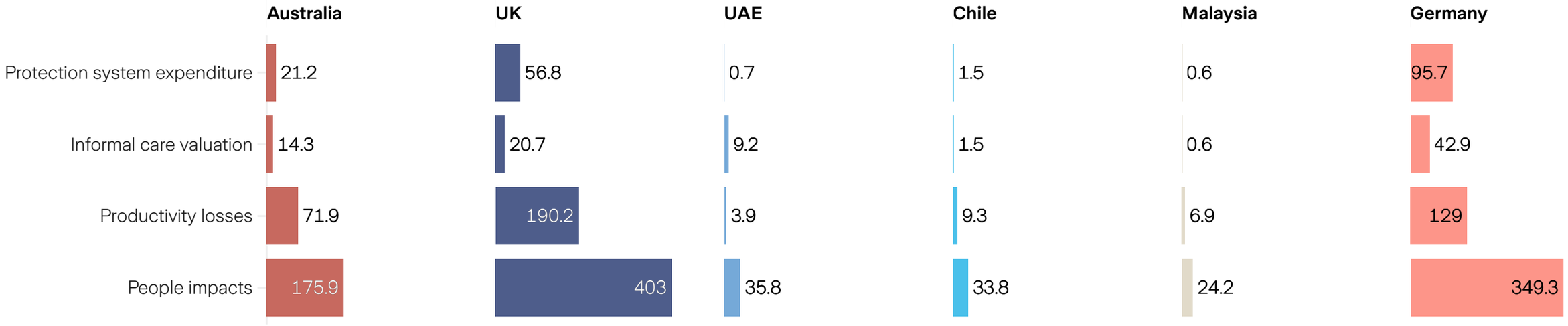
In comparison, Chile exhibits higher prevalence, but lower public spend (USD 1.5 billion, or 0.4% of GDP). This implies a system where visibility may have increased faster than investment, creating structural gaps that families, employers, and private services fill. Chile's dual insurance model and long public wait times mean that public spend understates true system pressure, shifting the burden toward out-of-pocket payments and informal care.

Comparative expenditure on mental health care protection systems (2026)
By prevalence rate (%) and as a proportion of GDP (%)



Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Projected impacts of mental health conditions on people, productivity and protection systems (2026)
USD billion, by country



Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Because visible public budgets capture only part of the overall cost, much of the burden sits in a larger and less visible ecosystem of out-of-pocket spending, employer-borne costs, and unpaid care that fills the gaps when public provision falls short. In every market, private and informal systems absorb substantial costs – and the smaller the public investment, the greater the burden on individuals and families.

Out-of-pocket expenditure is a defining feature of mental health care in lower-spend markets, particularly in Chile and Malaysia (42% to 43% of overall spend on protection systems). Private insurance plays a complementary role – through life insurance, income protection and private health plans – offering faster access and financial stabilization during periods of illness. But as recovery pathways lengthen and access to clinical care is delayed, insurers increasingly face the downstream consequences of system strain.

Informal care is one of the largest, least visible components of protection systems, and in Malaysia, Chile and the UAE, it exceeds both public and private spend combined (with the valuation of informal care ranging from USD 0.6 billion to USD 9 billion in these markets in 2026). This community-driven support reflects the resilience of families – particularly women and lower income households – who play a central role in wellbeing, however greater support could enable more individuals to participate fully in the labor market and strengthen household stability.

Across markets, the pattern is consistent: when formal systems reach capacity, the cost burden on households, employers, insurers and individuals grows.

Systems are beginning to act earlier

Despite significant differences in structure, funding, and culture, all six markets face the same challenge: ensuring support arrives in time. Whether because of delayed help-seeking or stretched clinical capacity and wait times, intervention often begins only after distress has escalated into impaired functioning, absence, or disengagement.

But across the countries examined, new approaches are emerging that push intervention earlier in the pathway, aiming to stabilize individuals before symptoms escalate and before work, study, or daily life are disrupted.

Australia: reducing upstream risk exposure

Australia has introduced one of the most explicit upstream interventions – restricting social media access for under 16-year-olds to reduce exposure to digital environments associated with heightened anxiety and distress. This complements widespread GP-based screening and reinforces a system increasingly focused on reducing early-stage risk, not only treating clinical symptoms once they are established.

Chile: shifting early intervention into communities

Chile's *Atención Primaria de Salud (APS)* anchors mental health support in both primary care and community settings. APS enables earlier assessment, brief psychological support, and coordinated follow-up – although bottlenecks in specialist capacity still delay deeper intervention. Its evolution illustrates a system trying to pull mental health action closer to first contact, reducing the long periods of untreated symptoms that drive later impairment and prolonged absence.

Germany: earlier routing through flexible, integrated care

Germany's Flexible and Integrated Treatment (FIT) program replaces per day hospital payments with a single budget, allowing hospitals to deliver care wherever it is most appropriate. This approach has reduced reliance on inpatient care – avoiding roughly five inpatient days per patient – and enables clinical teams to follow individuals across settings. FIT demonstrates how funding flexibility can support earlier intervention and reduce pressure on specialist units.

Malaysia: tele-health as a first point of engagement

In Malaysia, early support increasingly begins outside traditional clinical settings, through employer-facilitated and private tele-health services. Remote assessments and counseling reduce barriers created by stigma, travel constraints, and long waits for public services. Tele-health is not a substitute for clinical capacity, but it provides an accessible bridge for mild to moderate symptoms where early action can have significant effects.

The UAE: protecting participation before crisis

The UAE's Federal Mental Health Law signals a preventative shift anchored in employment rights. By restricting dismissal and discrimination on mental-health grounds, the law encourages earlier disclosure and help-seeking, reducing the risk that short episodes of distress become long-term disengagement while also helping break stigma and persistent barriers to greater identification.

The UK: employers as frontline early action partners

UK government initiatives, including the *Keep Britain Working Review*, outline a new approach where mental health becomes a shared responsibility with employers leading on prevention and early intervention. The premise is clear: if employers act earlier, and government supports that action, more people stay healthy in work, recover faster, and return sooner. Evidence shows individuals off work for fewer than 12 months are nearly five times more likely to return than those absent longer, highlighting the need to act before absence becomes prolonged.

5. From awareness to action:
Where the next opportunity lies

Across six very different health, cultural, and labor market systems, mental health conditions are being recognised earlier and more widely than ever before. While countries start from different positions, the next opportunity is strikingly consistent: act early, support individuals to stay connected to work, family, and communities, and strengthen both system and personal resilience.

1. Shift intervention upstream – where need first emerges

Prevalence is rising fast in children, adolescents, and young adults, and the earlier support arrives, the less likely it is that mild or situational distress becomes entrenched. Across countries, this means:

- Promoting emotional literacy, coping capacity, and personal resilience so individuals can better manage early-stage distress. For example, evidence suggests that social and emotional learning programs can improve social adaptation and reduce psychological distress, while resilience-based interventions show promise in strengthening the ability of both children and adults to adapt to stressors.[11]

- Expanding rapid access and early intervention pathways across schools, universities, primary care, youth services, and digital channels. This can be particularly effective for neurodivergent adolescents, with related school-based interventions in the UK shown to lead to significant improvements in emotional wellbeing – including reductions in anxiety and depressive symptoms.[12]

- Ensuring early contact does not overwhelm systems by improving triage, routing, and clarity of thresholds – directing people to the right level of support and avoiding over-medicalization.

2. Protect participation by stabilizing work and income – including support for caregivers

In all markets, the greatest economic losses stem not from absence, but from reduced workforce participation – and employers increasingly sit on the frontline of early intervention. Across countries, this means:

- Expanding return-to-work, stay-at-work, and caregiver pathways that meet individuals where they are – through job design, flexible duties, and phased hours. Work-focused interventions that modify job demands and support continued participation have been shown to improve mental health outcomes.[13]

- Strengthening coordination between employers, primary care, community services, and insurers so that protection system tools – such as income support arrangements, coaching, early notification insights, and rehabilitation guidance – are used effectively to stabilize recovery.

- Reinforcing financial resilience through savings tools, income smoothing supports, and budgeting assistance, helping people and households manage periods of reduced capacity.

11. Cai, et. al. School-based interventions for resilience in children and adolescents: a systematic review and meta-analysis of randomized controlled trials (2025); Hosokawa, et. al. Enhancing social-emotional skills in early childhood: intervention study on the effectiveness of social and emotional learning (2024); Greenberg, Evidence for Social and Emotional Learning in Schools (2023).
12. Adindu. The Effectiveness of UK School-Based Mental Health Programs for Neurodivergent Adolescents: A Policy Review of Sen (Special Educational Needs) and Inclusive Education Strategies (2025).
13. Sanatkar, et. al. A systematic review and meta-analysis of the effectiveness of work-focused interventions for employees with symptoms of depression, anxiety, and psychological distress (2025).

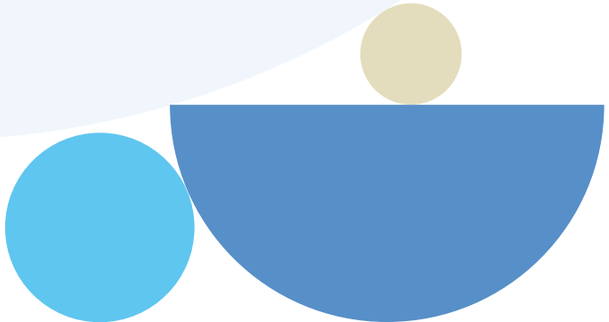
Spotlight

Acting before absence – Zurich's approach

In Switzerland, most employers purchase collective daily sickness benefits insurance *(Krankentaggeldversicherung, KTG)*, which protects employees' income if illness prevents them from working. Employers choose a waiting period – typically 30 to 60 days – during which they continue paying salary before the insurer steps in. Because this initial period can be costly and disruptive, Zurich Switzerland embeds early intervention services into its KTG offering to prevent avoidable sick leave.

Zurich's care management model supports employers on three fronts. Corporate health management provides stress risk assessments, workshops, and manager training to flag early warning signs. A team of mental health coaches offers confidential, voluntary one-to-one support for employees showing signs of overload, anxiety, burnout or acute stress – helping them rebuild routines, manage energy, and strengthen self-awareness – and, with consent, liaise with HR where workplace factors contribute.

If an employee does enter sick leave, specialist case managers coordinate a workplace-focused reintegration plan across the employer, insurer, and healthcare providers. Together, these services intervene early to reduce avoidable absences and keep people safely connected to work before distress escalates.



3. Build system capacity where it matters most – and strengthen resilience alongside care

Systems everywhere face rising pressure: long waits for psychological therapies, uneven access, and limited specialist supply. Yet not all capacity needs to be clinical. Flexible, integrated, community-based care can reduce bottlenecks while supporting more stable recovery. Across markets, this means:

- Strengthening specialized mental health treatment and support services, which play a critical role in treatment and recovery and have demonstrated positive clinical outcomes in evaluations.[14]

- Expanding multidisciplinary and community-based teams that reduce reliance on inpatient and specialist care and enable smoother transitions across settings. One district in Chile's Community Models of Mental Health Care demonstrated 21% lower emergency visits than comparable districts with partial implementation, underscoring the role of community capacity in relieving system pressure.[15]

- Aligning investment with the conditions driving the greatest cumulative loss – especially anxiety and depressive disorders – including through flexible and integrated funding and care models. Evidence from Germany's FIT hospitals shows that global treatment budgets have enabled more continuous, coordinated care, with inpatient use increasing by 5.1 fewer days than under routine treatment models.[16]

Stronger system-wide capacity paired with strengthened personal resilience is what ultimately protects health, workforce participation, and economic stability. When countries move upstream, connect support across work and health, and enable individuals to maintain confidence and capability, mental health conditions are far more likely to remain manageable, recoverable, and compatible with everyday life.

14. Australian Institute of Health and Welfare. Consumer outcomes in mental health care (2025).
15. Zitko, P. et al. Implementing a Community Model of Mental Health Care in Chile: Impact on Psychiatric Emergency Visits (2017).
16. Neumann, A. et al. Changes in patient care through flexible and integrated treatment programs in German psychiatric hospitals: meta analyses based on a series of controlled claims-based cohort studies (2024).

Insights by country

Australia: A system under pressure as early identification grows

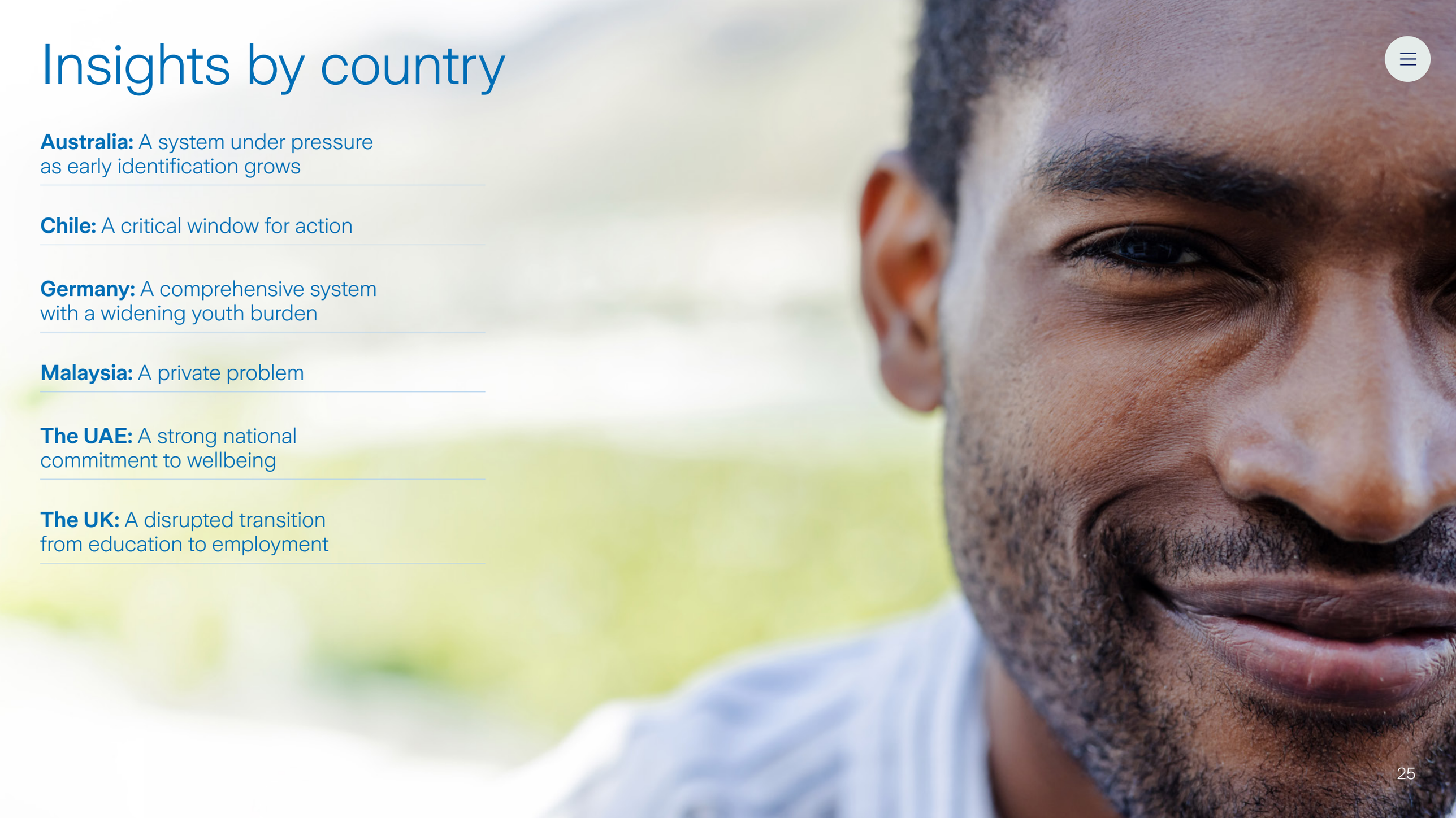
Chile: A critical window for action

Germany: A comprehensive system with a widening youth burden

Malaysia: A private problem

The UAE: A strong national commitment to wellbeing

The UK: A disrupted transition from education to employment

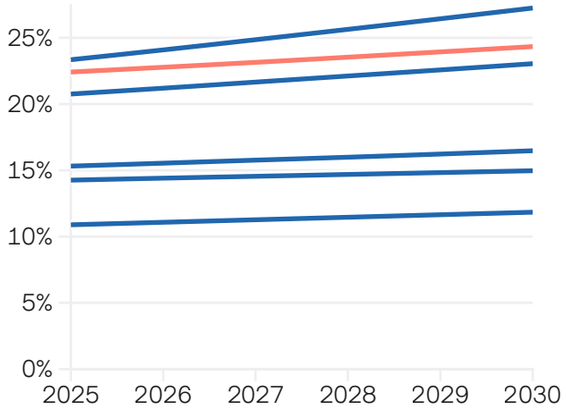


Australia

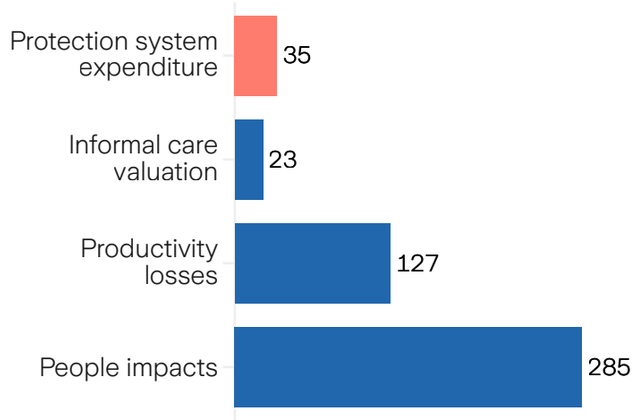
A system under pressure as early identification grows

This section brings together the latest data, modeling, and policy analysis to understand the scale, drivers, and implications of mental health conditions in Australia. We focus on three pillars: People (the human impact), productivity (economic consequences), and protection systems (system pressures, and policy landscape), that are shaping prevention, early intervention, access to support, and long-term recovery. The goal is to offer a clear, evidence-based view of the nation's mental health outlook and to highlight select opportunities for strategic action to strengthen wellbeing, resilience, and inclusion in the years ahead.

By 2030, mental health conditions are projected to affect nearly 1 in 4 people living in Australia (24%)



Estimated impacts on people, productivity and protection systems (2030) AUD billion



By 2030, an average person living in Australia with a mental health condition is projected to face...

Low days of healthy life lost

60 days
of healthy life lost

Higher average employment gap

18%
employment gap

Higher average sick days

0.7 days
of excess sick leave for mental health reasons per year

Low out-of-pocket expenditure

3%
of treatment costs covered by out-of-pocket expenditure

Lower annual hours of informal care

56 hours
of informal care received per year

Australia

Prevalence: Recognition is shaping how the burden is felt

Australia records one of the highest reported prevalence rates of mental health conditions among peer economies. In 2026, nearly one in four people (23%) are estimated to be living with a mental health condition – equivalent to more than 6.3 million people, with prevalence rising steadily toward 2030 (2.5% CAGR).

At face value, this is a population under strain. In practice, Australia's high prevalence reflects a system that has largely succeeded in breaking stigma and expanding recognition. Mental health is part of the public conversation; screening is normalized; and primary care – particularly through general practitioners – provides an accessible first point of contact.

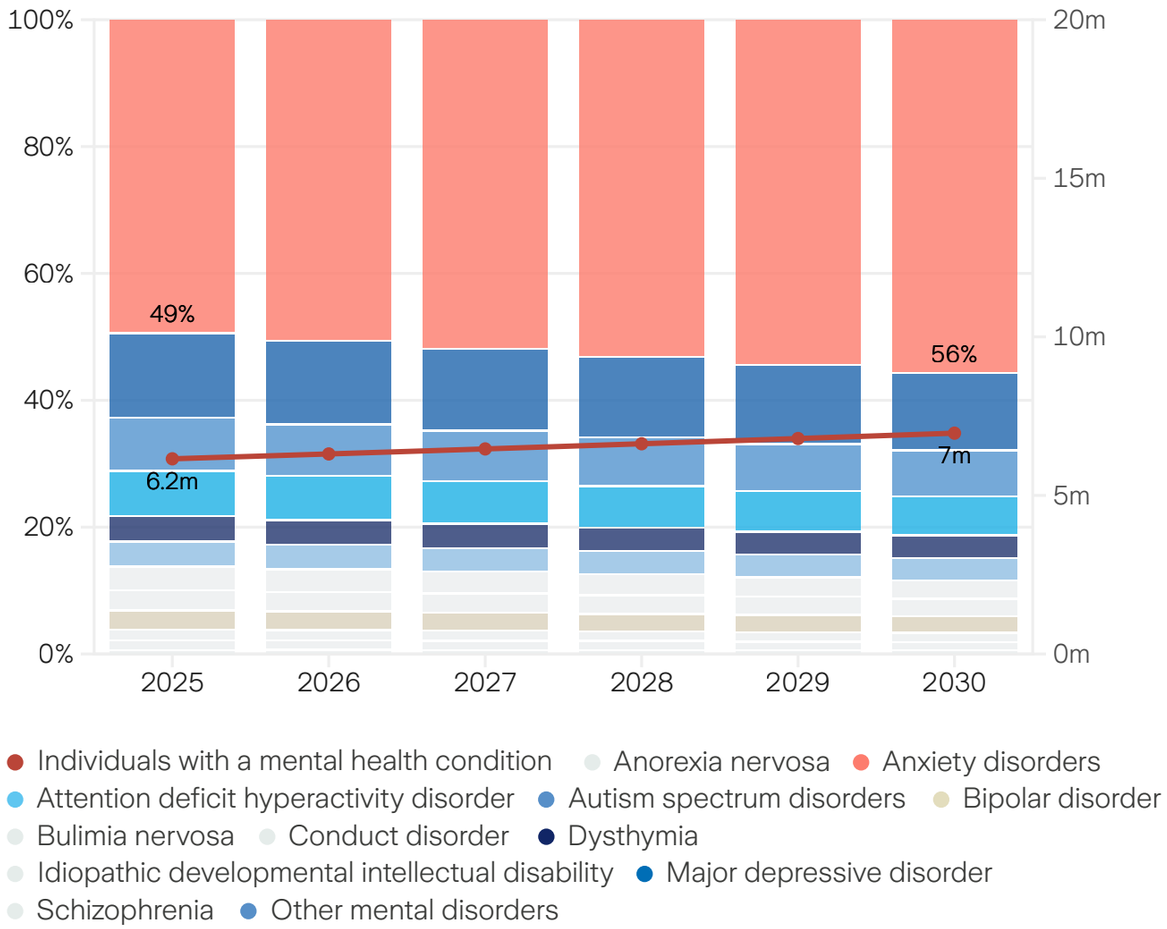
Rising prevalence therefore likely reflects recognition as much as deterioration. A broader spectrum of health-related experiences – from severe and persistent illness to milder, episodic or situational distress – is now visible in the data. Psychological distress that may remain family-managed or unrecorded elsewhere is more likely to be identified, labelled, and treated within the health system.

Early and widespread recognition has brought clear benefits, particularly in normalizing help-seeking and pathways to appropriate treatment. But it also influences demand, shaping how mental health conditions are experienced and managed:

1. **Recognition influences more than access.** In some cases, distress may not always meet strict diagnostic thresholds or necessarily require medical intervention. While diagnosis provides legitimacy and a route to care, it can also frame mental illness primarily in clinical terms, potentially crowding out lighter-touch, non-medical responses that enable people to rebuild coping capacity and resilience.
2. **Diagnosis can become part of personal identity.** Where some forms of mental distress were once understood as temporary responses to life events or environmental shocks, formal diagnosis of these episodic experiences can signal – and in some cases reinforce – a more enduring condition. Diagnosis can shape how individuals see themselves, how others respond to them, and how systems interact with them. For some, this may lower expectations of recovery amid weak incentives to return to full participation.
3. **Scale can obscure severity.** Early identification does not always translate into early support. When large volumes of lower-impairment cases enter the system, visibility of high-needs cases can be diluted, placing pressure on public clinical capacity – particularly in community and specialist services – and reducing timely access for those with more complex needs. These effects tend to fall most heavily on lower-income groups without private coverage.

The challenge Australia now faces is one of proportionate response, balancing strong clinical support for those who need it most with greater emphasis on individual capability, resilience, and recovery where appropriate. External shocks – bereavement, economic uncertainty, social volatility – will always occur. The task is to strengthen people's ability to weather these pressures – avoiding automatic entry into sustained clinical pathways or long-term loss of participation.

Australia: Projected prevalence of mental health conditions (2025-2030)
Projected share of cases by condition (%) and total number of individuals with a mental health condition (million)



Primary sources: IHME (2025), World Bank (2025).

Total number of individuals with a mental health condition accounts for co-morbidities.

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Anxiety is driving rapid growth

Anxiety disorders are projected to account for over half (56%) of recorded mental health conditions by 2030, growing at an average rate of around 6% per year – far faster than any other condition. Most other mental health conditions grow more slowly (2% per year or less), with some declining.

This concentration matters. Anxiety spans a wide continuum – from situational distress linked to life events, to persistent, clinically diagnosable disorders. Many people experience anxiety-related mental illness without meeting formal diagnostic thresholds. But as awareness increases and help-seeking rises, a larger share of this spectrum is likely to be captured in recorded prevalence.

The social media ban

Australia is among the first countries to restrict social media access for younger age groups, reflecting growing concern about the role of digital environments in shaping mental health during formative years. While long-term effects are still emerging, the move signals a deliberate shift toward upstream intervention – aiming to reduce exposure to risk before mental health conditions translate into disrupted education, delayed labor market entry, or long-term disengagement.

Prevalence peaks among young adults

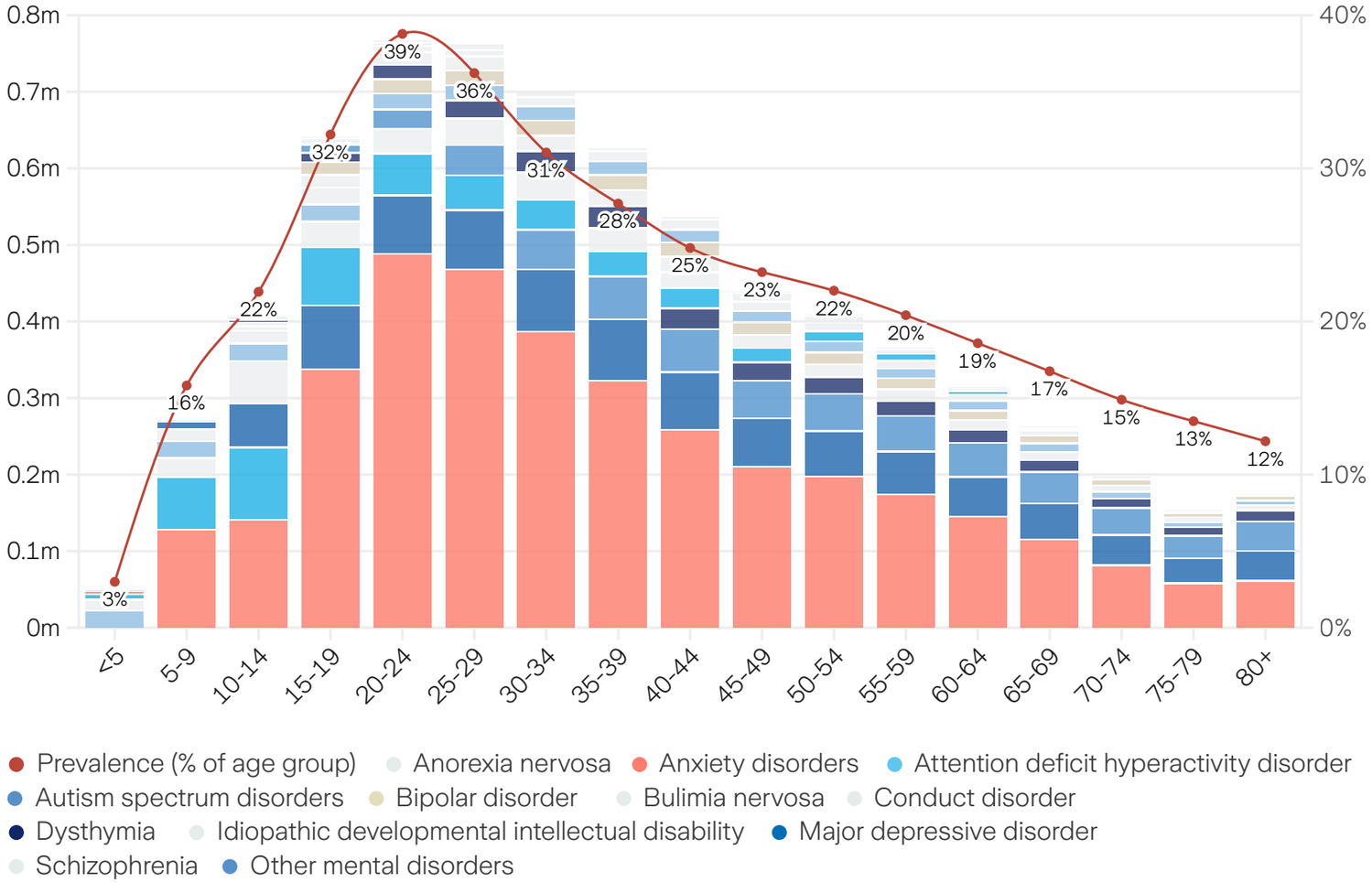
Mental health conditions are most common among people aged 15 to 34, with close to one in three estimated to be living with a condition, and prevalence peaking at around 39% among those aged 20 to 24.

Early adulthood is a period of rapid transition – from education to early careers, housing, relationships, and rising financial responsibility. These pressures heighten exposure to mental distress and when conditions are diagnosed at this stage, they can shape trajectories long before severe or persistent illness emerges.

But early diagnosis can also shape how individuals navigate education, work, and risk-taking, and it influences how systems respond to them over time – including labor market attachment and longer-term insurability.

Australia: Projected prevalence of mental health conditions by age (2026)

Number of mental health conditions (million) and prevalence rate (%), by age group



Primary sources: IHME (2025), World Bank (2025).

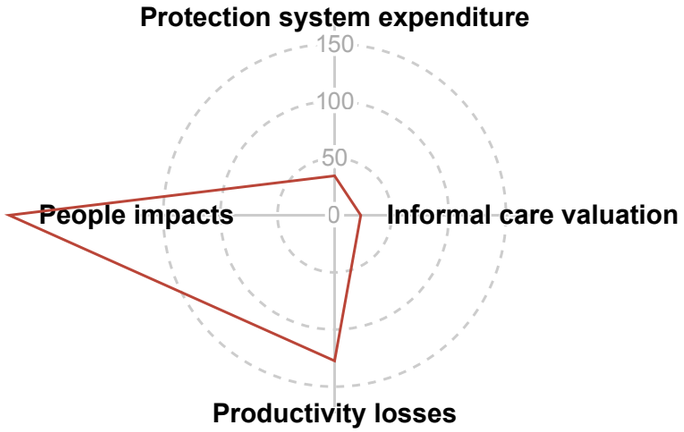
Projected prevalence by age group (%) includes comorbidities.

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

A high-awareness, high-prevalence market

Australia's prevalence profile has far-reaching consequences.

Australia: Estimated impacts on people, productivity and protection systems (2030)
AUD billion



Refer to ⇨ Data and methodology for a full set of data sources, assumptions and calculations.

By 2030, despite sustained investment in protection systems – estimated at nearly AUD 35 billion (about 1.1% of GDP) – mental health conditions are associated with:

AUD 285 billion
in wellbeing losses related to morbidity and mortality.

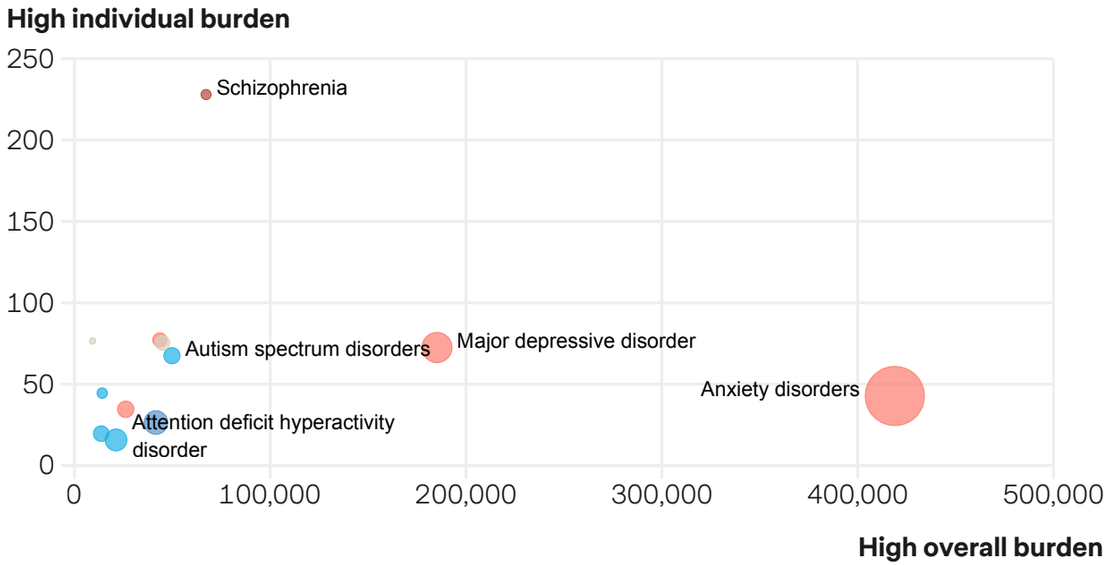
AUD 127 billion
in reduced workforce participation and increased absenteeism.

AUD 23 billion
in the value of informal care.

These impacts illustrate both the scale of loss associated with mental health conditions in Australia, and the opportunity to mitigate it – by concentrating clinical resources where they are most needed, while strengthening resilience and recovery beyond the formal health system.

People: The greatest cost is reduced quality of life

Australia: Impact of mental health conditions on morbidity (2026)
Estimated individual impairment (days living with disability), morbidity impact (total YLDs) and share of cases (%), by condition



Primary sources: IHME (2025), World Bank (2025).

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Mental health conditions and self-harm result in two months (60 days) of healthy life lost each year for the average person living with a mental health condition – and over one million years of healthy life lost across Australia each year.

By 2030, these losses are projected to grow from AUD 259 billion[1] to reach AUD 285 billion annually, underscoring the scale of impact borne by individuals and communities.

As in other advanced economies, the overwhelming share of this relates to morbidity (88%), rather than mortality. This reflects the cumulative effect of reduced daily functioning – disrupted sleep, impaired concentration, lower energy, and diminished social engagement.

High-prevalence conditions drive most wellbeing loss

Anxiety disorders are the single largest driver of wellbeing loss in Australia – 45% of years lived with disability (YLD). This reflects volume rather than intensity: anxiety affects a large share of the population (about 13% in 2026), even though average impairment per person is lower than for many other conditions (43 days per year). Major depressive disorder, the next most common condition, affects only about 3% of the population.

High prevalence conditions mean that even mild to moderate impairment can accumulate into large scale wellbeing loss. Anxiety-related impairment often affects the rhythm of everyday life – the ability to focus, sustain effort, engage socially, or recover. It may not present as recurring or persistent disruption, but each episode carries a cost in lost healthy life, even when individuals remain outwardly functional in work or family life.

1. A value of a statistical life year of USD 176,000 has been applied.

Lower prevalence conditions carry high individual burden

Less common conditions contribute to disproportionately high individual impairment. Australia has the highest prevalence of neurodevelopmental disorders of countries across this study, with autism affecting 1% of the population and ADHD nearly 2% in 2026.

While ADHD is more common, autism is associated with a far greater individual burden – nearly 68 days of healthy life lost per person and 5% of total YLDs, compared with around 16 days and 2% of YLDs for ADHD. Autism is also among the faster growing conditions, increasing at about 1.4% a year through 2030. This may also contribute to the comparatively high levels of comorbidity in Australia, as neurodevelopmental disorders are more likely to coexist with other mental health conditions.

A dual burden

Australia's mental health burden is therefore shaped by two contrasting dynamics: widespread, lower-severity conditions affecting many people, and conditions marked by more severe impairment concentrated among fewer.

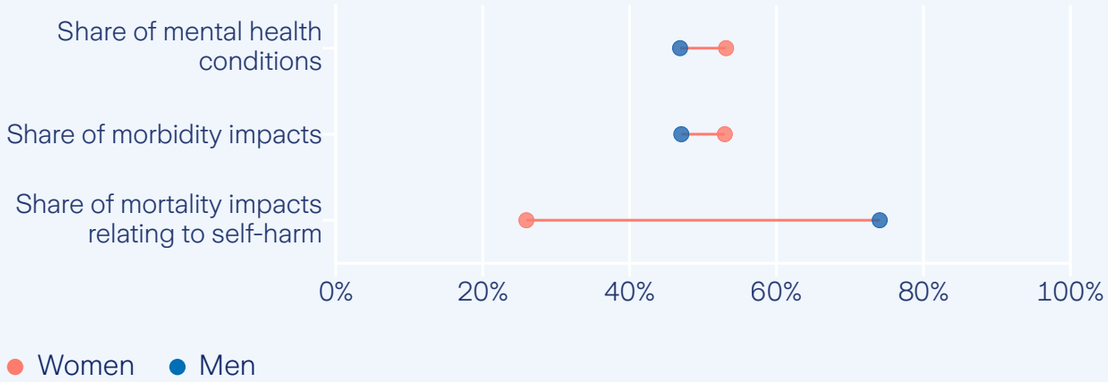
Managing this balance is the central challenge: large volumes of milder needs can absorb system capacity, highlighting the importance of triage and proportionate response to avoid crowding out care for those with the greatest need.

Gender divides in Australia

As in peer markets, women exhibit higher overall prevalence (around 24% compared with 22% among men), faster growth (2.8% versus 2.2% average annual growth 2026-2030), and account for a larger share of the total disease burden.

Consistent with all other markets, men, by contrast, experience lower recorded prevalence but higher mortality impacts, bearing a disproportionate share of suicide related loss.

Australia: Projected impacts of mental health conditions by gender (2026)
% of total cases, YLDs and YLLs, by gender



Primary sources: IHME (2025), World Bank (2025).

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Clinical impairment can translate into enduring disadvantage

The personal cost of mental health conditions are not confined to symptoms or episodes of care. Along with reduced quality of life, individuals living with mental health conditions experience greater financial strain, weaker financial buffers, and lower overall life satisfaction. These impacts accumulate quietly – carried by individuals, families, and employers, and felt across communities long after clinical contact ends.

Australia-specific wellbeing indicators point to a consistent pattern.[2] People living with mental health conditions are more likely to report ongoing financial stress, reflecting both reduced capacity to work and greater exposure to unexpected costs. Among women, reported financial stress is on average about 18 percentage points higher than among those without a mental health condition.

The effects extend beyond immediate finances to longer term economic resilience. Reduced ability to build or maintain savings, lower participation in investment income, and delayed asset accumulation all weaken long-term financial resilience. Even where individuals remain in employment, intermittent impairment can translate into slower progression, more fragile income paths, and reduced capacity to absorb shocks.

61% lower average investment income

among women with a mental health condition in Australia compared to those without (57% for men).

Mental health conditions are also associated with lower reported life satisfaction, with gaps of about 10 and 11 percentage points for men and women respectively. Individuals living with a mental health condition in Australia are:

- Less likely to feel part of their local community (8 to 17 percentage points across working-age groups).
- Less satisfied with their financial situation (13 and 15 percentage points for men and women respectively).
- Less satisfied with job opportunities (over 11 percentage points for most cohorts).
- Less likely to report feeling safe (7 percentage points for select groups).

Stronger wellbeing and financial security underpin resilience, while financial vulnerability and reduced wellbeing erode it over time, leaving individuals less able to absorb shocks, adapt to change, and recover quickly from disruption.

And because mental health conditions are widespread, these individual effects accumulate across the population and intersect with constrained system capacity, shaping downstream impacts on productivity, participation, and reliance on formal and informal support systems.

2. Based on the Household, Income and Labour Dynamics in Australia (HILDA) Survey (refer to Data and methodology).

Productivity: Employment impacts are set to hit 4% of GDP by 2030

Mental health conditions represent a significant drag on Australia's economic capacity, with 30% of the working-age population estimated to be living with a mental health condition by 2030 – among the highest in this report, exceeded only by the UK.

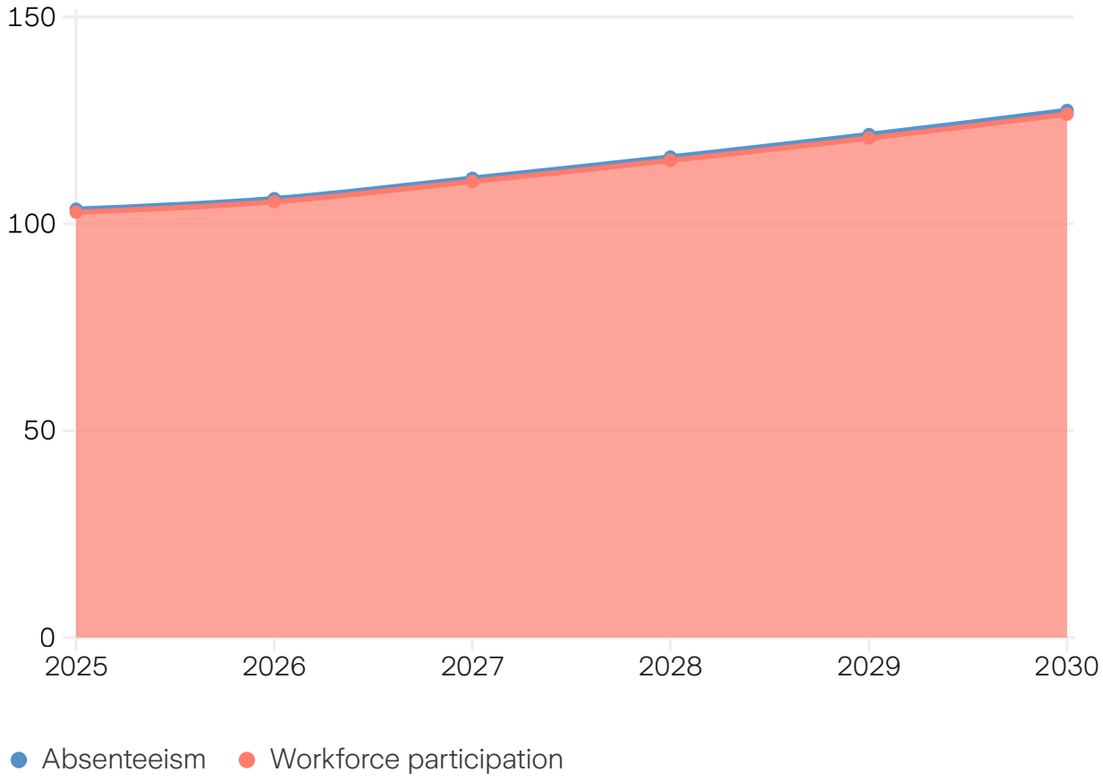
Lost wages – combining reduced workforce participation and absenteeism – are estimated at AUD 106 billion in 2026, (equivalent to 3.5% of GDP). By 2030, productivity-related losses are projected to exceed AUD 127 billion per year, or about 4.0% of GDP. These losses far outweigh formal mental health spending (around 1.0% of GDP), underscoring that the economic burden of mental health conditions is carried through lost work rather than health care costs.

Almost all employment-related losses come from reduced participation, not short-term absence. Absenteeism – captured here as average excess sick days relating to mental health, taken by individuals with a mental health condition – accounts for less than 1% of losses (AUD 749 million).[3]

The average worker with a mental health condition in Australia is estimated to take 0.7 days of excess sick leave per year. Women take nearly twice as many days as men (0.9 versus 0.5), consistent across age groups.

Absenteeism is most visible in public administration and safety, financial and insurance services, and education and training – sectors characterized by high workloads, regular interaction with the public or clients, and limited scope to adjust pace or responsibilities in the short term. High absence rates also appear among machinery operators and drivers, professionals, and managers.

Australia: Projected economic impact of mental health conditions (2025-2030)
Absenteeism and workforce participation losses associated with mental health conditions, AUD billion

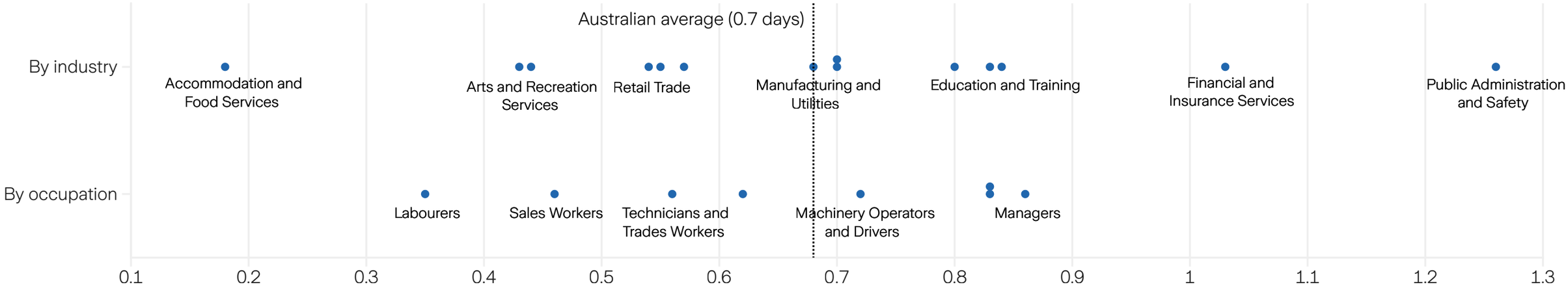


Refer to Data and methodology for a full set of data sources, assumptions and calculations.

3. Phrased as lost wages for valuation purposes, however the individual still receives the wage if taken under paid sick leave entitlements.

Australia: Estimated excess sick days by industry (2026)

Annual excess days of sick leave taken by employed individuals with mental health conditions, by industry



Refer to Data and methodology for a full set of data sources, assumptions and calculations.

These patterns reflect roles exposed to high cognitive or operational demand, responsibility for outcomes or safety, time pressure, and limited recovery time. For some workers this stems from fatigue, shift patterns, and safety critical environments; for others it reflects decision density, emotional regulation, and accountability. Together, these dynamics point to where early, role-specific workplace support and job design – including workload management, fatigue mitigation, and flexibility – can have the greatest preventative impact.

But it is not the biggest driver of system-level losses.

Impacts are shaped by who is able to work

In Australia, mental health conditions are more likely to translate into longer-lasting disengagement from work, rather than temporary reductions in hours or performance. Nearly all employment-related impacts (99%) stem from people being unable to enter, remain in, or return to work at full capacity. Employment rates among people living with a mental health condition are around 18 percentage points lower than among those without (48% employment for those with a condition versus 66% among those without in 2026).

Behind this already substantial headline figure lie particularly acute disparities. Men aged 35 to 39 face an employment gap of 37%, followed closely by men aged 55 to 59 at 34%. Across nearly all age groups, men with mental health conditions face higher employment barriers, but gaps remain pronounced for women approaching retirement age (28% those aged 55 to 64).

These patterns suggest that productivity losses are not simply a function of short-term illness, but of how mental health conditions interact with labor market structures over time. In Australia, the largest losses arise when people exit the workforce earlier, struggle to re-enter, or never fully enter at all.

Greater access to diagnosis has lowered barriers to recognition and support – a clear strength of the system - but may also, in some cases, lower the threshold for labor market exit when not matched by timely treatment, rehabilitation, and structured return-to-work support.

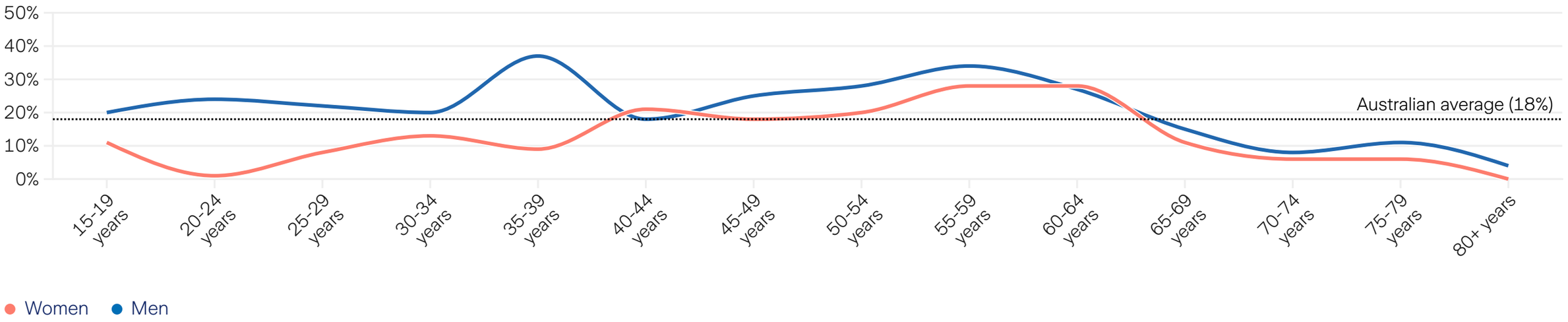
Short-term withdrawal can become long-term exit if:

- Clinical care is delayed.
- Workplace accommodation is limited.
- Income support stabilizes income but not participation.
- Return to work assumes a linear recovery that doesn't match lived experience.

Over time, this leads to structural disengagement: skills erode, confidence weakens, and employer attachment fades.

Australia: Estimated employment gap by gender (2026)

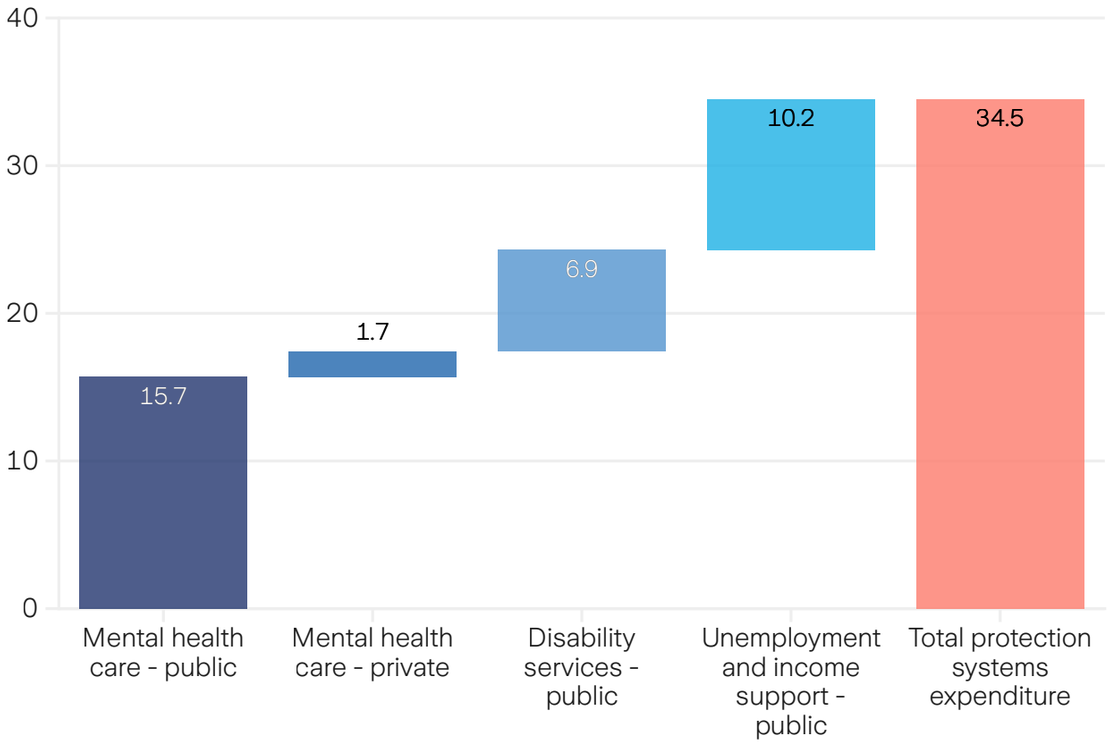
Percentage point gap in employment rate between those with a mental health condition and those without, by gender and age group



Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Protection systems:
Strong foundations under pressure

Australia: Mental health care protection systems (2030)
Projected expenditure, AUD billion



Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Despite the scale of productivity losses associated with mental health conditions, formal mental health-related expenditure in Australia remains modest. By 2030, spending across health care services, disability support, income assistance, and community programs is projected to reach about 1.1% of GDP – materially lower than in the UK (1.5%) and Germany (1.8%).

But expenditure levels should not be interpreted in isolation. Australia has relatively strong clinical capacity on some measures – with 16 psychiatrists per 100,000 people in 2023, compared with 10.1 in the UK.[4] Yet this has not necessarily translated into faster access. Average wait times for in-person mental health care services reached 77 days in 2022, longer than peer markets,[5] and has been exacerbated by workforce disputes, churn and short-term staffing models in parts of the system.

In Australia, a significant share of formal mental health-related costs also falls outside the health care system, in income replacement, disability support, and out-of-pocket expenses. This reflects how mental health conditions are experienced and managed over time – not only as a clinical issue, but as a sustained participation risk.

Private insurance, including life and income protection, forms part of this safety net – absorbing a growing share of the financial consequences when mental health conditions disrupt work. As claim volumes rise and durations lengthen, however, insurers are increasingly exposed to the same pressures seen elsewhere.

4. AIHW. Mental health workforce (2024); Royal College of Psychiatrists. Workforce figures (2023); Yang, O. & Chang, Y. Wait times for Psychiatric Specialist Services in Australia (2025); Centre for Mental Health. The economic and social costs of mental ill health (2024); Kruse, J. et al. Outpatient Psychotherapy in Germany (2024).

5. AIHW. Mental health workforce (2024); Royal College of Psychiatrists, Workforce figures (2023).

Protection systems sit at the interface of health and work. Where income support and coverage are paired with timely treatment, rehabilitation, and structured return-to-work pathways, they can help stabilize individuals while preserving labor market attachment. Where clinical capacity is limited and coordination across health care, employers, and insurers is fragmented, protection systems can drift toward compensation rather than reengagement.

This does not diminish the value of Australia's safety net – which is essential during periods of illness – but highlights its limits: income replacement can stabilize hardship without restoring participation.

In a labor market where productivity losses are driven overwhelmingly by exit and non-entry, rather than short-term absence, this distinction is critical. Rising prevalence and population growth are placing growing pressure on systems that were not designed to manage sustained, large-scale participation risk.

Formal systems capture only part of the support ecosystem

By 2030, families and informal networks in Australia are projected to provide over 301 million hours – or AUD 22.9 billion – of unpaid mental health care each year. This rivals formal system expenditure, yet its costs – emotional, financial, and occupational – are borne privately.

Informal care can act as a stabilizer in the short term. But where clinical access, rehabilitation, or return-to-work pathways are constrained, it risks becoming a substitute for structured support. This shifts the burden beyond institutions to households and communities, with additional impacts such as reduced labor market participation and lost income among caregivers.

> Resilience in mental health is not about coping in isolation. Supporting people to stay connected – to work, to family, to community – is often a critical part of care, and one of the strongest protections against long-term disengagement.

Antony Vriens, Head of Health Services, Zurich Australia

From access to outcomes:
Where Australia's next opportunity lies

Australia's mental health care system has clear strengths: high awareness, broad coverage, and sustained public investment. The next phase of progress will depend less on recognizing need and more on enabling people to build resilience across the life course – particularly at moments where mental health conditions risk translating into permanent disengagement from work and society. This means:

1. **Early attachment shapes long-term resilience.** Supporting young adults to build a durable first connection to work – and enabling individuals to reenter after periods of illness – can prevent early disruption from shaping entire working lives. Practical levers include flexible entry roles, supported transitions from education to work, and graduated return-to-work pathways that rebuild confidence and capability over time.

2. **Resilience is built by maintaining agency, connection, and momentum through disruption.** Periods of mental distress do not always require withdrawal from work or study. Individuals are more likely to sustain resilience where financial protection cushions short-term shock without severing attachment – supporting continued connection to routines, skills, and purpose. Where income support and coverage are paired with incentives and structured pathways for gradual reengagement, people are better able to rebuild confidence, stability, and independence.

3. **More targeted pathways can prevent low severity conditions from becoming entrenched.** Wider access to diagnosis has lowered barriers to recognition and support but also increases the importance of accurate assessment and tailored pathways. Better alignment between clinicians, employers, and insurers can help ensure that support is proportionate to severity, directing individuals toward effective treatment and rehabilitation.

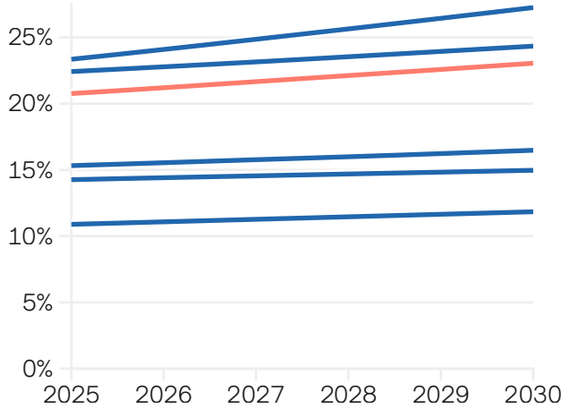
Taken together, these priorities point toward a shared objective: helping people withstand periods of mental illness without losing their footing in work, income, and opportunity. In a labor market where the greatest losses stem from exit and non-entry, building personal resilience is not a peripheral concern – it is central to Australia's long-term economic and social capacity.

Chile

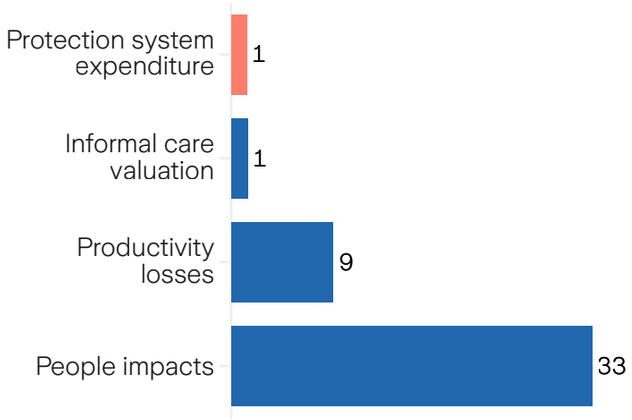
A critical window for action

This section brings together the latest data, modeling, and policy analysis to understand the scale, drivers, and implications of mental health conditions in Chile. We focus on three pillars: People (the human impact), productivity (economic consequences), and protection systems (system pressures and policy landscape), that are shaping prevention, early intervention, access to support, and long-term recovery. The goal is to offer a clear, evidence-based view of the nation's mental health outlook and highlight select opportunities for strategic action to strengthen wellbeing, resilience, and inclusion in the years ahead.

By 2030, mental health conditions are projected to affect nearly 1 in 4 people living in Chile (23%)



Estimated impacts on people, productivity and protection systems (2030) CLP trillion



By 2030, an average person living in Chile with a mental health condition is projected to face...

Higher days of healthy life lost

63 days
of healthy life lost

Lower average employment gap

14%
employment gap

High average sick days

5.6 days
of excess sick leave for mental health reasons per year

High out-of-pocket expenditure

43%
of treatment costs covered by out-of-pocket expenditure

Higher annual hours of informal care

81 hours
of informal care received per year

Chile

Prevalence: A system in transition towards wide and early identification

Chile is moving rapidly from a model where mental illnesses remained largely unspoken to one where conditions are increasingly recognized – though not always early enough to prevent functional impact.

In 2026, an estimated 4.2 million people (21% of the population) are living with a mental health condition, rising to 4.7 million by 2030. This represents an annual average growth rate of around 2.5%, at the higher end of in-scope markets.

These headline figures, however, mask a system in transition. Chile is shifting from deep-rooted under-recognition toward broader visibility and this is playing out differently across generations:

- **Higher prevalence amidst younger cohorts:** More than one in four (27%) people aged 15 to 19 are estimated to be living with a mental health condition – a pattern similar to, but not as pronounced as, higher-awareness markets such as Australia and the UK, where shifting norms support earlier disclosure and help-seeking.

- **Lower prevalence among older cohorts:** Among older Chileans who screen positive for depression, it is estimated that only 18% of men and 44% of women receive a formal diagnosis[1] – underscoring how stigma, limited geriatric mental health capacity, and lower help-seeking delay recognition until symptoms meaningfully interfere with daily functioning.

Chile's dual system – public *Fondo Nacional de Salud (FONASA)* and private *Instituciones de Salud Previsional (ISAPREs)* – also contributes to uneven visibility. Over the past three decades, national mental health plans have expanded community-based public care, broadening access points. But identification does not consistently translate into timely support. University students, for instance, frequently go untreated due to stigma and limited access to support,[2] while earlier treatment remains more common in private pathways.

Chile's prevalence profile therefore reflects a system in mid-transition: younger cohorts are driving rising visibility, but the legacy of late recognition persists for older adults and those reliant on stretched public pathways.

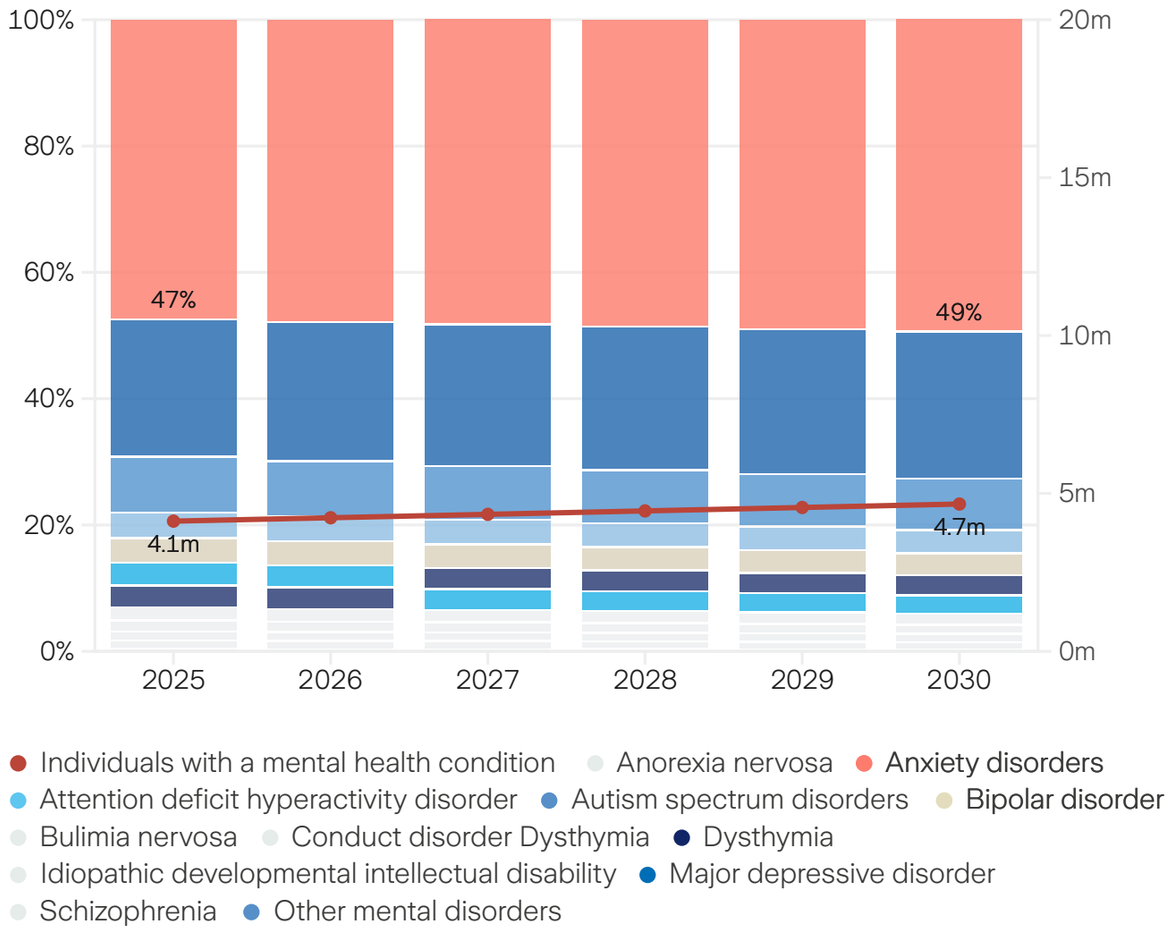
1 in 4

people in Chile (23%) are projected to be living with a mental health condition by 2030.

1. Moreno, X. et al. Subjective Assessments of Quality of Life Are Independently Associated with Depressive Symptoms among Older Adults Enrolled in Primary Care in Chile (2022).

2. Beroíza-Valenzuela, F. The challenges of mental health in Chilean university students (2024).

Chile: Projected prevalence of mental health conditions (2025-2030)
Projected share of cases by condition (%) and total number of individuals with a mental health condition (million)



Primary sources: IHME (2025), World Bank (2025).

Total number of individuals with a mental health condition accounts for co-morbidities.

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Anxiety is a signal of rising visibility

Nearly half of all recorded cases (48%) are anxiety disorders, a share closely aligned with higher-awareness markets where broader identification of distress has become the norm. In contrast, more privately-managed markets such as Malaysia and the UAE show materially smaller anxiety shares (23% to 30%), reflecting lower help-seeking. Chile's pattern therefore supports the picture of a country moving into an earlier and wider-identification phase.

While anxiety continues to rise, the pace is measured. Prevalence is projected to grow at about 3.7% per year, notably slower than the 5.3% to 6.2% annual growth seen in Australia, the UK, and Malaysia. This suggests Chile may be entering a stabilization stage, with a substantial share of previously unmet need already emerging through improved visibility.

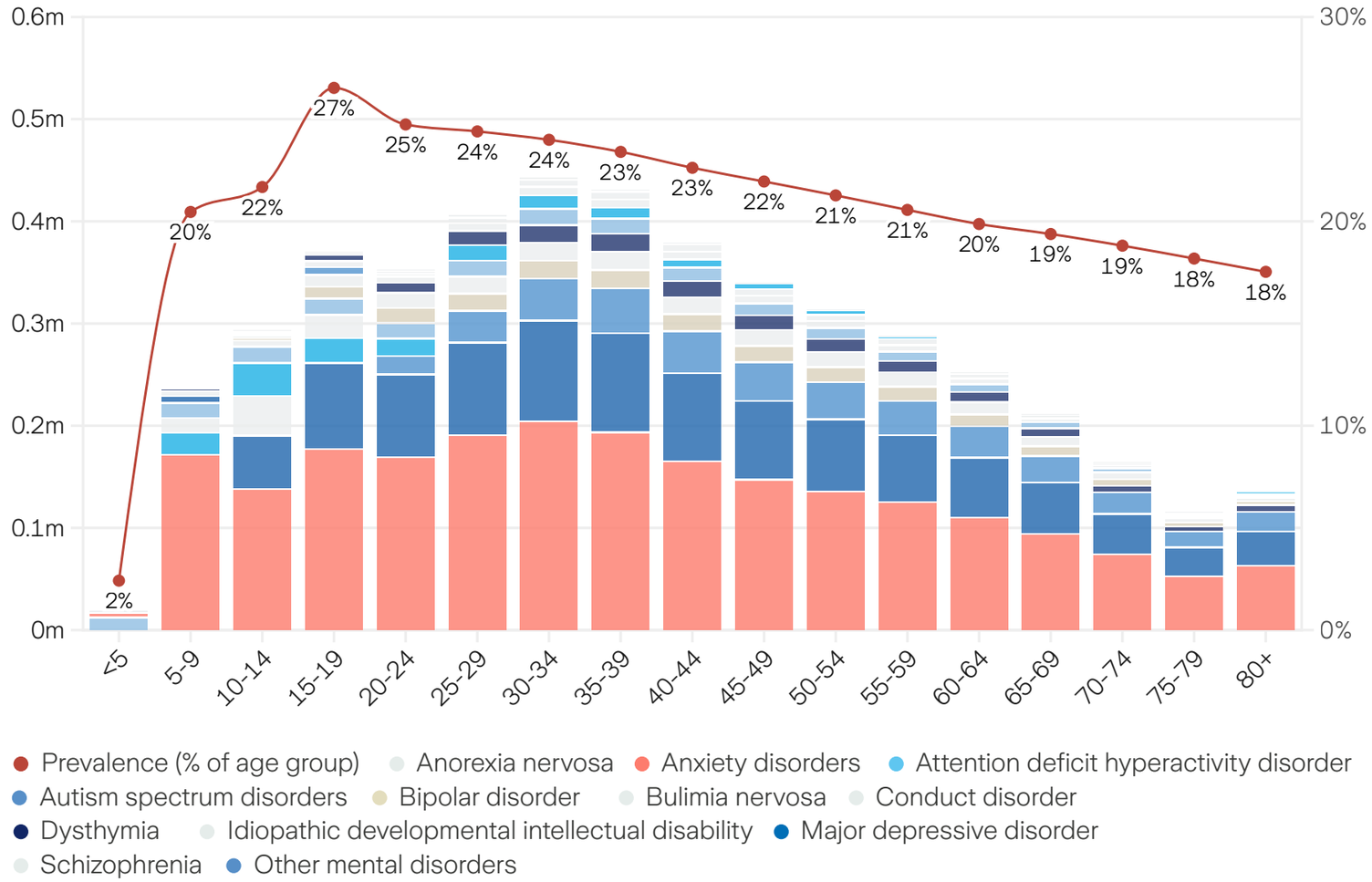
Major depressive disorder accounts for a further 22% of cases but stands out as the fastest growing condition in Chile, growing at about 4.3% per year – a pattern not observed in other markets, where anxiety remains the dominant growth driver. Growth accelerates from age 35 to 39 onward, indicating that depression is increasing – or is increasingly being recognized – later in life, among cohorts where stigma and barriers to care may have previously limited acknowledgement and diagnosis.

> For many women in early adulthood, mental health challenges emerge at the same moment that economic pressures, caregiving responsibilities, and societal expectations are most intense – creating an invisible strain with national consequences.

Angeles Quintana, Chief Customer Officer, Zurich Chile

Chile: Projected prevalence of mental health conditions by age (2026)

Number of mental health conditions (million) and prevalence rate (%), by age group



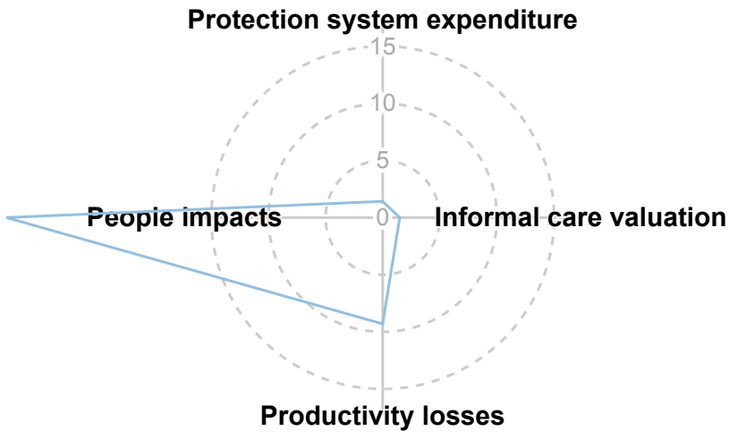
Primary sources: IHME (2025), World Bank (2025).

Projected prevalence by age group (%) includes comorbidities.

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Wider diagnosis shapes pressures on health, welfare and employment systems

Chile: Estimated impacts on people, productivity and protection systems (2030)
CLP trillion



Refer to ⇨ Data and methodology for a full set of data sources, assumptions and calculations.

By 2030, despite an estimated CLP 1.4 trillion (0.4% of GDP) in expenditure on mental health support and protection, mental health conditions are projected to result in approximately:

CLP 33 trillion
in wellbeing losses related to morbidity and mortality.

CLP 9 trillion
in reduced workforce participation and increased absenteeism.

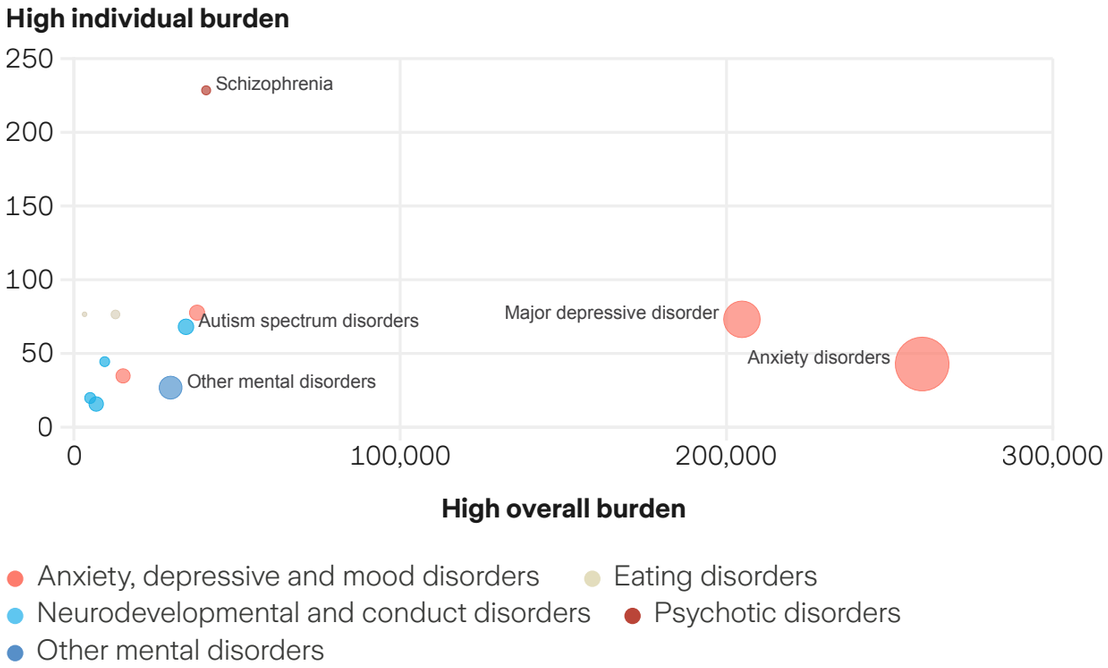
CLP 1 trillion
in the value of informal care.

Together, these figures underscore both the scale of impact associated with mental health conditions in Chile and the importance of how conditions are identified and managed. As awareness grows, the opportunity is now clear: convert rising visibility into earlier, sustained engagement – before conditions escalate into deeper impairment, longer absences, and higher system pressure.

People: Scale and severity both matter

Chile's rising visibility has made the lived impacts of mental illnesses clearer and more measurable. In 2026, individuals living with a mental health condition or self-harm are estimated to lose an average of 63 days of healthy life each year, contributing to 738,000 years of healthy life lost nationwide and nearly CLP 30 trillion in wellbeing losses.[3]

Chile: Impact of mental health conditions on morbidity (2026)
Estimated individual impairment (days living with disability), morbidity impact (total YLDs) and share of cases (%), by condition



Primary sources: IHME (2025), World Bank (2025).

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

As in other markets, most of this burden comes from morbidity rather than premature mortality, with 89% of total healthy life loss driven by the long, steady erosion of wellbeing that affects how people work, study, parent, and participate in daily life.

This burden reflects the interaction of scale and severity:

- **Higher-prevalence conditions:** Anxiety disorders and major depressive disorder affect large numbers of people, and even moderate impairment, when experienced at scale, drives substantial wellbeing loss.

  Anxiety disorders account for around 260,000 years lived with disability in 2026, making them the single largest contributor (40%) to Chile's overall burden. Their impact stems less from severe daily impairment – an average of 43 days lived with disability per year – and more from their persistence and broad population reach.

- **Higher-severity conditions:** About half of total morbidity losses – 51% of years lived with disability (YLD) – arise from conditions with average impairment exceeding 60 days per year, including anorexia, autism, bipolar disorder, bulimia, major depressive disorder, and schizophrenia. In comparison, these diseases account for 66% of total YLDs in Malaysia, reflecting a smaller volume of lower impairment conditions.

  These conditions require sustained, specialist-driven support, which – when capacity is constrained – places significant demands on families and informal networks.

Together, this split profile implies two complementary priorities: scalable interventions that reduce cumulative impairment across common conditions, and high-intensity specialist services for severe or complex disorders where delayed treatment carries irreversible consequences.

3. A value of a statistical life year of USD 48,000 has been applied and converted into CLP to reflect local conditions.

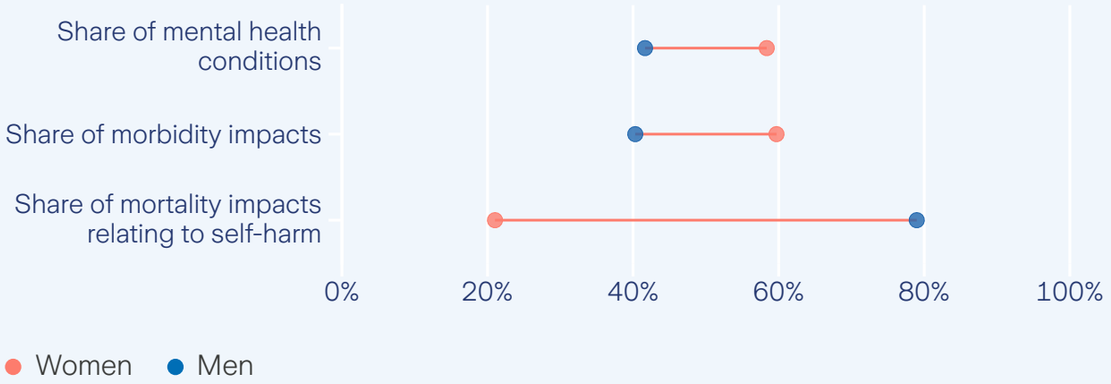
Gender divides in Chile

The prevalence of mental health conditions in Chile display a persistent gender divide.

Prevalence among women is significantly higher – 25% compared with 18% among men – a pattern consistent across all age groups and particularly evident for major depressive disorder, which is associated with an average of about 73 days lived with disability per year. Depression prevalence among women is more than double that of men (about 7% versus 3%).

These differences are most pronounced during working age (15 to 64). The largest gap in prevalence – about 9 percentage points – emerges in the 20 to 34 age cohort, a life stage often marked by high demands on time, caregiving responsibilities, and constrained access to flexible support.

Chile: Projected impacts of mental health conditions by gender (2026)
% of total cases, YLDs and YLLs, by gender



Primary sources: IHME (2025), World Bank (2025).

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

These pressures not only elevate risk but also intensify the cumulative impact of mental health conditions, reinforcing wider gender inequalities. Women account for around 60% of mental health cases and morbidity related healthy life loss.

However, observed gender gaps are unlikely to reflect underlying need alone. They also point to differences in recognition, help seeking, and engagement with mental health care services. Men, by contrast, face a disproportionate burden of mortality linked to suicide, accounting for 79% of all related deaths, suggesting men are more vulnerable to acute, crisis-driven outcomes when distress goes unrecognized or support is delayed.

Productivity: The drag on economic potential

Mental health conditions profoundly shape Chile's economic trajectory. Their impact extends well beyond individual wellbeing, driving reduced workforce participation, prolonged sick leave, and lower productivity while at work.

In a labor market defined by formal medical certification, long waits for specialist care, and more limited employer-led intervention, mental health conditions translate directly into large and persistent economic losses. These losses do not arise because people immediately disengage from work – but because recovery and return take too long.

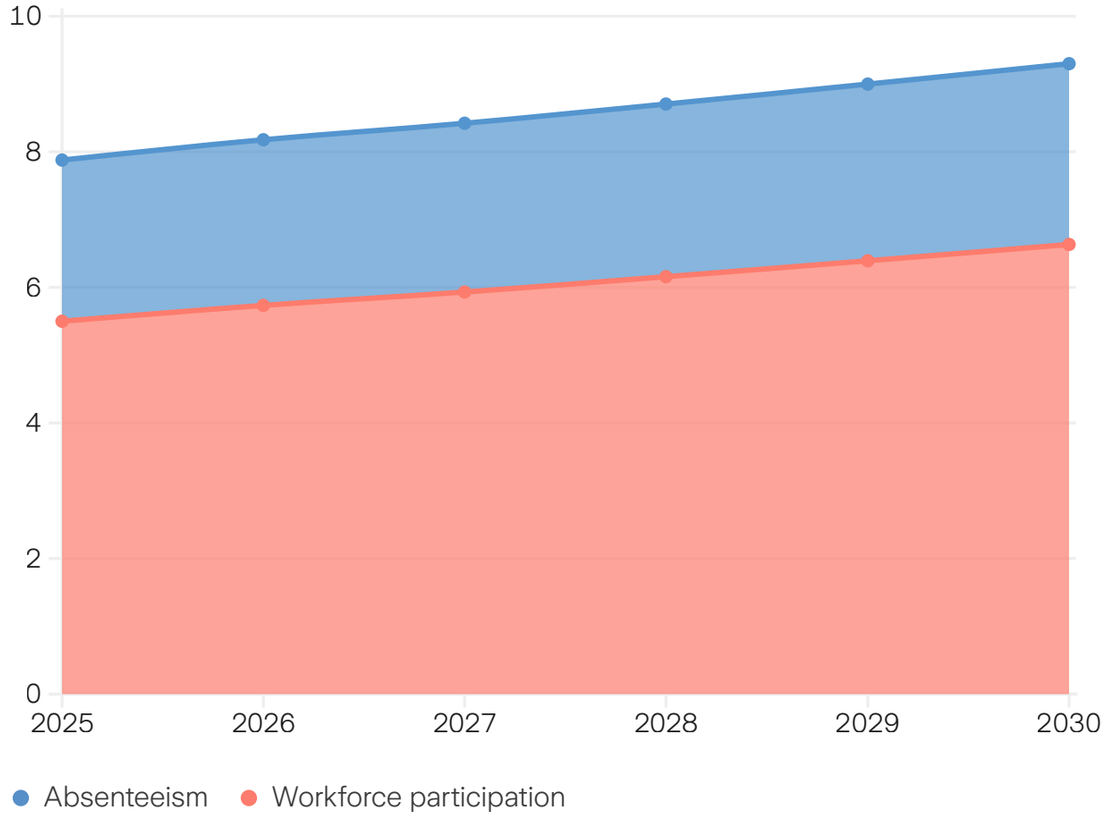
In 2026, the combined productivity impact of reduced participation and absenteeism is estimated at over CLP 8 trillion, rising to CLP 9 trillion by 2030 (3.3% average annual growth). These losses reflect rising prevalence and wage growth, but also structural features that shape how mental health conditions interact with work: whether people remain attached to employment, and how long they remain away once symptoms emerge.

Participation losses are more moderate

The largest share of productivity loss in Chile – about 70% of the 2026 total – comes from reduced workforce participation. This represents almost CLP 6 trillion, equivalent to 1.6% of GDP, driven by a 14 percentage point[4] employment gap (54% employment among those with a mental health condition, compared with 69% among those without).

While substantial, Chile's participation gap is more moderate than in some higher-income markets, where mental health conditions are associated with much larger, permanent exits from the labor force. In Chile, many individuals with a diagnosis remain formally employed – with productivity losses shaped by how the system mediates the relationship between symptoms, absence, and return.

Chile: Projected economic impact of mental health conditions (2025-2030)
Absenteeism and workforce participation losses associated with mental health conditions, CLP trillion



Refer to Data and methodology for a full set of data sources, assumptions and calculations.

4. Without rounding error.

Absenteeism is strikingly high

Chile records exceptionally high levels of mental health-related sick leave compared with other markets. The average employee is estimated to take 5.6 days of mental health related sick leave per year.[5] In aggregate, this amounts to about 50 million mental health related sick leave days in 2026, equivalent to over CLP 2 trillion in lost output (around 0.7% of GDP).

High recorded absenteeism in Chile reflects how the system identifies and manages absence. Under both FONASA and ISAPREs, employees must obtain a doctor-issued medical certification *(licencias médicas)* from the first day of illness, unlike many other markets. This creates a comprehensive administrative record of absence and can help preserve the employment relationship during periods of certified incapacity. In practice, certified sick leave often acts as a buffer between mental health conditions and labor market exit, allowing individuals to remain formally employed while managing symptoms.

The challenge is that delayed access to care lengthens time away from work. In the public sector, the median wait time for an adult psychiatric consultation was 236 days in 2024,[6] reflecting sustained pressure on specialist services. With only 8.5 psychiatrists per 100,000 people,[7] capacity constraints often mean that the system cannot intervene early enough. What might begin as a short episode of distress can escalate into a formal, extended period of absence.

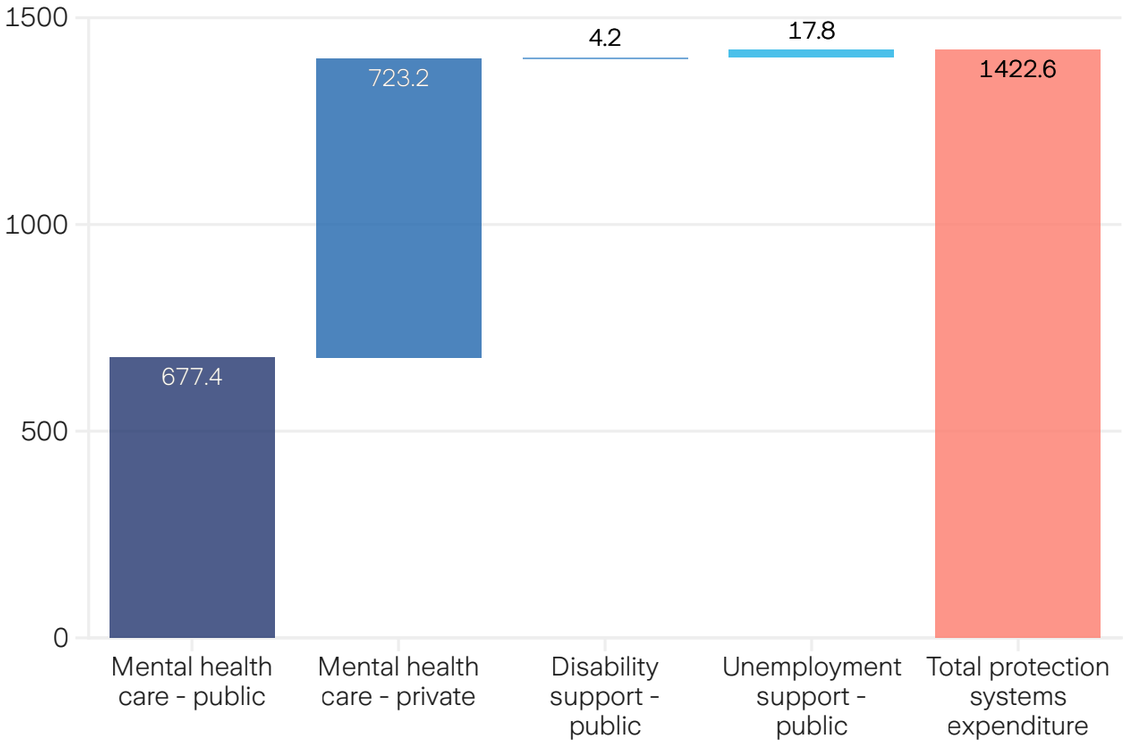
A distinct system trade-off

Compared with markets where mental health conditions more often lead to labor force exit, Chile's social insurance-based sick leave framework can help keep people formally connected to employment, but it struggles to shorten the time it takes to recover and re-engage. Earlier, coordinated action – combining public and private mental health support with employer-linked reintegration pathways – could allow Chile to retain the employment protection benefits of *licencias médicas* while reducing the duration and cost of absence. This represents one of the country's most important opportunities to keep more people healthy, productive, and connected to work as mental health awareness continues to rise.

5. Absenteeism is expressed as the average excess sick days per worker related to mental health conditions. The figure includes both workers with and without a mental health condition.
6. INDH. Situación de los Derechos Humanos en Chile (2024).
7. WHO. Mental Health Atlas (2020).

Protection systems: A dual system with uneven access

Chile: Mental health care protection systems (2030)
Projected expenditure, CLP trillion



Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Public and private expenditure on mental health care services continues to grow across a complex landscape of financing, provision, and coverage. In 2026, mental health protection spending is estimated at over CLP 1 trillion (about 0.4% of GDP, or more than CLP 304,000 per person with a mental health condition).

This level of spend is higher than in lower-awareness markets, such as Malaysia and the UAE (0.1% of GDP), but is markedly below higher-income, high-awareness systems like Australia and the UK (1.0% and 1.4% of GDP). Despite similar levels of total health care spending (10% to 11% of GDP), Chile allocates only 2% of its health budget to mental health, compared with 7.6% in Australia.[8]

This may partly reflect one of the defining features of Chile's health system, its dual insurance structure.

Public capacity constraints

The public system, FONASA, covers around three-quarters of the population.[9] Public mental health expenditure is estimated at CLP 614 billion in 2026: 48% of protection spend. Most funding (CLP 550 billion) goes toward mental health care services and pharmaceuticals, with a further CLP 64 billion allocated to mental health programs and grants. Additional public spending includes CLP 4 billion in worker disability subsidies and CLP 16 billion in unemployment support for individuals with mental health conditions.

8. OECD Health At a Glance (2023).
9. Diana Contreras; Srirama Bhamidipati; Sean Wilkinson. Social vulnerability and spatial inequality in access to healthcare facilities: The case of the Santiago Metropolitan Region, Chile (2023).

Successive National Mental Health Plans have moved away from hospital-based psychiatric care toward a community-based model anchored in *Atención Primaria de Salud (APS)*. The APS forms the backbone of mental health provision, designed to enable early assessment and short-term support, without waiting for specialist intervention.

Despite sustained investment and clear policy direction, capacity within the public system remains uneven. The APS absorbs demand through GP-led assessment, brief psychological interventions, and follow up. But workforce constraints mean many people still face long waits for specialist care: median wait times for psychiatric consultations for adults in the public sector were 236 days in 2024.[10]

When the APS cannot intervene early or intensively enough, individuals are more likely to enter the system later in their illness trajectory, increasing both clinical severity and long-term system costs.

Private access

Private provision helps relieve pressure on the public system but also reinforces structural inequities in access, speed, and outcomes – shaping when and how conditions are identified and treated.

Private mental health expenditure is estimated at CLP 654 billion in 2026. Most of this – CLP 549 billion (84%) – reflects out-of-pocket spending, especially for psychotherapy and other non-pharmaceutical treatments that are only partially reimbursed. Only CLP 105 billion relates to voluntary insurance premiums paid to ISAPREs – private insurers offering a range of health care plans, typically providing shorter waits and more tailored services.

Spotlight

National Mental Health Plans

Chile's mental health reforms have been shaped by successive NHMPs (1993, 2000 and 2017) that have shifted care toward a community-based system centered on primary care (the APS) and multidisciplinary teams.

Over nearly three decades, short- and long-stay psychiatric hospital beds have fallen dramatically – from 19 to 2 per 100,000 people,[11] as acute care moved into general hospitals and community settings. This reconfiguration has driven the expansion of protected housing, psychiatric day hospitals, and outpatient services, strengthening the foundation for continuous, community-led support.

Districts that fully implemented the model have seen 21% fewer psychiatric emergency visits than those with partial implementation.[12] But outcomes remain uneven. Access and quality vary significantly by region, driven by differences in workforce capacity, local implementation, and coordination between public, private and specialist services.

The NMHPs offer a clear national vision. The challenge now is converting that vision into consistent, equitable access across all regions – one of Chile's greatest opportunities for accelerating earlier, more stable recovery.

10. INDH. Situación de los Derechos Humanos en Chile (2024).
11. Mundt, A. P. et al. The effects of national mental health plans on mental health services development in Chile (2022).
12. Zitko, P. et al. Implementing a Community Model of Mental Health Care in Chile: Impact on Psychiatric Emergency Visits (2017).

Despite the presence of private insurance, Chile retains a comparatively high out-of-pocket burden for mental health care. Coverage varies widely across ISAPRE plans, and reimbursement for non-pharmaceutical treatments remains limited.

This leads to a two-speed mental health system: individuals with financial means can access faster, more continuous care, while others face higher cost barriers, longer waits, or delays in diagnosis.

An informal system carrying the burden

Chile's mental health care system also relies heavily on informal care, provided predominantly by women. In 2026, an estimated 378,000 informal caregivers provided over 5 million hours of unpaid care each week – amounting to 273 million hours annually or more than CLP 1 trillion per year. This hidden contribution exceeds total public and private spending on mental health care, and without it, formal services would be unable to meet demand.

The burden of informal care follows clear gender and socioeconomic gradients. Women shoulder most caregiving responsibilities, often alongside paid work and support for children or older relatives. Lower income households provide the greatest volume of care while having the least financial buffer, and caregiving frequently constrains labor market participation – reinforcing cycles of disadvantage and household vulnerability.[13]

Respite services, training, psychosocial support, and navigation assistance within the APS would reduce burnout, improve outcomes, and strengthen Chile's broader economic resilience.

CLP 1.5 trillion

of informal care to individuals suffering with a mental health condition in Chile by 2030.

13. Zitko, P. et al. Implementing a Community Model of Mental Health Care in Chile: Impact on Psychiatric Emergency Visits (2017).

From delayed care to early stability:
Where Chile's next opportunity lies

Chile now has an unusually clear view of its mental health landscape. A highly formalized sick leave system reveals patterns that remain hidden in other countries; the APS increasingly acts as the first point of contact; and successive NMHPs have already shifted care away from psychiatric hospitals into community and primary care settings. The challenge ahead is not recognizing mental health conditions – Chile does that more transparently than most – but intervening early to prevent escalation and long-term disengagement.

The next phase requires connecting the system components Chile already has – the APS, employers, insurers, community mental health care services, and families – so support arrives before individuals have already stepped back from work, education, or caregiving. This means:

1. **Make early intervention the system default:** Long waits for specialist care mean the APS must function as a stronger early intervention engine, not simply a referral gateway. Rapid assessment, brief psychological support, proactive follow up, and expanded access to psychology and counseling in primary care would shorten time to first support and prevent escalation. Strengthening multidisciplinary APS teams and community-based mental health centers would reduce pressure on specialist services, limit deterioration, and protect participation before absence becomes entrenched.

2. **Shift from certified absence to supported participation:** Chile's *licencias médicas* provide visibility but not continuity. People can move from crisis to certified leave without a coordinated plan to remain connected to work or return safely. Structured stay-at-work and return-to-work pathways – including graded duties, phased hours, temporary adjustments, and joint planning between APS teams, employers, and insurers – would allow people to manage symptoms while remaining economically active.

3. **Support caregivers as core infrastructure:** Targeted measures, such as respite, caregiver training, navigation assistance, and psychosocial support embedded within the APS would reduce burnout, protect labor market participation, and strengthen system resilience.

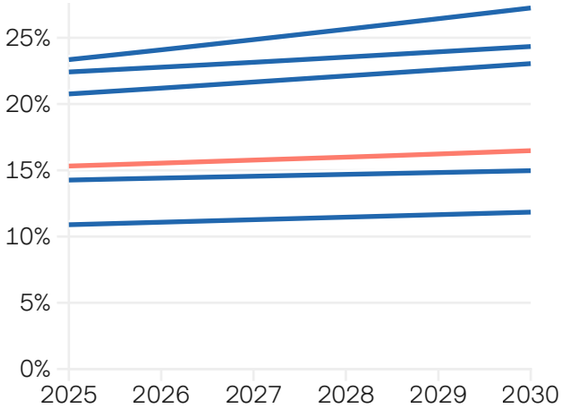
The task ahead is clear: act earlier, connect system components, and design care and work pathways that prevent symptoms from becoming crises, and short absences from becoming long periods of inactivity. By shifting from delayed intervention to early stability, Chile can strengthen wellbeing, participation, and resilience across the working-age population – and turn today's system pressures into the foundation for a healthier, more inclusive decade.

Germany

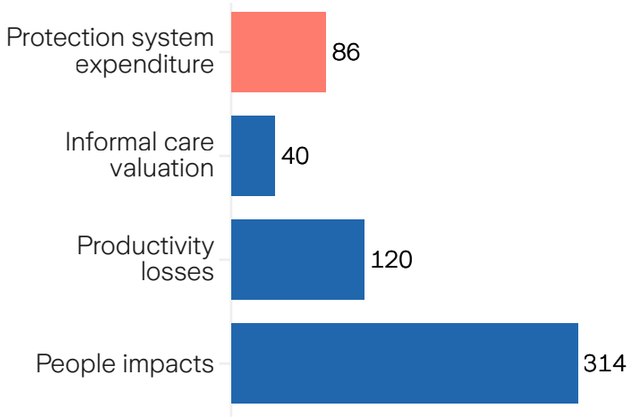
A comprehensive system with a widening youth burden

This section brings together the latest data, modeling, and policy analysis to understand the scale, drivers, and implications of mental health conditions in Germany. We focus on three pillars: People (the human impact), productivity (economic consequences), and protection systems (system pressures, and policy landscape), that are shaping prevention, early intervention, access to support, and long-term recovery. The goal is to offer a clear, evidence-based view of the nation's mental health outlook and highlight select opportunities for strategic action to strengthen wellbeing, resilience, and inclusion in the years ahead.

By 2030, mental health conditions are projected to affect around 1 in 6 people living in Germany (16%)



Estimated impacts on people, productivity and protection systems (2030) EUR billion



By 2030, an average person living in Germany with a mental health condition is projected to face...

High days of healthy life lost

67 days
of healthy life lost

Lower average employment gap

17%
employment gap

Higher average sick days

2.5 days
of excess sick leave for mental health reasons per year

Lower out-of-pocket expenditure

10%
of treatment costs covered by out-of-pocket expenditure

Higher annual hours of informal care

89 hours
of informal care received per year

Germany

Prevalence: A growing burden behind a strong system

Germany's mental health landscape reflects a system built on strong institutional foundations: high spend, dense psychiatric coverage, a long-established psychotherapy tradition, and universal health insurance that guarantees access at a level matched by few other markets. These features shape how early needs are recognized, how quickly people can access support, and how effectively the system can absorb rising demand.

They also could help explain why Germany has maintained comparatively stable prevalence – even as the absolute number of people living with mental health conditions approaches 13 million – about 16% of the population.

Yet this stability conceals important shifts in who is affected and how. Younger generations show much higher and faster-rising need, with prevalence peaking in late adolescence and early adulthood. Earlier disclosure, reduced stigma, and stronger school and primary care engagement mean a wider spectrum of anxiety-related and situational distress is now reaching formal systems.

At the same time, milder concerns among adults often remain outside clinical settings, with higher-impairment conditions continuing to dominate recorded diagnoses – suggesting comparatively higher thresholds for formal diagnosis.

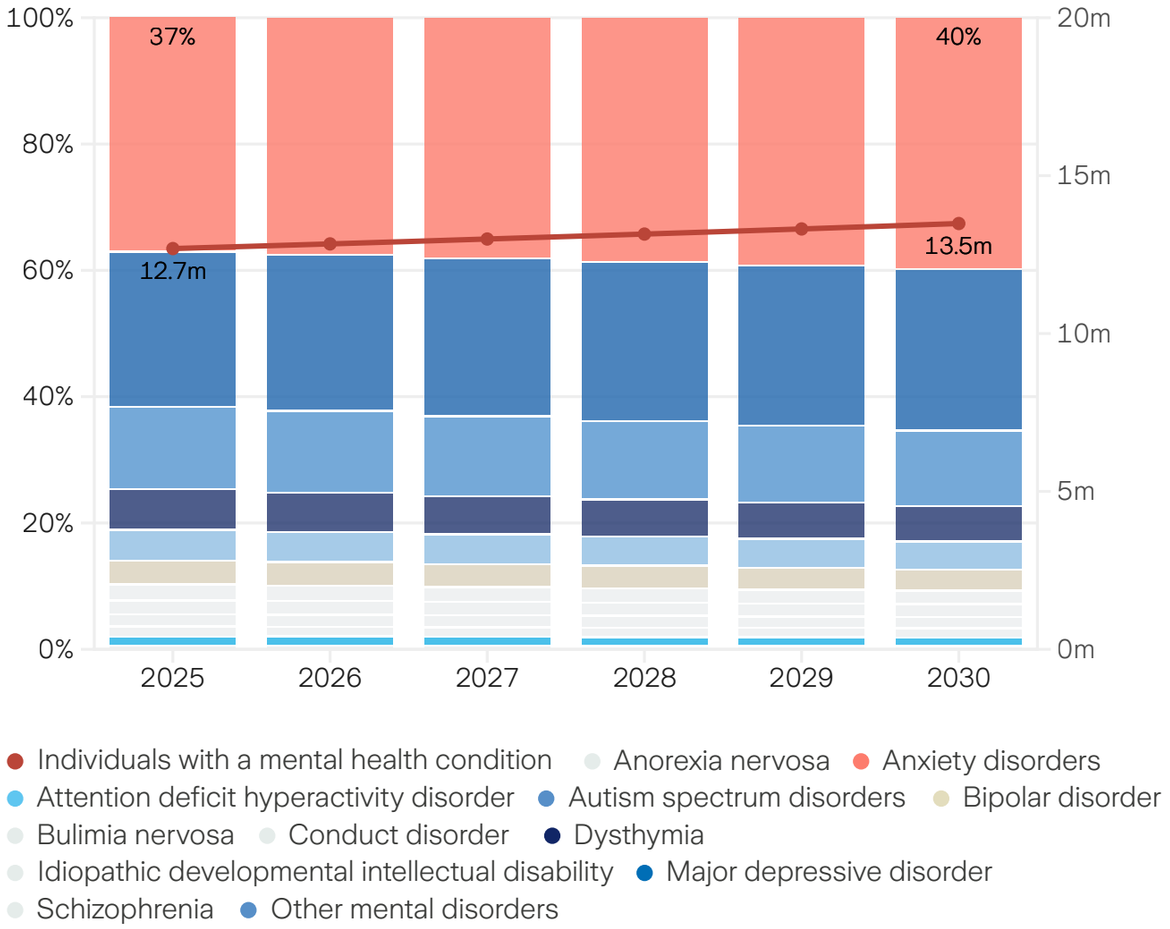
These structural dynamics shape the country's wider mental health burden. Germany's strong access pathways mean many individuals reach support earlier, but workforce pressures, rising youth distress, and growing demand for psychological therapies are stretching capacity in key areas. Cultural norms, family supports, and socioeconomic differences also influence who seeks help and when, creating uneven visibility across age groups and communities.

Germany's profile is one of high capability but with rising strain threatening stability – a system with the tools to respond effectively, but one increasingly defined by youth-driven demand, complex needs, and the challenge of bringing earlier, more preventive support into everyday settings. The task now is to use Germany's strong foundations to deliver support closer to where need first emerges, while helping individuals build the resilience that can prevent temporary distress from becoming long-term disengagement.

1 in 3

15- to 19-year-olds (30%) in Germany are estimated to be living with a mental health condition.

Germany: Projected prevalence of mental health conditions (2025-2030)
Projected share of cases by condition (%) and total number of individuals with a mental health condition (million)



Primary sources: IHME (2025), World Bank (2025).

Total number of individuals with a mental health condition accounts for co-morbidities.

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

A more stable burden?

While the data does not allow firm conclusions about severity, findings point to a more balanced model of high visibility and early identification, without broad prevalence inflation.

Recorded prevalence in Germany sits in the mid-range of countries examined, at about 16% of the population in 2026, growing slowly at 1.2% per year.

Like most other markets, anxiety accounts for the highest share of cases in Germany (38%), with a similar share of higher-impairment conditions.[1] This places Germany between higher-visibility markets like Australia and the UK – where anxiety-related distress makes up a larger proportion – and countries like Malaysia and the UAE, where more severe conditions are more common.

These patterns could suggest a system where earlier and broader engagement can coexist with stable prevalence when capacity, thresholds, and care pathways are aligned to support both personal resilience and higher-impact need.

A high burden among adolescents

High prevalence among adolescents – peaking at almost one in three (30%) of 15- to 19-year-olds – also points to early engagement, but this has not translated into rapid overall prevalence growth.

High concentration of mental health conditions among younger cohorts – including, worryingly, more than one in five (22%) of 10- to 14-year-olds – suggest Germany is experiencing a front-loaded mental health curve, where mental health conditions are emerging earlier, and possibly more persistently than in older adults.

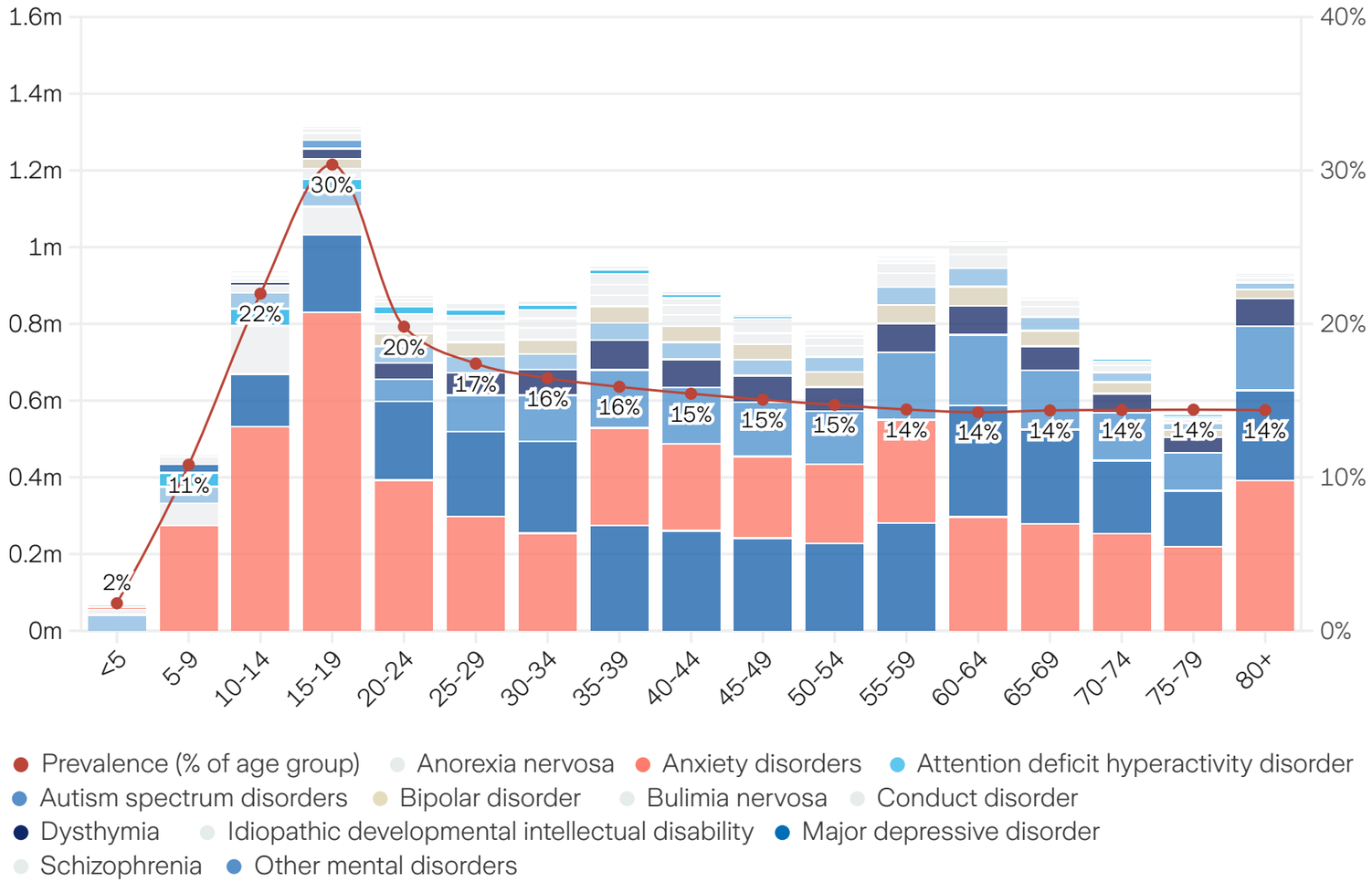
1. More than 60 days of healthy life lost on average per individual per year.

Part of this trend may reflect greater awareness and reduced stigma, leading to earlier identification of need. Schools, pediatric care, and primary care teams increasingly identify mental health conditions sooner, which brings real benefits: faster access to therapy, less deterioration, and improved functioning at school and at home. However, this trend may also indicate a genuine rise in need, driven by factors such as academic pressure, social media exposure, and the stresses associated with major life transitions.

Either way, the underlying pattern is clear: Mental health conditions are emerging earlier in Germany, and the intensity among adolescents and pre-teens now materially exceeds the burden observed in adults.

Germany: Projected prevalence of mental health conditions by age (2026)

Number of mental health conditions (million) and prevalence rate (%), by age group



Primary sources: IHME (2025), World Bank (2025).

Projected prevalence by age group (%) includes comorbidities.

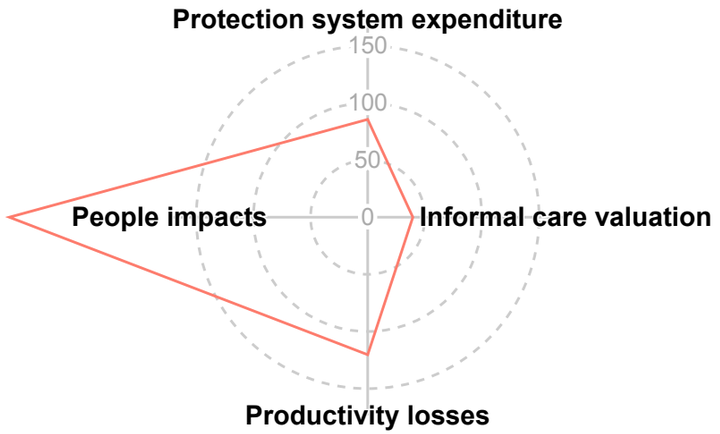
Refer to Data and methodology for a full set of data sources, assumptions and calculations.

A legacy of informal management

While younger people are increasingly visible in the mental health system, patterns among older adults are more muted – not necessarily because the burden is lower, but because symptoms are less frequently reported. Like the UAE, major depressive disorder accounts for a larger share of recorded cases than anxiety disorders among older cohorts (35- to 59-year-olds), reversing the pattern seen in most other markets examined.

This suggests a visibility gap, where older adults may appear less affected because many symptoms remain unreported, unrecognized, or uncoded in clinical data. A national study shows that 15% of adults who screen positive for a mental health indicator do not report needing mental health care – with perceived need even lower among people with less formal education.[2]

Germany: Estimated impacts on people, productivity and protection systems (2030)
EUR billion



This may indicate strong personal resilience, with higher thresholds for seeking formal care and diagnosis. Alternatively, it could point to ongoing gaps in recognition and uptake, which may result from lower digital engagement, stronger stigma, or symptoms masked by ageing, physical decline, and comorbidities.

These trends have impacts that extend far beyond mental health diagnosis. By 2030, despite nearly EUR 86 billion (1.8% of GDP) in combined public and private expenditure on mental health support and protection, mental health conditions are projected to result in nearly:

EUR 314 billion
in wellbeing losses related to morbidity and mortality.

EUR 120 billion
in reduced workforce participation and increased absenteeism.

EUR 40 billion
in the value of informal care.

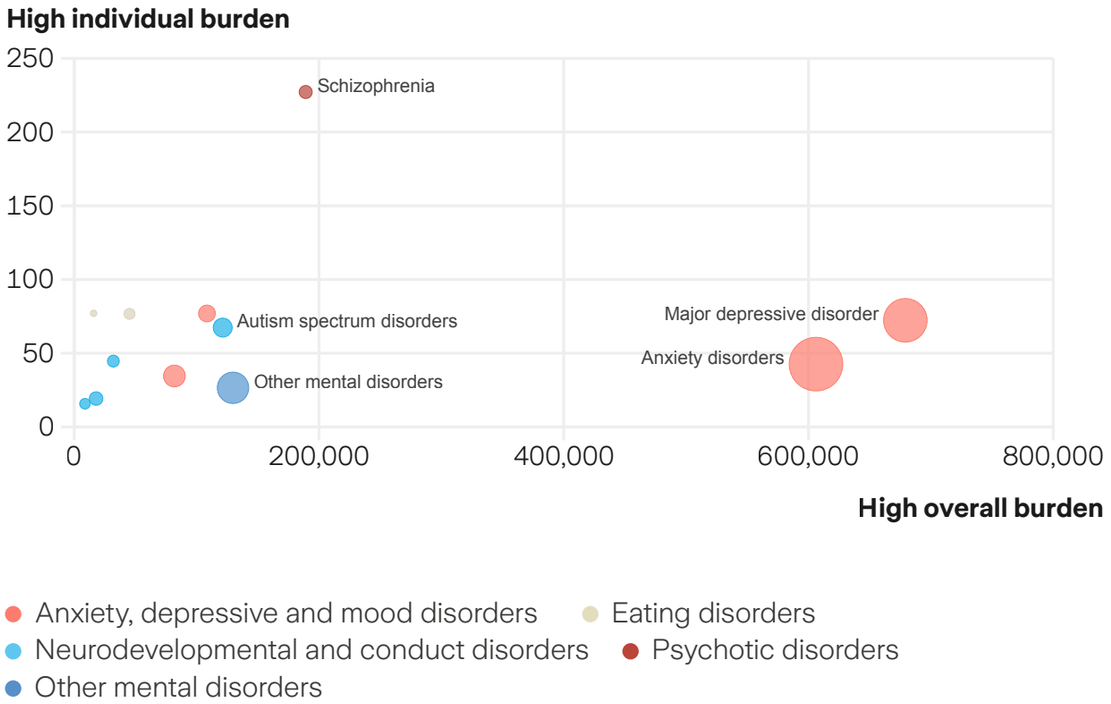
Refer to Data and methodology for a full set of data sources, assumptions and calculations.

2. Walther L, Vogelsang F, Thom J, Hölling H, Grobe TG, Frerk T, Marschall U, Peitz D. Assessing Perceived Need for Mental Healthcare Among Adults in Germany (2025).

People: A high personal cost

In 2026, an individual living in Germany with a mental health condition or self-harm is estimated to lose 67 days of healthy life each year – the highest figure across the six countries examined, reflecting a unique mix of mental health conditions.

Germany: Impact of mental health conditions on morbidity (2026)
Estimated individual impairment (days living with disability), morbidity impact (total YLDs) and share of cases (%), by condition



Primary sources: IHME (2025), World Bank (2025).

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Nationally, this amounts to over 2 million years of healthy life lost, valued at approximately EUR 297 billion in 2026.[3] The majority of this burden (85%) is due to morbidity, rather than premature mortality.

Scale and severity both matter

Germany's mental health burden reflects two realities:

- **Lower-impairment conditions:** Anxiety disorders make up about 38% of recorded conditions in Germany, compared with 49% to 51% in the UK and Australia. Because these conditions affect many people, even moderate impairment at this scale leads to substantial impacts on wellbeing, accounting for 30% of total years lived with disability (YLD) in 2026.

- **Higher-impairment conditions:** In comparison, major depressive disorder is more highly impairing, resulting in 72 days lived with disability, compared to 43 days for anxiety. Although it is less common than anxiety, it contributes a larger share of wellbeing loss (34% of total YLDs).

Together they account for over 1 million years – or nearly two-thirds (64%) of all healthy life lost in 2026.

This split profile suggests two clear priorities: scalable interventions that reduce cumulative impairment for more common conditions, and specialist, high-intensity services for severe or complex cases.

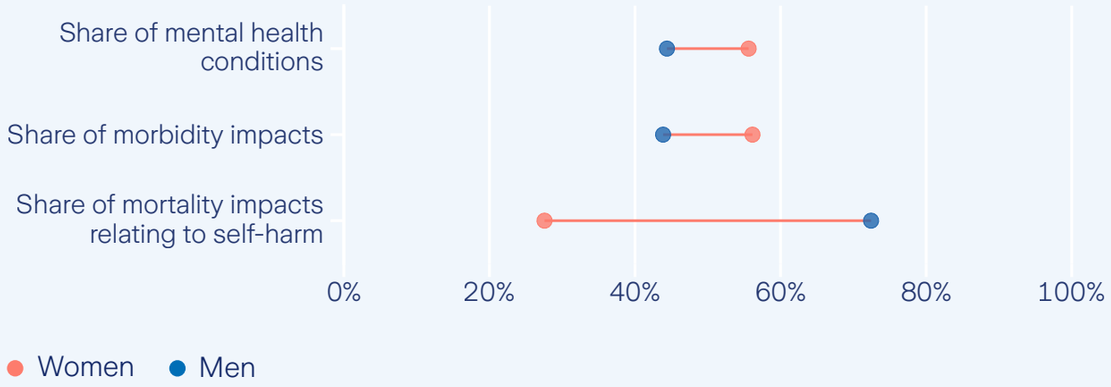
3. The value of a statistical life year of USD 156,000 has been applied and converted into EUR to reflect local conditions.

Gender divides in Germany

As in other markets, mental health conditions in Germany show a distinct gender pattern. Women represent 56% of all cases, compared with 44% of men, and experience a similar proportion of healthy life lost due to morbidity. This reflects both higher prevalence and faster growth among women.

Men, by contrast, face a higher share of premature mortality, accounting for 72% of all deaths attributable to suicide.

Germany: Projected impacts of mental health conditions by gender (2026)
% of total cases, YLDs and YLLs, by gender



Primary sources: IHME (2025), World Bank (2025).

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Productivity: A strong labor market carrying a rising load

Mental illnesses shape Germany's economic trajectory in ways that are often underestimated. The impact is not only felt when people leave work altogether, but also in the quieter accumulation of reduced hours and repeated periods of absence. In a high-wage, highly-regulated labor market, these patterns translate directly into substantial economic loss.

In 2026, the combined productivity impact of reduced participation and absenteeism is estimated at EUR 110 billion, rising to EUR 120 billion by 2030.

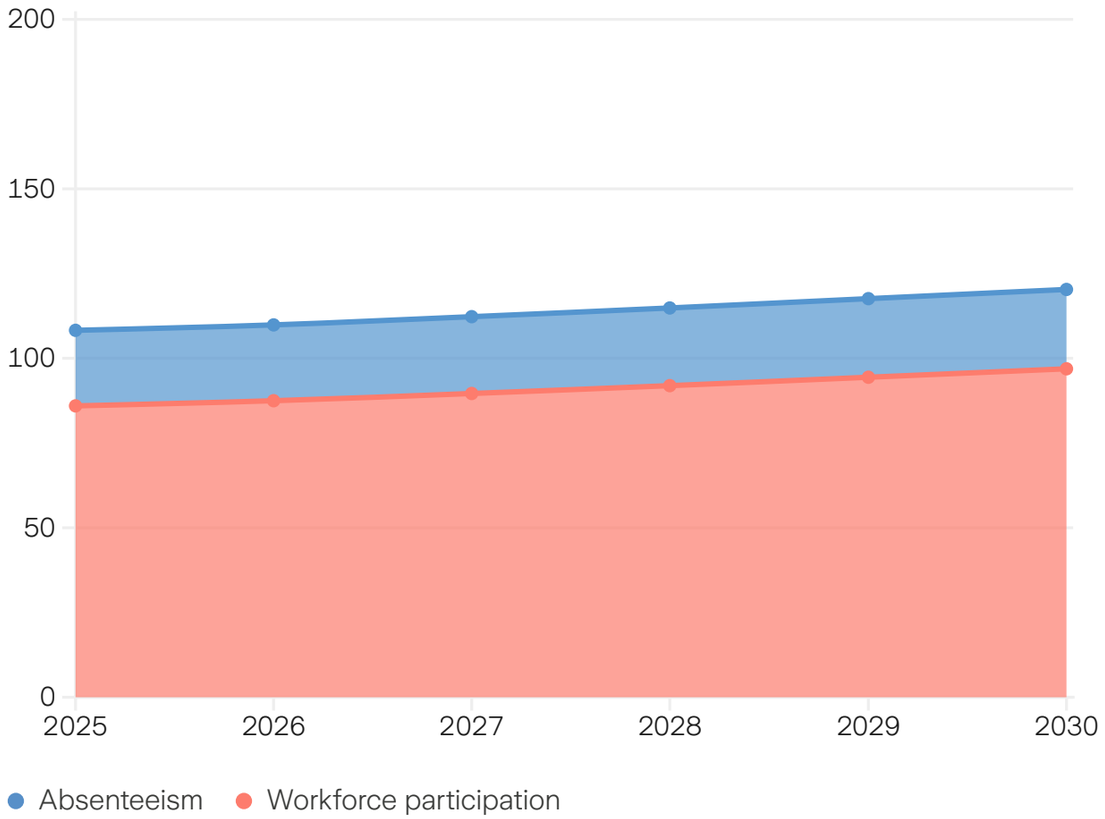
A wide and persistent employment gap

About 80% of losses in 2026 are due to reduced workforce participation, totaling EUR 87 billion – equivalent to 1.9% of GDP. This is driven by a 17 percentage point employment gap between individuals with and without a mental health condition (61% employment for those with a mental health condition, compared to 78% for those without).

Although this gap is smaller than the figure observed in the UK (29%), it still represents tens of thousands of people who could work, want to work, and benefit from working – but are unable to maintain participation without timely support. In a high-wage labor market, each period of inactivity or reduced working hours carries a substantial economic cost.

This highlights the economic value of earlier access to effective support – whether in primary care, the workplace, or through faster entry into psychotherapy – even before considering the individual clinical benefits.

Germany: Projected economic impact of mental health conditions (2025-2030)
Absenteeism and workforce participation losses associated with mental health conditions, EUR billion



Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Absenteeism and presenteeism

In contrast to the employment gap, mental health-related sick leave in Germany is significantly higher than in the UK – suggesting people stay formally connected to employment, but with long periods to recover and re-engage.

German workers take an average of 2.5 mental health-related sick days per year.[4] This amounts to 98 million mental health-related sick leave days in 2026, costing more than EUR 22 billion in lost output (0.5% of GDP), rising to EUR 23 billion by 2030.

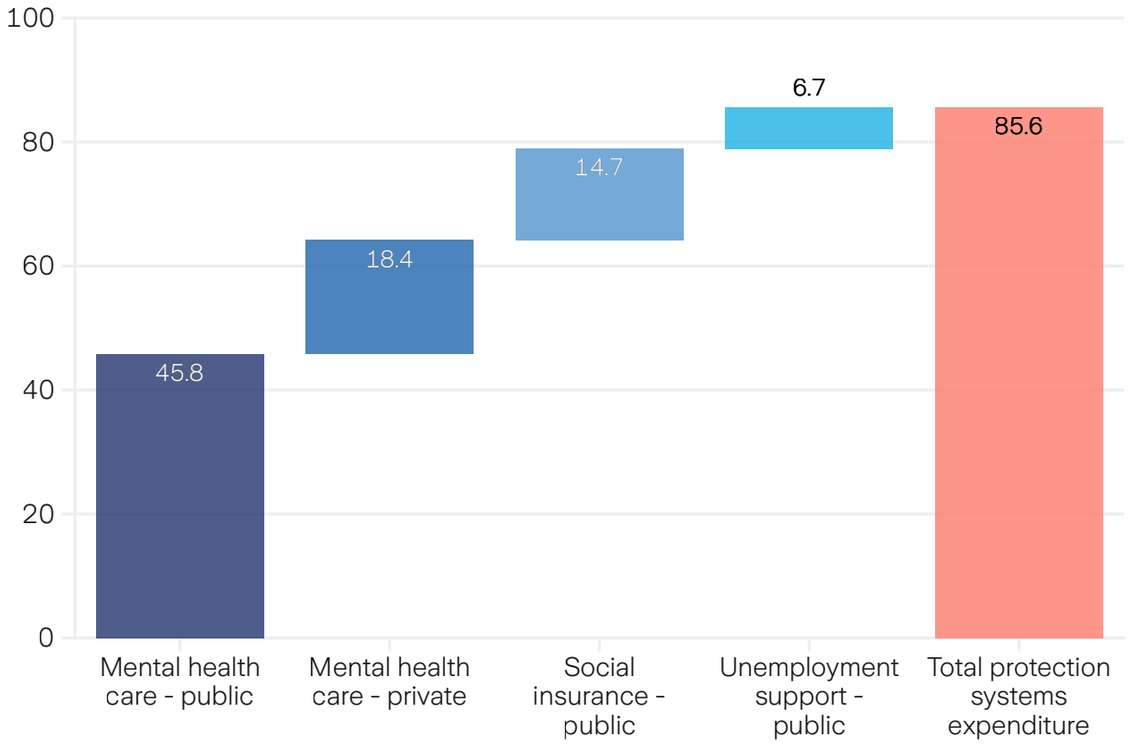
However, these figures do not account for presenteeism – when individuals continue to work while unwell and perform below their capacity. Consistent with patterns observed across the OECD, underreporting of mental illness among some adults suggests that presenteeism likely plays a significant, though currently unmeasured, role in overall productivity. As a result, the true economic burden of mental illnesses is almost certainly underestimated.

Reducing absenteeism and preventing presenteeism are not just operational concerns for employers – they are essential to preventing long-term inactivity. The longer someone is away from work due to a mental health condition, the lower their likelihood of returning. Earlier, coordinated action – in primary care and at work – shortens recovery, protects participation, and reduces future productivity loss.

4. Absenteeism is expressed as the average excess sick days per worker related to mental health. The figure includes both workers with and without a mental health condition.

Protection systems: Strong institutions but uneven delivery

Germany: Mental health care protection systems (2030)
Projected expenditure, EUR billion



Refer to ⇨ Data and methodology for a full set of data sources, assumptions and calculations.

Total mental health protection system spend (excluding informal care) is estimated at nearly EUR 82 billion in 2026 (around 1.8% of GDP). This is projected to rise to close to EUR 86 billion by 2030.

Germany's mental health system spans multiple sources of financing: statutory insurance, private insurance, employer contributions, out-of-pocket spending, and a vast layer of unpaid informal care. This blend of funding and responsibility makes Germany's system both comprehensive and complex. Understanding how mental health care needs are met requires looking not just at how much is spent, but at how these structural features shape access, speed, and the distribution of support across the state, insurers, employers, and families.

A dual path system

Germany's mental health protection system is built around a dual-insurance model that strongly shapes access, speed of care, and the visibility of mental health conditions. At its core sits the statutory scheme – *Gesetzliche Krankenversicherung (GKV)* – which covers nearly 90% of the population through income-based social contributions. GKV guarantees broad entitlements to mental health care, including psychotherapy, psychiatric treatment, and pharmaceuticals, delivered through a nationwide network of outpatient providers and hospitals.

Government spending on mental health care accounts for 79% of this, estimated at nearly EUR 44 billion in 2026. Beyond clinical services, government expenditure also covers around:

- EUR 9 billion in social insurance benefits.
- EUR 5 billion in mental health-related social services.
- EUR 6 billion in unemployment support for people living with mental health conditions.

Taken together, total government expenditure on mental health is estimated at EUR 64 billion in 2026, rising to EUR 67 billion by 2030.

Private access

Alongside it operates *Private Krankenversicherung (PKV)*, which insures a smaller share of higher-income employees, civil servants, and the self-employed. PKV often provides faster access, greater flexibility in choosing providers, and higher reimbursement for psychotherapy.

The private system adds a further layer of spending, rising to EUR 18 billion by 2030. Of the 2026 total, around EUR 6 billion goes on voluntary private insurance premiums while EUR 3 billion reflects employer spending. It also includes EUR 9 billion on out-of-pocket expenditure, especially for psychotherapy accessed outside statutory insurance capacity, as well as services that receive only partial reimbursement.

A two-speed system

The two pathways mean that the same mental health conditions may emerge at different speeds, depending on whether someone enters through GKV or PKV. This affects not only waiting times, but also when conditions are diagnosed, coded, and counted. Individuals with private coverage or financial means can access more flexible, faster, and broader psychological support, while those relying on statutory care often face longer waits and fewer reimbursed options.

Germany also has one of the highest psychiatric workforce densities in Europe – 28.9 psychiatrists per 100,000 people,[5] but people still face an average waits of 66.7 days between initial contact and a probatory psychotherapy session, and 112.1 days between initial contact and a guideline psychotherapy appointment.[6] These pressures reflect a system with strong entitlements but uneven capacity, particularly in high-demand specialties such as psychotherapy.

A hidden workforce of caregivers

A further layer of support sits outside formal services entirely. In 2026, over 2 million informal mental health caregivers in Germany provide nearly 21 million hours of unpaid care each week – amounting to over 1 billion hours a year, valued at almost EUR 37 billion. This is not a public expense, but rather the economic value of work that families already provide – helping with daily routines, medication adherence, transportation, appointments, and emotional support.

Despite the strength of Germany's formal system, it could not function without this informal support.

5. Eurostat. Physicians by category (2025).
6. Kruse, J. et al. Outpatient Psychotherapy in Germany (2024).

Spotlight

FIT hospitals

One of Germany's most significant mental health reforms has been the introduction of Flexible and Integrated Treatment (FIT) programs in psychiatric hospitals. Unlike the traditional model – where hospitals are reimbursed per inpatient day – FIT is financed through global treatment budgets, giving hospitals the freedom to provide care in the setting that works best: inpatient, day hospital, outpatient, or home-based. This removes the incentive to keep people in hospital longer than necessary and allows the same care team to stay with the patient across settings.

Evidence from 12 cohort studies covering 36,069 patients shows that FIT hospitals slowed the growth in inpatient care use. Over time, inpatient days in FIT hospitals increased far less than in routine-care hospitals – a difference equivalent to avoiding around five inpatient days per patient.[7] Many FIT programs reduced inpatient days altogether, and lengths of stay were shorter. Patients were also more likely to move smoothly between treatment settings because the same clinical team could follow them throughout their care.

These findings suggest that flexible, integrated funding models can reduce pressure on inpatient units while supporting more stable, person-centered care.

7. Neumann, A. et al. Changes in patient care through flexible and integrated treatment programs in German psychiatric hospitals: meta analyses based on a series of controlled claims-based cohort studies (2024).

From stability to scalability: Where Germany's next opportunity lies

Germany enters the next decade with one of the strongest mental health care infrastructures among advanced economies: universal insurance, a deep psychotherapy tradition, and a large specialist workforce. These assets have historically enabled the country to absorb high levels of mental health care needs without tipping into system crisis.

But as needs rise, the challenge is to deploy this infrastructure earlier, more flexibly, and closer to where need first emerges. This means:

1. **Strengthening early access for young people while building lifelong resilience:** With prevalence highest among adolescents and young adults, Germany's greatest opportunity is to expand rapid access and early intervention pathways across schools, youth services, primary care, and child and adolescent psychotherapy. By supporting young people earlier – and pairing clinical care with skills that build confidence, coping capacity, and emotional regulation – Germany can prevent mild or episodic distress from escalating into long-duration impairment.

2. **Targeting conditions that drive the greatest loss of healthy life:** Anxiety and depressive disorders account for nearly two-thirds of Germany's healthy life loss. Scaling evidence-based therapies, stepped care models, and relapse prevention support is essential – but outcomes improve further when these are combined with tools that help individuals manage symptoms, maintain routines, and rebuild stability over time. Integrated approaches such as FIT, which reduce reliance on inpatient care and support smoother transitions between settings, demonstrate how flexible pathways can reinforce both clinical recovery and personal resilience.

3. **Protect work participation through coordinated support:** More than 80% of Germany's productivity losses stem from reduced participation rather than short-term absence. Earlier workplace accommodations, structured return-to-work pathways, and closer coordination between employers, primary care, and insurers can help sustain attachment to work and prevent short-term disruption from becoming long-term exit.

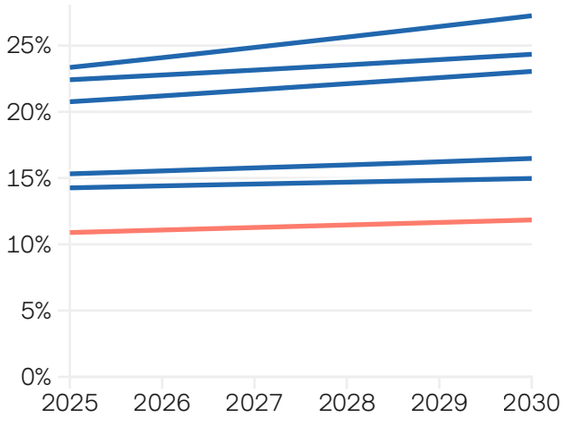
By acting early and supporting both participation and personal resilience, Germany can ensure that rising need does not erode stability but becomes the catalyst for a more adaptive, inclusive mental health care system.

Malaysia

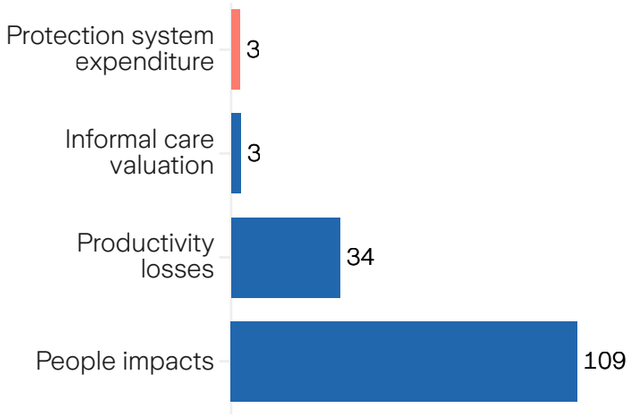
A private problem

This section brings together the latest data, modeling, and policy analysis to understand the scale, drivers, and implications of mental health conditions in Malaysia. We focus on three pillars: People (the human impact), productivity (economic consequences), and protection systems (system pressures, and policy landscape), that are shaping prevention, early intervention, access to support, and long-term recovery. The goal is to offer a clear, evidence-based view of the nation's mental health outlook and highlight select opportunities for strategic action to strengthen wellbeing, resilience, and inclusion in the years ahead.

By 2030, mental health conditions are projected to affect nearly 1 in 9 people living in the Malaysia (12%)



Estimated impacts on people, productivity and protection systems (2030)
RM billion



By 2030, an average person living in Malaysia with a mental health condition is projected to face...

Lower days of healthy life lost

62 days
of healthy life lost

Higher average employment gap

18%
employment gap

Lower average sick days

0.5 days
of excess sick leave for mental health reasons per year

Higher out-of-pocket expenditure

42%
of treatment costs covered by out-of-pocket expenditure

Low annual hours of informal care

35 hours
of informal care received per year

Malaysia

Prevalence: Recorded prevalence is relatively low – but understates true need

By 2030, over 4 million people in Malaysia are projected to be living with a mental health condition. At about 12% of the population, this places Malaysia below other markets on headline prevalence. At the same time, Malaysia is projected to experience one of the fastest rates of growth at 2.8% average annual growth.

Structural factors shape this pattern:

- **Social stigma:** Mental health in Malaysia continues to be treated as a private issue, managing distress informally or delaying seeking help. Research suggests that up to four in five people with a mental disorder may not be accessing professional care, with stigma, lack of awareness, and misconceptions acting as major barriers.[1]

- **Access pathways:** Diagnosis typically requires a specialist assessment, rather than being made routinely in primary care. This raises the threshold for diagnosis, skewing recorded cases toward more severe presentations.

- **Cost and continuity of care:** Public mental health care services are generally affordable and accessible, but care is often delivered across multiple clinicians. Given the complexity and long-term nature of many mental health conditions, this can hinder effective assessment, treatment planning and follow-up. Private providers often allow for a continuous therapeutic relationship, but treatment is only accessible to those who can afford it.

- **Capacity limitations:** Specialist availability remains low by international standards, at less than 2 psychiatrists per 100,000 people,[2] contributing to delays in recognition and limiting consistent follow-through.

Many mental health conditions exist along a wide continuum, from episodic distress linked to life events to persistent clinical illness. Unlike in Australia or the UK, conditions that sit lower on the clinical spectrum – including many anxiety-related disorders – are more likely to remain informal in Malaysia. Recorded prevalence should therefore be interpreted as a floor, not a ceiling, on the true scale of mental illness.

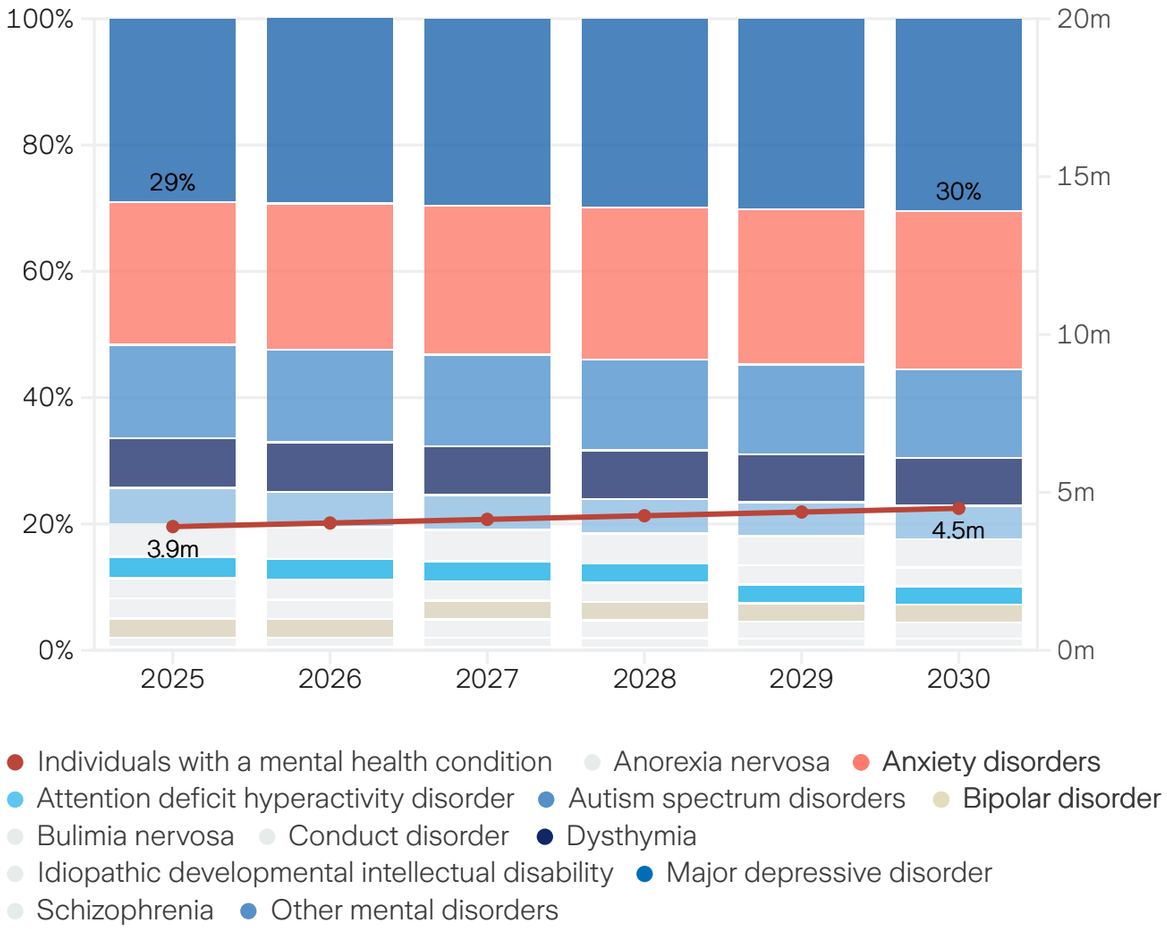
But a countervailing trend is now emerging. Reflecting recent policy emphasis on stigma reduction and expanded access beyond traditional clinical settings, digital and tele-mental health care services have expanded rapidly, enabling online counselling, tele-psychology and crisis support.[3] These models offer two critical advantages: greater privacy and lower cost, lowering barriers to initial engagement.

1 in 9

people in Malaysia (12%) are projected to be living with a mental health condition by 2030.

1. Lally et al. Mental disorders in Malaysia: an increase in lifetime prevalence (2021)
2. Bernama. Only 623 registered psychiatrists in Malaysia (2024).
3. Samad, R. A. and R.W. Abdullah. Global and Malaysian Perspectives on Mental Health and Digital Interventions (2020–2025): A Narrative Review (2025).

Malaysia: Projected prevalence of mental health conditions (2025-2030)
Projected share of cases by condition (%) and total number of individuals with a mental health condition (million)



Primary sources: IHME (2025), World Bank (2025).

Total number of individuals with a mental health condition accounts for co-morbidities.

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Hidden severity behind low prevalence

Malaysia's condition mix differs markedly. Major depressive disorder accounts for a larger share of recorded cases than anxiety in most age groups, reversing the pattern seen in most other markets examined.

This divergence is consistent with high thresholds for recognition, shaped by stigma and access, with recorded prevalence capturing the more severe end of the continuum, rather than the full spectrum of mental illness. Mild to moderate distress – particularly anxiety – is frequently managed informally, through family support, counselling or self-coping. Recorded cases in Malaysia are skewed toward conditions that cross a higher threshold of impairment and trigger specialist assessment. Depression is more likely to cross that threshold, making it disproportionately visible in the data (projected 30% of cases by 2030).

Growth rates nonetheless indicate rising pressure across both anxiety and depressive disorders. Anxiety disorders are projected to grow at more than 5% per year, and major depressive disorder at more than 4%, far outpacing most other conditions.

Generational divides

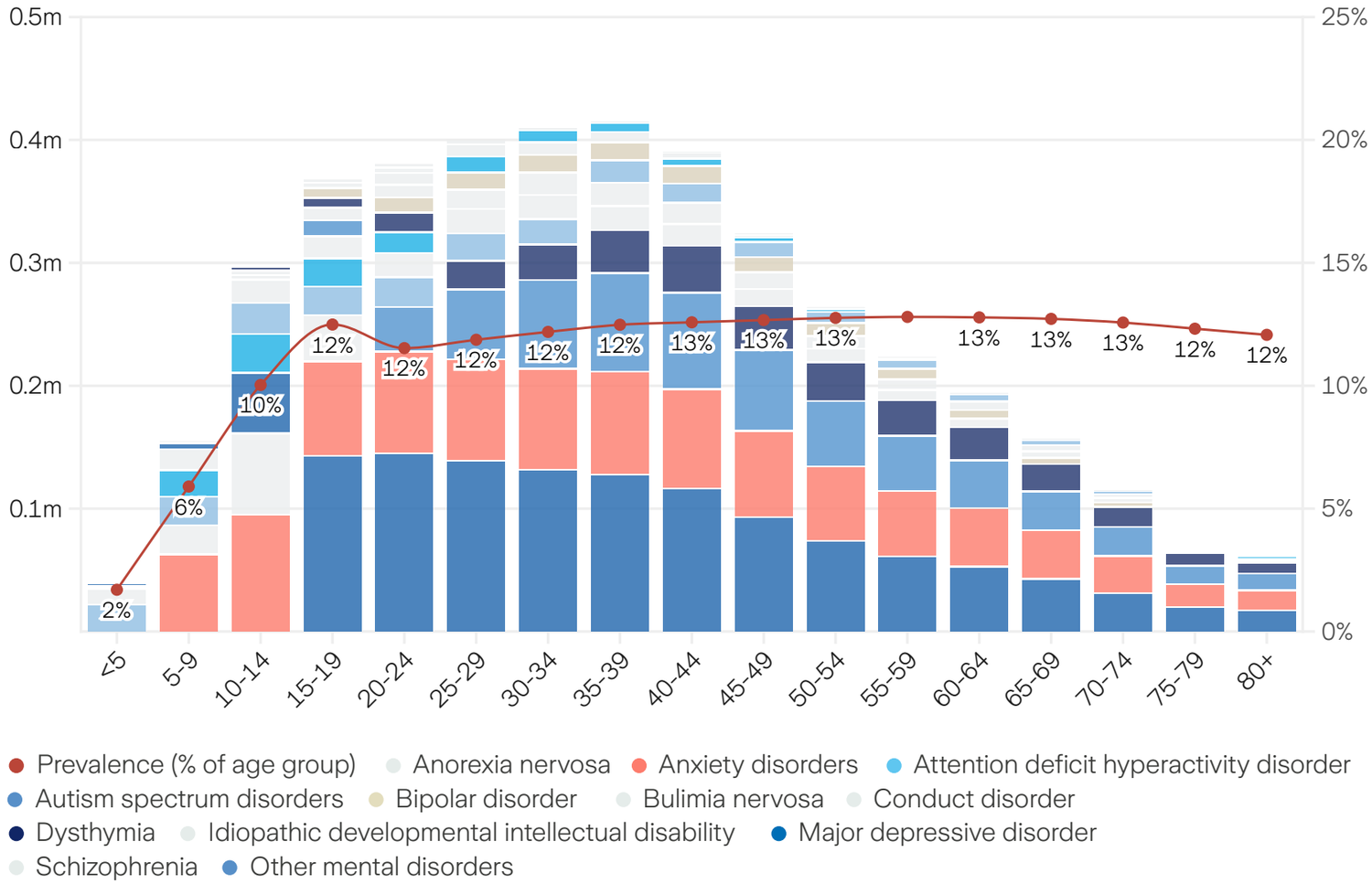
Despite widespread concern about the high prevalence of mental health conditions in children and young people, Malaysia does not yet show a sharp peak in prevalence among young adults. Recorded rates remain relatively consistent across age groups, reflecting similar access and stigma dynamics that limit early recognition.

Yet growth rates tell a more revealing story. Older working-age adults and those above 60 are projected to experience some of the fastest increases: prevalence among those aged 45 to 54 is expected to rise by more than 5% annually, while rates among adults over 60 range from nearly 5% to more than 8% per year.

These patterns suggest that while distress can emerge earlier, formal diagnosis occurs later – increasing the likelihood that conditions become more entrenched by the time support is accessed, with clear implications for wellbeing, participation, and long-term recovery.

Malaysia: Projected prevalence of mental health conditions by age (2026)

Number of mental health conditions (million) and prevalence rate (%), by age group



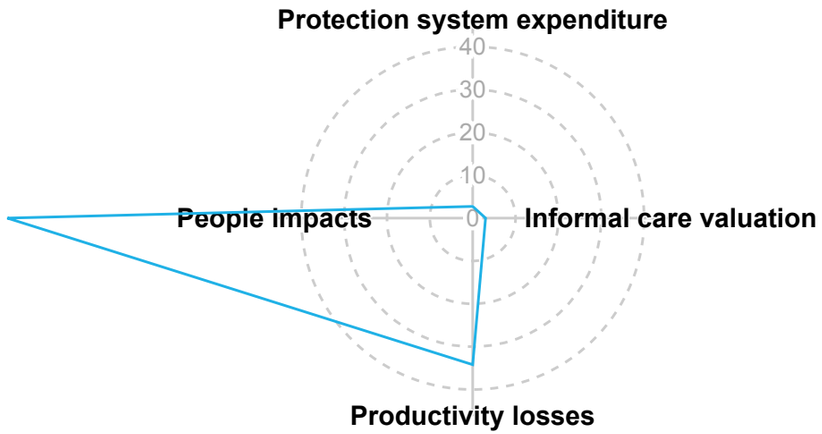
Primary sources: IHME (2025), World Bank (2025).

Projected prevalence by age group (%) includes comorbidities.

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Conditions that remain hidden for longer can carry greater economic and functional costs once they surface

Malaysia: Estimated impacts on people, productivity and protection systems (2030)
RM billion



Refer to ⇨ Data and methodology for a full set of data sources, assumptions and calculations.

By 2030, despite an estimated RM 2.7 billion in formal protection system spending (0.1% of GDP), mental health conditions are associated with:

RM 109 billion
in wellbeing losses related to morbidity and mortality.

RM 34 billion
in reduced workforce participation and increased absenteeism.

RM 3 billion
in the value of informal care.

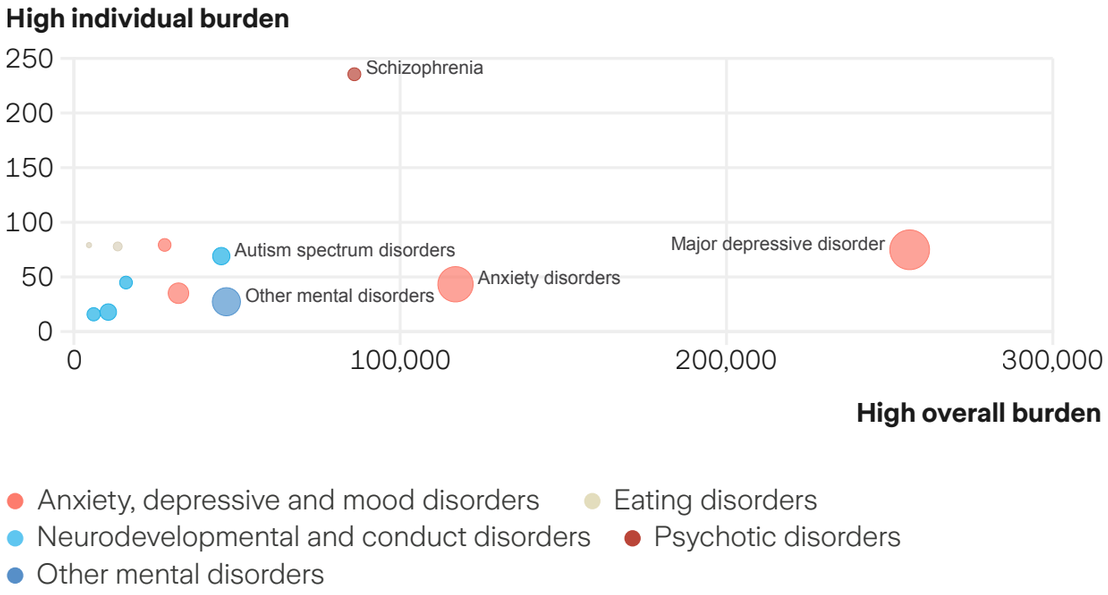
These figures represent the value that could be recaptured through more effective prevention, early intervention and sustained, continuous support.

People: Substantial wellbeing loss despite low recorded prevalence

Once mental health conditions are recorded in Malaysia, its impact on individuals is significant. In 2026, mental health conditions and self-harm account for nearly 700,000 years of healthy life lost – the equivalent of over RM 97 billion, rising to RM 109 billion by 2030. For the average person living with a mental health condition, this translates to about two months (62-63 days) of healthy life lost per year.

Malaysia: Impact of mental health conditions on morbidity (2026)

Estimated individual impairment (days living with disability), morbidity impact (total YLDs) and share of cases (%), by condition



Primary sources: IHME (2025), World Bank (2025).

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

As in other markets, the vast majority of this burden reflects reduced quality of life rather than early death. Around 95% of wellbeing loss is driven by morbidity. But Malaysia's recorded burden is shaped by a distinct condition mix. Mirroring prevalence, major depressive disorder is the single largest contributor to wellbeing loss – accounting for 39% of total years lived with a disability (YLD).

This pattern reflects which cases enter the formal system. Recorded burden is weighted toward conditions associated with more sustained disruption to daily life, while lower-acuity distress – particularly anxiety-related conditions – is less likely to be captured unless impairment becomes substantial.

As a result, a larger share of Malaysia's recorded wellbeing loss is due to conditions associated with higher average days of healthy life lost. About two thirds (66%) of total morbidity relates to conditions with more than 60 days of impairment per year, such as anorexia, autism, bipolar disorder, bulimia, major depressive disorder, and schizophrenia. In Australia, these conditions account for only 43% of total years lived with disability, reflecting a much broader inclusion of lower-impairment conditions.

These dynamics suggest that the personal burden of mental health conditions in Malaysia is shaped less by scale and more by timing and case composition. For many individuals, significant wellbeing loss has often already accumulated by the time support is accessed, increasing the risk that impairment becomes entrenched and continues into later life. This results in a pattern of concentrated individual burden, with clear implications for participation, continuity of care, and long-term recovery.

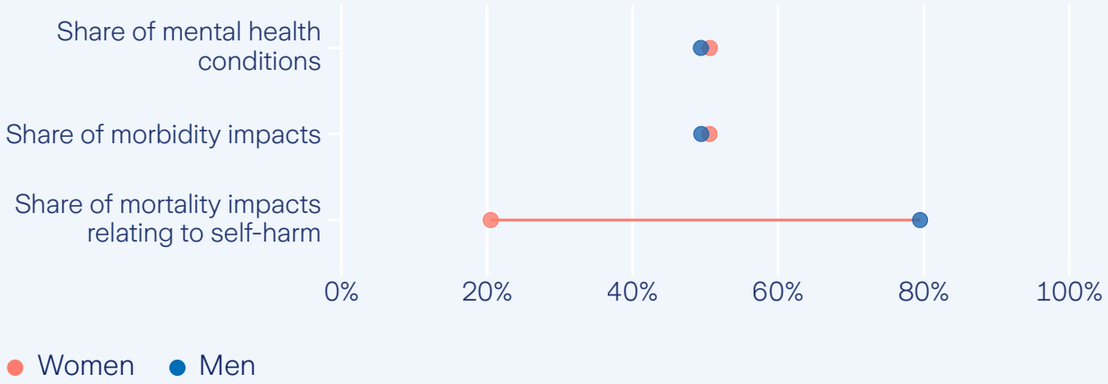
Gender divides in Malaysia

Similar to other markets, women exhibit higher overall prevalence - 12% compared with 10% among men - and faster average annual growth (3.1% versus 2.4%).

However, Malaysia does not show a pronounced gender divide in the overall burden of mental health conditions. Men and women account for a broadly balanced share of diagnoses and morbidity, reflecting similar levels of wellbeing loss once cases reach formal care.

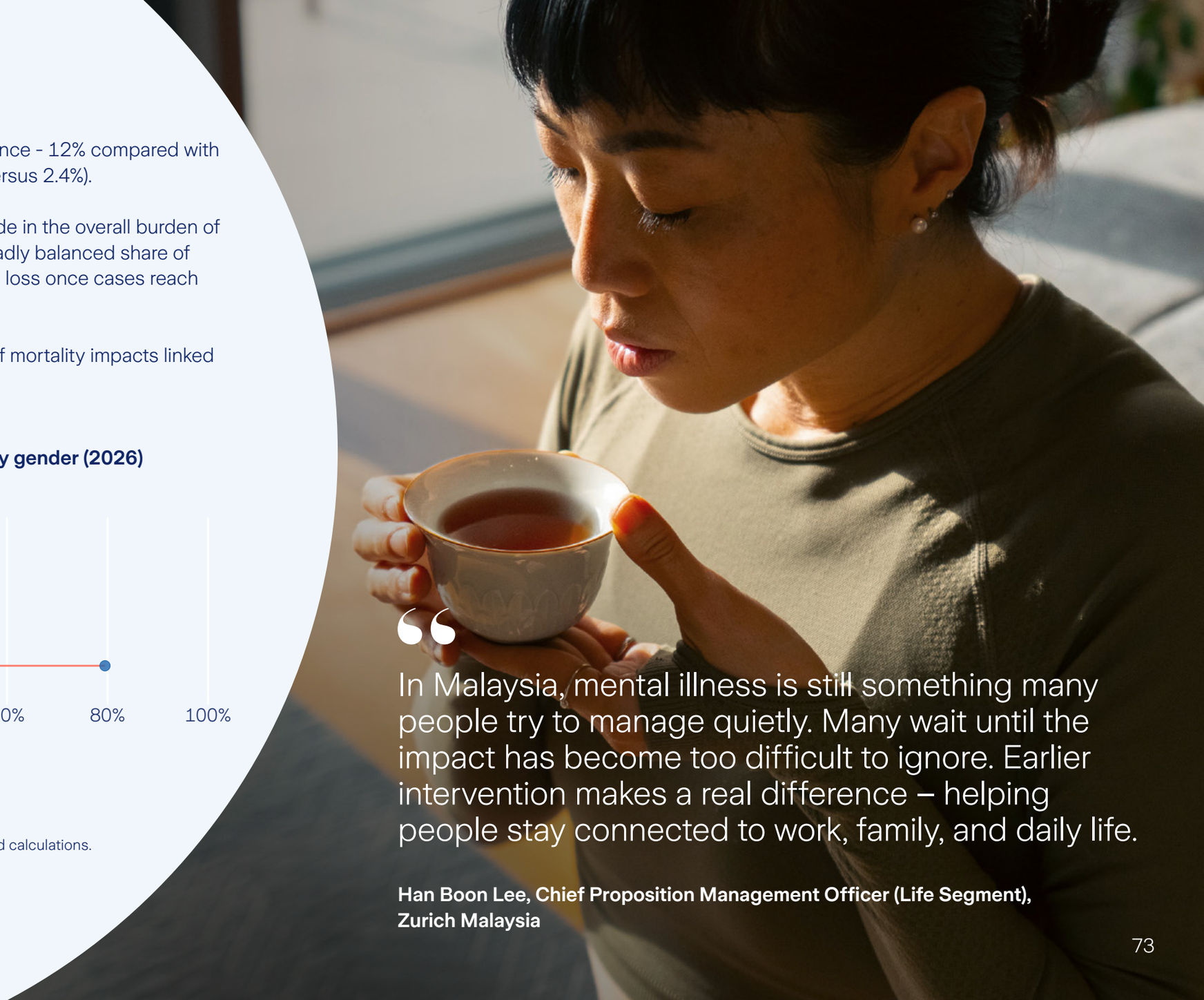
At the same time, men experience a disproportionate share of mortality impacts linked to suicide, mirroring trends observed in many markets.

Malaysia: Projected impacts of mental health conditions by gender (2026)
% of total cases, YLDs and YLLs, by gender



Primary sources: IHME (2025), World Bank (2025).

Refer to Data and methodology for a full set of data sources, assumptions and calculations.



“In Malaysia, mental illness is still something many people try to manage quietly. Many wait until the impact has become too difficult to ignore. Earlier intervention makes a real difference – helping people stay connected to work, family, and daily life.

Han Boon Lee, Chief Proposition Management Officer (Life Segment), Zurich Malaysia

Productivity: Economic losses driven by labor market disengagement

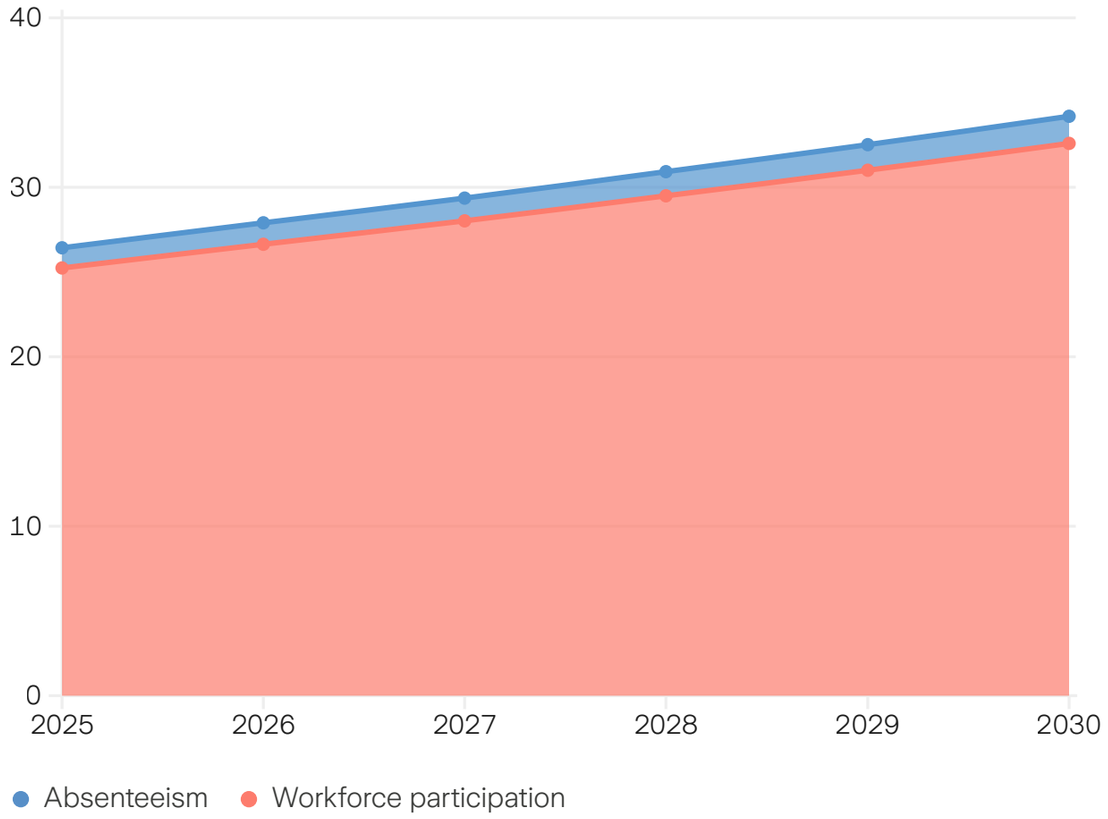
In 2026, mental health conditions are estimated to result in RM 28 billion in lost productivity due to absenteeism and reduced workforce participation, rising to around RM 34 billion by 2030 – equivalent to 1.4% of GDP.

Mental health-related sick leave costs over RM 1 billion per year, with individuals taking an estimated 0.5 sick days for mental health reasons in 2026.[4] This low figure likely reflects both limited access to certified leave and continued reluctance to disclose mental health needs at work.

Labor market disengagement is the dominant driver of productivity loss, accounting for 95% of total losses. People living with a mental health condition are 18 percentage points less likely to be employed than those without (56% compared to 74%), resulting in nearly RM 27 billion in lost wages.

Timing reinforces this pattern. Many conditions are recognized only after impairment has become entrenched, leading to deeper and longer-lasting disruptions to work by the time support is accessed. Earlier entry points can help people stay connected to work, but positive outcomes depend on continuity, coordination, and affordability.

Malaysia: Projected economic impact of mental health conditions (2025-2030)
Absenteeism and workforce participation losses associated with mental health conditions, RM billion



Refer to Data and methodology for a full set of data sources, assumptions and calculations.

4. Absenteeism is expressed as the average excess sick days per worker related to mental health. The figure includes both workers with and without a mental health condition.

Spotlight

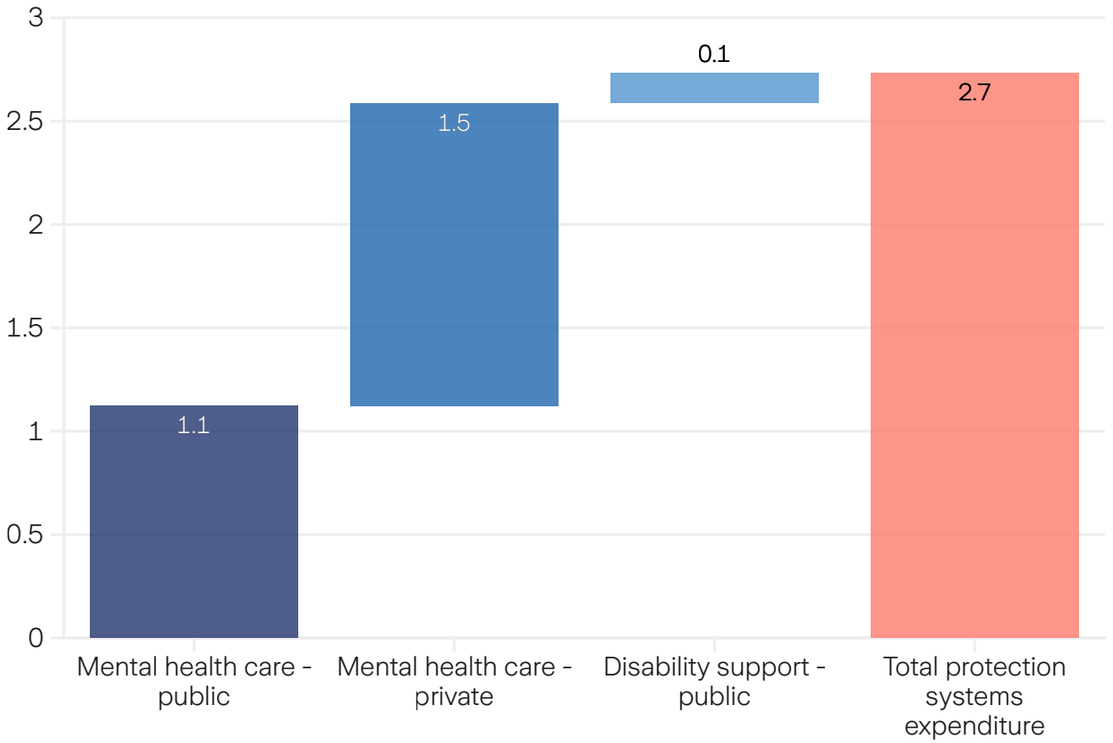
Tele-health as a bridge to earlier intervention

Tele-health has emerged as a valuable response to stigma, confidentiality concerns, and time away from work. Through life and health insurance arrangements, individuals can access remote assessments, counseling, and guided referrals – privately and without the need for in-person visits

However, tele-health is not a substitute for system capacity. It shares many of the same constraints as in-person care, including limits to clinician availability, continuity, and management of complex or acute conditions. Its value lies in providing an earlier, more accessible entry point to support that might otherwise be delayed or avoided.

Protection systems: Public provision is constrained

Malaysia: Mental health care protection systems (2030)
Projected expenditure, RM billion



Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Mental health support in Malaysia operates through a lightly resourced formal system, complemented by significant private spending and household responsibility. Total mental health-related expenditure is estimated to rise to nearly RM 3 billion by 2030 – about 0.1% of GDP. Public spending accounts for under half of this amount (about RM 1 billion), placing Malaysia at the lower end of international benchmarks.

This pattern mirrors the broader health system: total health expenditure was 4% of GDP in 2023, the lowest among markets in scope, with the next closest – the UAE – at 5%.[5]

Public mental health care services remain essential, but capacity is limited. Specialist availability is low by international standards, and care is often fragmented across providers rather than delivered through a continuous therapeutic relationship.

Recent expansion of digital and community-based services signals growing recognition of the challenge, but deeper capacity and stronger coordination are still needed to support long-term recovery.

5. OECD. Health at a Glance (2023).

Private spending strengthens a thin formal safety net

A defining feature of Malaysia's protection landscape is the prominence of private and out-of-pocket expenditure. In 2026, private spending on mental health care services (RM 1.3 billion) exceeds government expenditure (RM 1.0 billion), with individuals bearing a large share of costs directly.

Alongside this is the largest hidden pillar support: informal care. Families and caregivers are projected to provide the equivalent of RM 3.0 billion in unpaid care by 2030. Each informal caregiver provides around 17 hours of care per week, underscoring the central role of households in sustaining people with mental health conditions – and the second-order productivity impacts this can create.

This structure shapes both access and outcomes. Those who can afford private care may access support more rapidly and with better continuity, whereas others face delays, interruptions, or reliance on short-term solutions. Formal protection systems, in this context, function less as a comprehensive backstop and more as a partial layer alongside private coping strategies.

In a labor market where productivity losses are driven primarily by disengagement rather than short-term absence, the limits of protection systems are clear. Income support and health care access can stabilize individuals during periods of illness, but structured pathways back to work are not yet consistently accessible – reinforcing the need for clearer bridges between private care, work, and formal support.

123 million hours

of unpaid mental health-related care provided by families and informal networks in Malaysia by 2030.

From private coping to earlier pathways:
Where Malaysia's next opportunity lies

Malaysia's mental health care system has clear strengths: strong self-coping and family networks, a substantial private health care ecosystem, and policy interest in enabling earlier intervention through public, private, and community channels.

The opportunity is not to replicate high-expenditure systems, but to re-sequence support – intervening earlier, improving care continuity, and strengthening connections between private support, work, and formal protection. This means:

1. **Lower barriers to early engagement:** Building on digital, community, and employer-facilitated entry points, expanding confidential and accessible first steps helps people seek support before impairment becomes entrenched. Scaled appropriately, these channels can normalize early engagement and reduce personal and workplace costs of delay. When early support is financially covered or bundled into existing benefits, barriers related to cost, disclosure, and stigma are reduced – especially when individuals disengage quietly rather than seek help.

2. **Improve continuity across fragmented care:** While first contact is increasingly available, follow-through remains uneven. Strengthening coordination between initial engagement, clinical treatment, and follow-up – including clearer referral and navigation pathways – would support more sustained recovery. Community-based models, such as Malaysia's MENTARI centers,[6] provide an important foundation, but continuity still depends on clear hand-offs, effective care navigation, and follow-up across providers, especially as needs change over time.

3. **Strengthen links between care and participation:** Recovery is most effective when paired with practical support to stay in or return to work. Expanding and better connecting rehabilitation, case-managed, and community-based pathways would help ensure care does not end at symptom stabilization. Malaysia already has elements of structured reintegration – including PERKESO's[7] return-to-work program – but these pathways are not yet consistently linked to early mental health engagement, limiting their reach. Aligning income protection, rehabilitation, and workplace accommodation with treatment can help ensure temporary distress does not lead to prolonged disengagement.

These shifts would help move mental health in Malaysia from a privately managed challenge to one addressed earlier and more effectively, preserving participation and reducing pressure on households and protection systems alike.

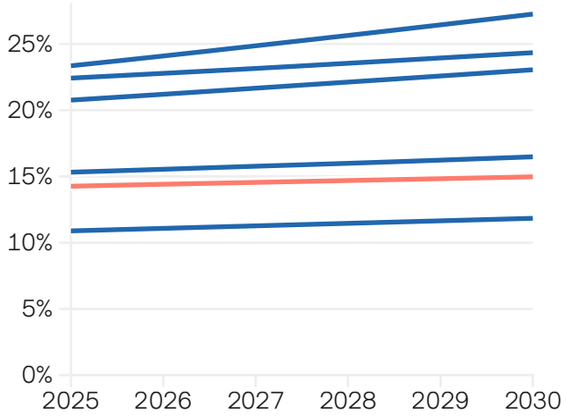
6. Malaysia's Ministry of Health community mental health centers network.
7. Malaysia's statutory social security organization.

The UAE

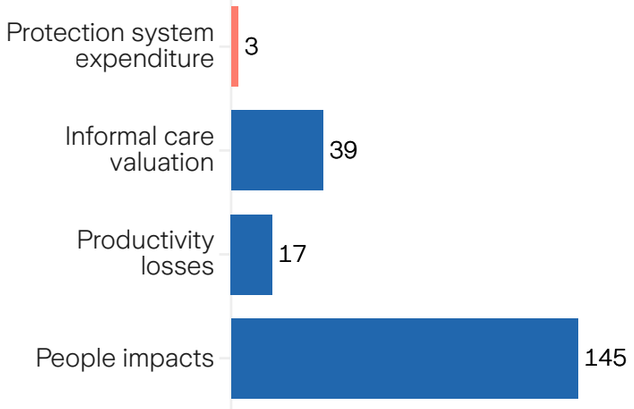
Mental health is more visible, but still managed privately

This section brings together the latest data, modeling, and policy analysis to understand the scale, drivers, and implications of mental health conditions in the UAE. We focus on three pillars: People (the human impact), Productivity (economic consequences), and productivity (system pressures, and policy landscape), that are shaping prevention, early intervention, access to support, and long-term recovery. The goal is to offer a clear, evidence-based view of the nation's mental health outlook and highlight select opportunities for strategic action to strengthen wellbeing, resilience, and inclusion in the years ahead.

By 2030, mental health conditions are projected to affect nearly around 1 in 7 people living in the UAE (15%)



Estimated impacts on people, productivity and protection systems (2030)
AED billion



By 2030, the average individual with mental health condition living in the UAE is projected to...

Higher days of healthy life lost

66 days
of healthy life lost

Low average employment gap

8%
employment gap

Low average sick days

0.2 days
of excess sick leave for mental health reasons per year

Higher out-of-pocket expenditure

19%
of treatment costs covered by out-of-pocket expenditure

High annual hours of informal care

1,275 hours
of informal care received per year[1]

● UAE

1. Care should be taken in cross-country comparisons given differences in methodological approaches.

Prevalence: A strong policy foundation prioritizing early identification and access

Over the past decade, the UAE government has elevated national wellbeing to a strategic priority. Wellbeing, resilience, and quality of life have been embedded into federal planning, supported by initiatives such as the appointment of a Minister of State for Happiness and Wellbeing, the National Strategy for Wellbeing 2031, and the Happiness Meter. These initiatives follow a preventative model that expands visibility, reduces stigma, and strengthens early pathways into support.

This policy commitment sits alongside near-universal health coverage delivered through a public-private model, which plays an important role in how mental health is managed. Emirati citizens access free or highly subsidized care through government facilities, while the expatriate majority rely on mandatory employer-funded insurance. Employers therefore increasingly act as a key early-access gateway, supported by growing digital platforms, workplace wellbeing programs, and community initiatives such as SAKINA.

However, several dynamics continue to shape how mental health conditions are experienced and managed:

- **Cultural and demographic factors:** Underreporting may remain an issue due to stigma,[2] and strong family networks among Emirati and long-established expatriate communities mean many individuals seek support at home before engaging with formal services. The UAE's international workforce also affects recorded prevalence, as some expatriates may leave the country when facing significantly complex or long-term health issues.
- **Rising visibility:** Reported prevalence may rise with improved identification, as expanded screening, employer gateways, and digital access increase contact with services. Over time, however, reforms – such as prevention, wellbeing promotion, and expanded outpatient care – could begin to reduce incidence and duration of conditions.
- **Environmental conditions:** Certain mental health conditions remain sensitive to shocks, from personal bereavement to security and social stressors. While projections follow historical trends, episodic events can temporarily elevate risk for some individuals.

In combination, these factors point to a system where early identification is growing, but the identification and experience of mental illness continues to reflect cultural norms, mobility patterns, and the pace of expanding support pathways.

1 in 10

people living in the UAE are projected to suffer from anxiety or depression by 2030.

This figure does not account for comorbidities.

2. Andrade, G., Bedewy, D., and A.B.A. Elamin et. al. Attitudes towards mental health problems in a sample of United Arab Emirates' residents (2022); Al-Huseini, S. and S.M.Y. Arafat (Eds.) Mental Health Care in the Middle East (2025).

Spotlight

The UAE’s response to mental health needs during the Middle East conflict

As the Middle East faces a period of uncertainty and conflict, the UAE has acted swiftly to support the mental health and wellbeing of its population. Guided by the statement “We are all Emirati,” leaders have maintained a visible presence in malls and other public spaces – amplified on social media – to reassure citizens, residents, and visitors and foster a sense of unity and inclusivity.

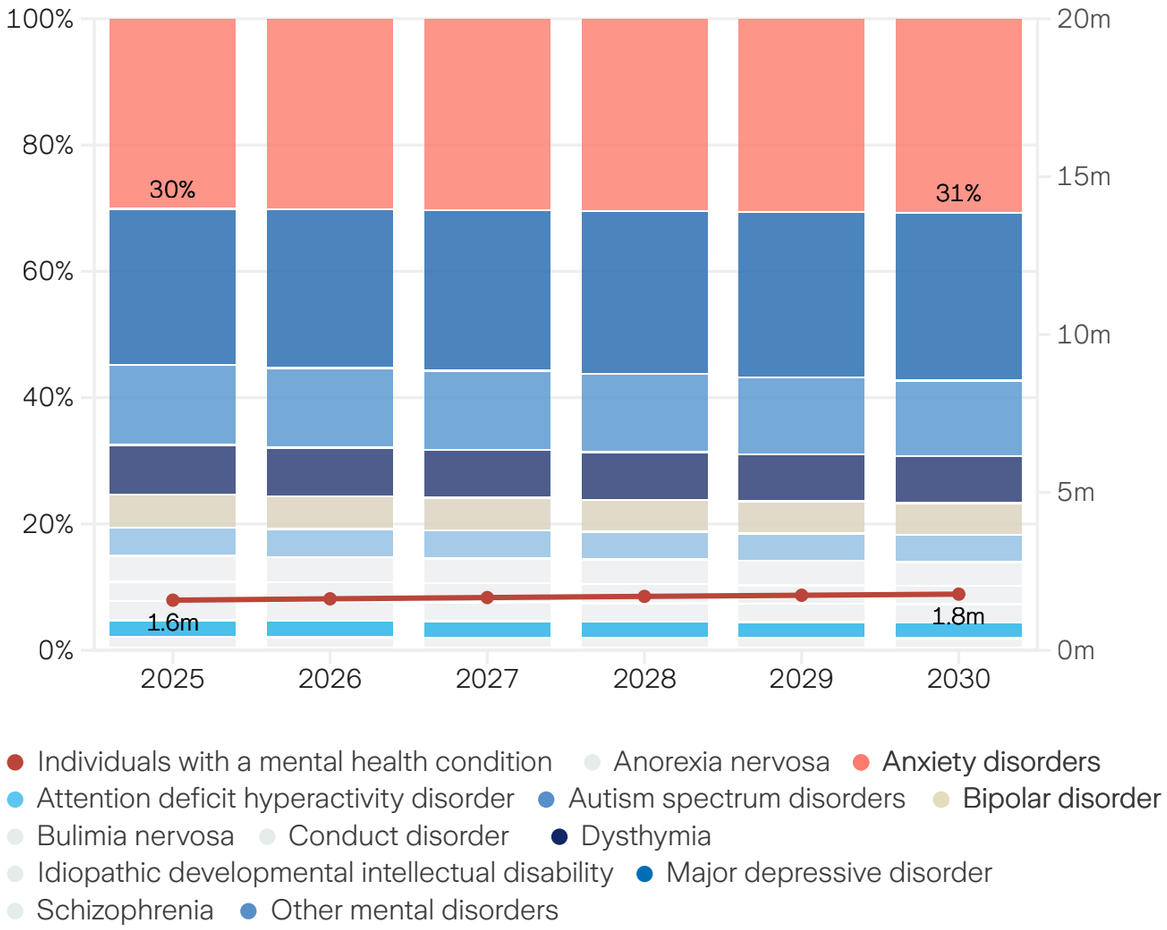
The government has expanded free mental health support, including 24/7 hotlines like HOPE, and specialist clinics such as Aspris and The Lighthouse Arabia, offering care for anxiety, depression, and trauma. New apps and digital tools also make mental health resources more accessible.

To protect mental and financial wellbeing, authorities have regulated airlines and hospitality sectors, ensuring visitors are cared for with free accommodation, rescheduling, and dedicated support. Essential food prices have been stabilized and measures taken to prevent panic buying, further reducing stress and uncertainty.

By combining visible leadership, timely communication, and practical support, the UAE has demonstrated a holistic response to mental health needs, reinforcing resilience and safeguarding wellbeing during times of crisis.

UAE: Projected prevalence of mental health conditions (2025-2030)

Projected share of cases by condition (%) and total number of individuals with a mental health condition (million)



Primary sources: IHME (2025), World Bank (2025).

Total number of individuals with a mental health condition accounts for co-morbidities.

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Cases are growing following global trends, but remain comparatively contained

Nearly two million people in the UAE – about 15 percent of the population – are projected to be living with a mental health condition by 2030 (a 2.2% annual growth rate), driven predominantly by population growth and increases in the two most prevalent conditions.

Anxiety disorders (30%) and major depressive disorder (25%) are the most common conditions, accounting for over half (55%) of recorded cases in 2026, with above-average growth rates projected to 2030 (2.8% and 3.9%).

Generational gaps

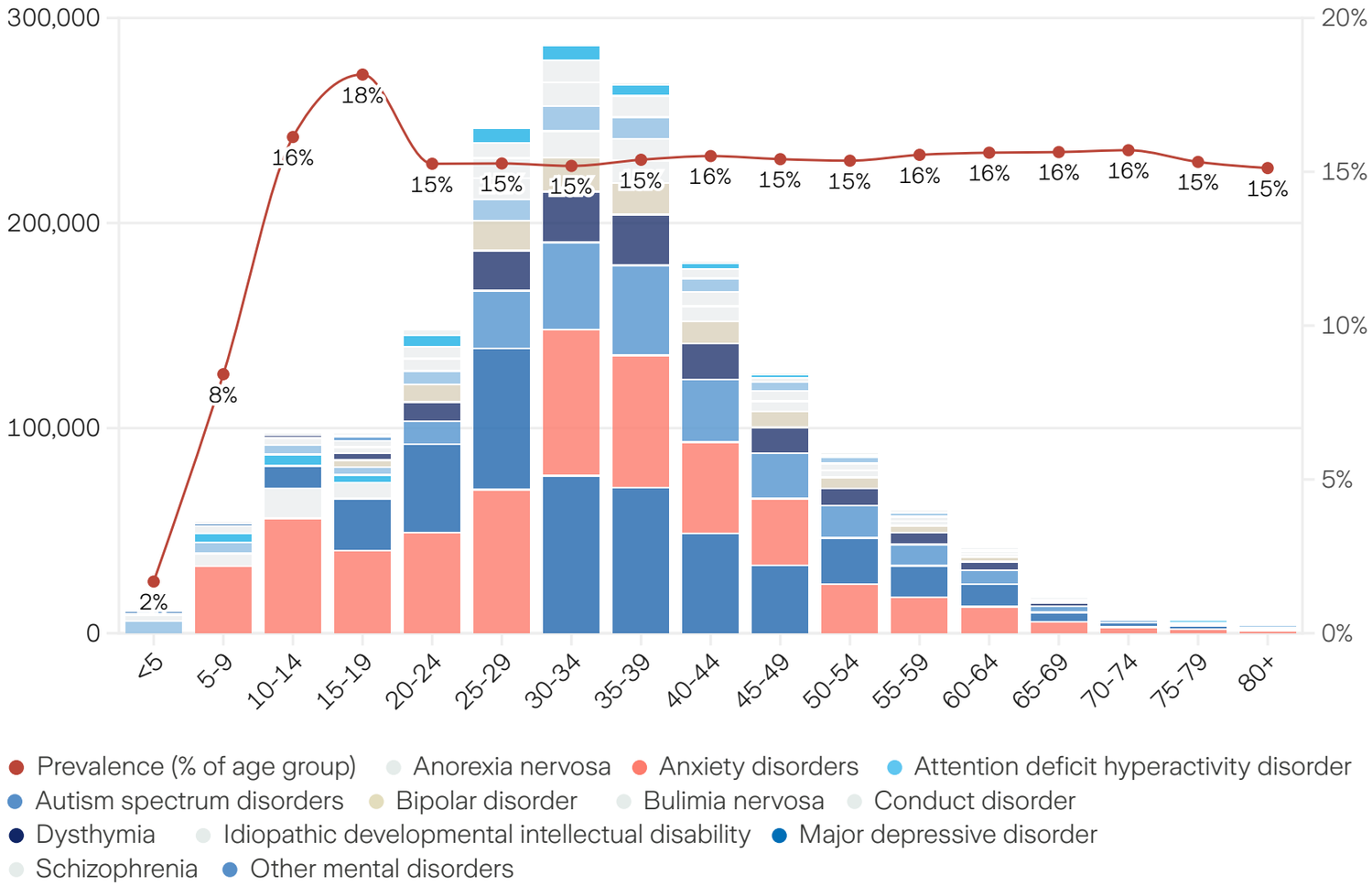
Prevalence is highest among teenagers, at 16% and 18% among 10- to 14-year-olds and 15- to 19-year-olds, respectively.

However, major depressive disorder accounts for a larger share of recorded cases than anxiety among 30- to 49-year-olds, reversing the pattern seen in most other markets examined.

This suggests that, like Malaysia and Chile, younger cohorts are driving rising visibility, but the legacy of later recognition and a higher threshold of impairment for formal diagnosis persists for much of the older workforce.

UAE: Projected prevalence of mental health conditions by age (2026)

Number of mental health conditions (million) and prevalence rate (%), by age group



Primary sources: IHME (2025), World Bank (2025).

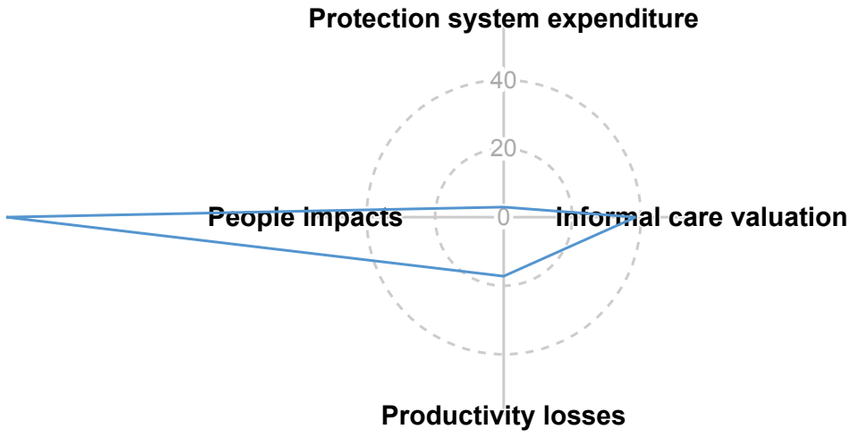
Projected prevalence by age group (%) includes comorbidities.

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

But prevalence provides only a partial view of the national picture

The duration and daily impact of mental health conditions shape quality of life and the ability to sustain employment, creating productivity losses and cost pressures that extend well beyond the health system.

UAE: Estimated impacts on people, productivity and protection systems (2030)
AED billion



Refer to ⇨ Data and methodology for a full set of data sources, assumptions and calculations.

By 2030, despite nearly AED 3 billion in estimated formal protection system expenditure (0.1% of GDP), mental health conditions are associated with around:

AED 145 billion
in wellbeing losses related to morbidity and mortality.

AED 17 billion
in reduced workforce participation and increased absenteeism.

AED 39 billion
in the value of informal care.

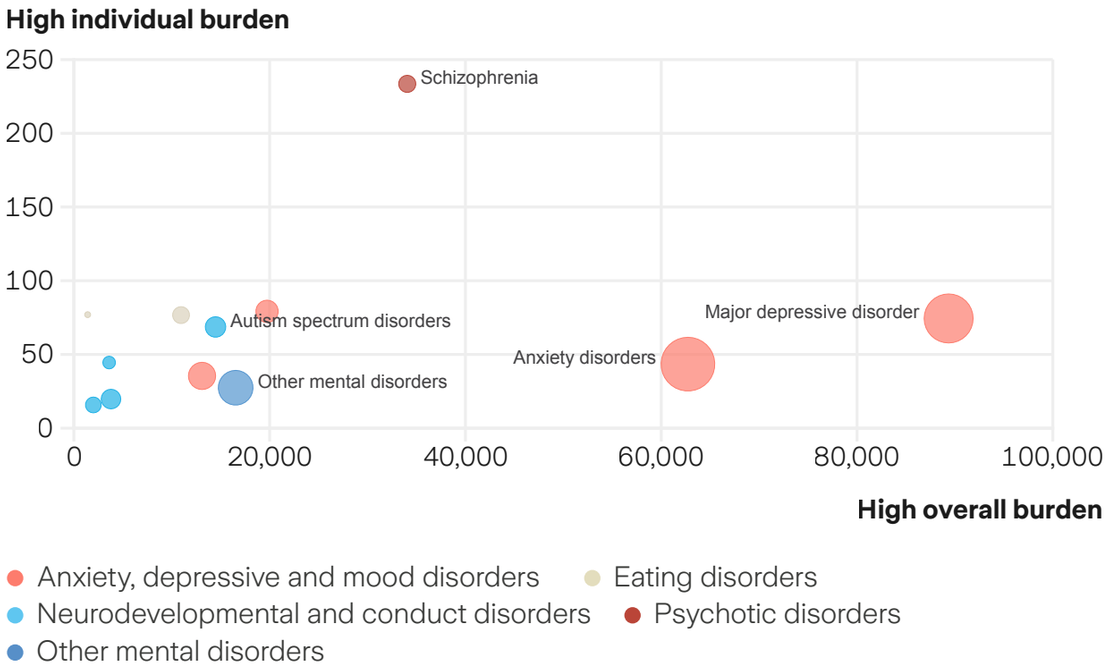
Taken together, these figures represent the annual opportunity cost of mental health conditions – or, put differently, the value that could be recaptured through more effective prevention, early intervention and sustained support.

People: A loss of nearly one-fifth of a year in healthy life

In 2026, the average person living with a mental health condition in the UAE is estimated to lose around two months (65 days) of healthy life per year. Nationally, this equates to over 292,000 years of healthy life lost, valued at AED 132 billion and rising to over AED 145 billion by 2030.[3]

UAE: Impact of mental health conditions on morbidity (2026)

Estimated individual impairment (days living with disability), morbidity impact (total YLDs) and share of cases (%), by condition



Primary sources: IHME (2025), World Bank (2025).

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Wellbeing impacts are driven by both scale and severity

Most wellbeing impact (93%) is driven by morbidity, reflecting the daily functioning challenges associated with mental health conditions. In the UAE, the burden is more evenly distributed across conditions, with outcomes shaped by both high-prevalence, moderate-severity conditions and lower-prevalence, high-severity disorders:

- **Higher prevalence conditions:** Anxiety and major depressive disorder together account for more than half of all years lived with disability (56%, or AED 71 billion). This is consistent with their prevalence, but the concentration is lower than in the UK or Australia. Major depressive disorder, however, is associated with more sustained impairment – 74 days per year, compared with 43 days for anxiety.

- **Higher severity conditions:** Among neurodevelopmental conditions, autism accounts for the largest share of impact (5% or nearly AED 7 billion), reflecting comparative impairment (69 days of healthy life lost per year per individual, compared to 16 days for ADHD).

The UAE's profile points to the need for complementary responses: scalable interventions that reduce the cumulative burden of common conditions, and specialist capacity to support those with severe or complex mental illness.

Reflecting its long-term prioritization on mental health, the UAE government has continued to invest in new facilities, tele-mental health care services, and public-private innovation. Recent examples include the Abu Dhabi Public Health Center's expansion of preventative screening to include mental health assessments and the Al Amal Hospital in Dubai – the first internationally accredited specialized mental health facility in the Middle East – which offers high-intensity, multidisciplinary care alongside expanding community-based support.[4]

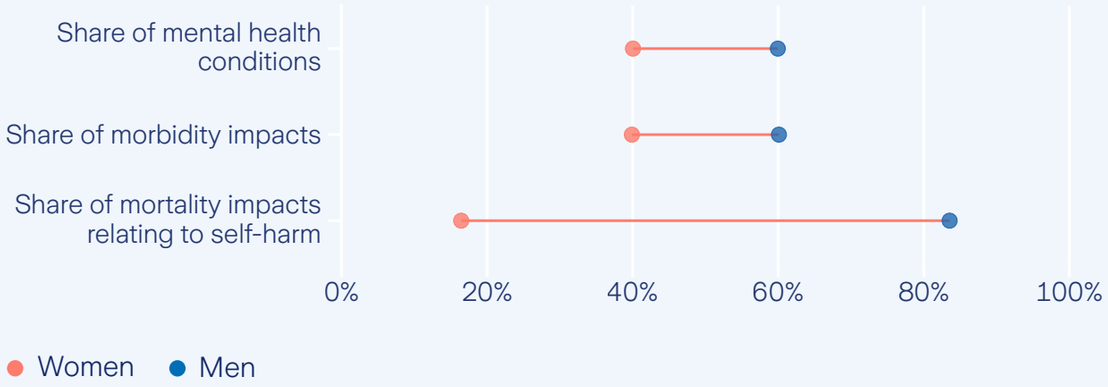
3. Includes self-harm. A value of a statistical life year of USD 127,000 has been applied.
4. UAE. Mental health (2026); ADPHC. Mental health (2023).

Gender divides in the UAE

Gender shapes how mental health conditions are experienced and managed across the UAE's population. Men account for a larger overall share of wellbeing loss – around 60% of total disease burden and related morbidity – a pattern driven mainly by the country's population mix.

At the same time, mental health conditions are more common and faster growing among women. In 2026, prevalence among women is estimated at 16% (2.8% average annual growth), compared with 14% prevalence and 1.8% annual growth among men.

UAE: Projected impacts of mental health conditions by gender (2026)
% of total cases, YLDs and YLLs, by gender



Primary sources: IHME (2025), World Bank (2025).

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

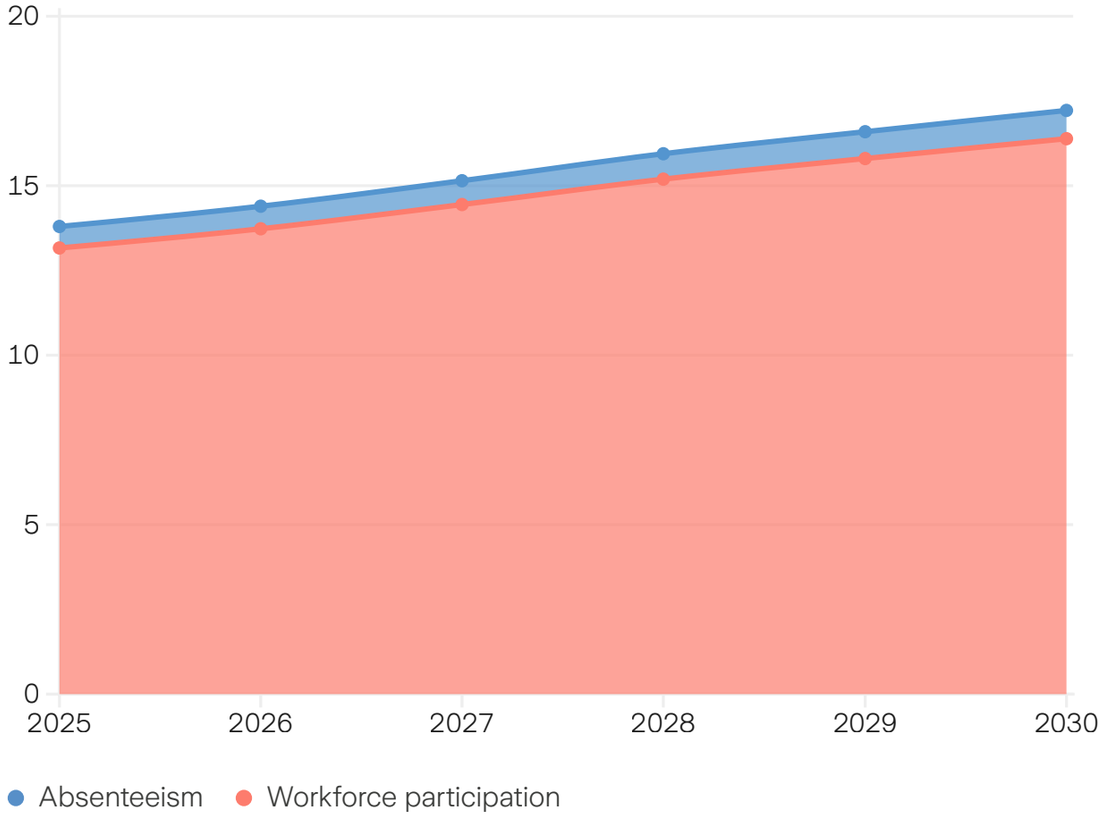
Productivity: Lost economic potential

The costs of mental health conditions for individuals do not stop with wellbeing. Mental health conditions affect the ability to enter the workforce, sustain full-time roles, perform consistently and remain employed. In the UAE's highly dynamic and internationally mobile labor market, these impacts carry meaningful consequences for employers, insurers, and the wider economy – but particularly for the large expatriate workforce, where visa and residency status are closely tied to employment.

In this context, investing in mental health could enhance overall economic potential. Using conservative estimates based on international proxies,[5] lost wages – combining reduced workforce participation and absenteeism – are estimated at over AED 14 billion in 2026, rising to AED 17 billion by 2030.[6]

At roughly 0.7% of GDP, these productivity-related losses highlight the significant opportunity for improvement. Increasing investment in mental health protection systems, which currently account for about 0.1% of GDP, could help reduce these losses and enhance overall productivity.

UAE: Projected economic impact of mental health conditions (2025-2030)
Absenteeism and workforce participation losses associated with mental health conditions, AED billion



Refer to Data and methodology for a full set of data sources, assumptions and calculations.

5. Refer to Data and methodology for a full set of data sources, assumptions and calculations.

6. Prevalence rates of mental health conditions within the working-age population mirror overall rates: 15.5% of the population in 2026.

Workforce participation is the larger – and less visible – challenge

Absenteeism accounts for 5% of productivity losses (AED 0.7 billion in 2026).[7] Employees in the UAE take, on average, only 0.2 days of mental health-related sick leave per year.[8] This could point to underreporting or informal accommodation outside formal leave channels, rather than an absence of need.

While absenteeism is visible to employers, it represents only a small fraction of the total productivity loss. The far greater impact comes from reduced workforce participation.

Barriers to entering or re-entering work mean that some individuals with mental health conditions are unable to participate fully in the labor market. The employment rate for individuals without a mental health condition is estimated at 86%, compared with 78% for those with one – an 8 percentage point gap that translates into nearly AED 14 billion in lost wages.

Although a smaller gap than other markets examined, the UAE's employment gap reflects a structurally distinct labor market. Several factors shape this profile:

- **Labor market dynamics:** Expatriate workers who cannot sustain employment due to illness may lose visa eligibility, limiting long-duration unemployment in-country.
- **Underdiagnosis:** Continued stigma and reliance on family-based support may mean some needs are managed informally within families and never enter clinical or HR systems, potentially understating employment impacts.
- **Emerging legal protections:** The Federal Mental Health Law, in force since 2024, restricts dismissal or disadvantage on mental health grounds. Effective implementation could support earlier interventions and reduce permanent exits from the workforce over time.

Containing productivity losses requires more than access to care. Diagnosis and treatment need to be paired with workplace practices that enable sustained participation, timely rehabilitation, and effective return-to-work pathways.

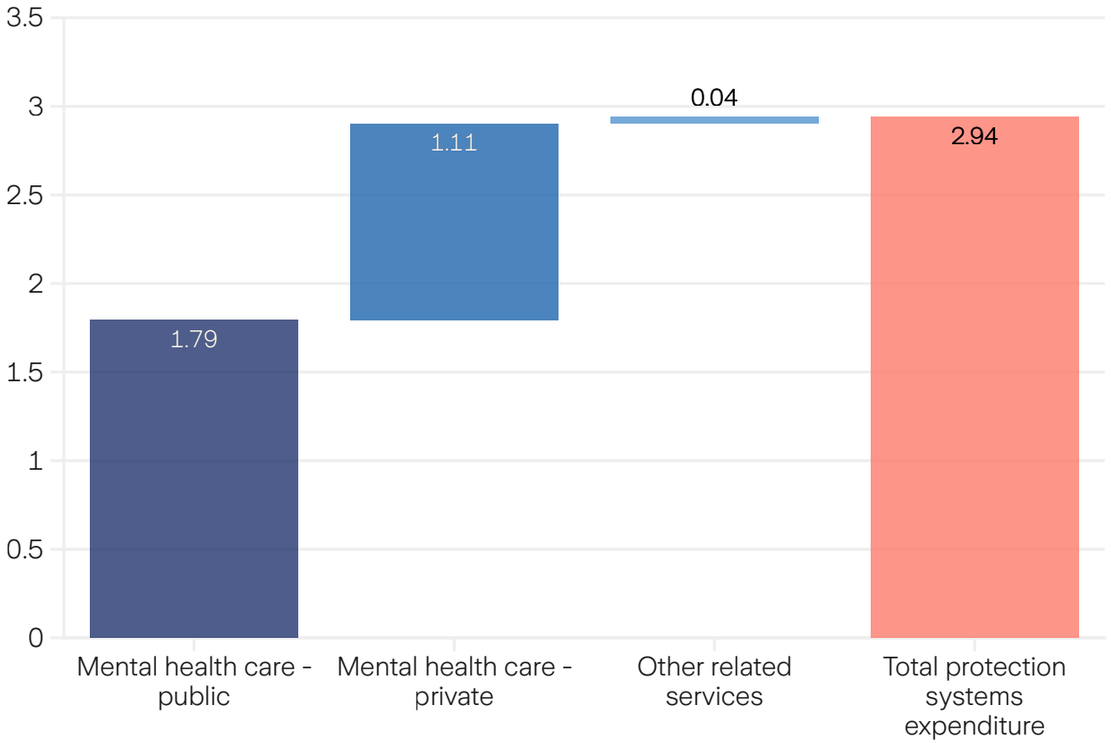
Counseling has become a cornerstone of mental health support in the UAE, with employers increasingly including it in health insurance plans. Post-COVID awareness and progressive legislation have spurred insurers to offer comprehensive coverage. This reflects a strong national commitment to holistic wellbeing.

In the UAE – where employers are the primary gateway to care for most residents – integrating early identification, case management, and return-to-work support into group health arrangements offers a practical way to reduce lost productivity while improving outcomes for individuals.

7. Phrased as lost wages for valuation purposes, however the individual still receive the wage if taken under paid sick leave entitlements.
8. Absenteeism is expressed as the average excess sick days per worker related to mental health. The figure includes both workers with and without a mental health condition.

Protection systems: Family as frontline support

UAE: Mental health care protection systems (2030)
Projected expenditure, AED billion



Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Mental health spending in the UAE remains modest relative to other high-income countries examined. Across government, private health care, and social welfare programs, formal mental health expenditure is projected to grow to AED 3 billion by 2030 (representing an average annual growth rate of 2.2%) – equivalent to about 0.1% of GDP.

This pattern aligns with the UAE's overall health spending profile: health expenditure represented 5% of GDP in 2023, lower than the 10% or more seen in Australia, the UK, and Germany.[9] Despite a long-standing policy commitment to mental health – and investment in digital access points and service infrastructure – specialist capacity also remains limited, with only 4.6 psychiatrists per 100,000 people in 2023.[10]

Expenditure levels, however, should not be interpreted in isolation as inherently positive or negative. They reflect broader system characteristics – including comparative prevalence, the balance between prevention and treatment, and the extent to which costs are shared between government, private providers, insurers, and individuals.

In the UAE, the government funds about two-thirds (62%) of formal mental health spending. But this only captures support delivered through clinics, hospitals and structured programs; it does not reflect the substantial support delivered within households – a core feature of the UAE's mental health landscape.

Informal care carries the load

In the UAE, the foundation of mental health support is rooted in the strength of families and communities. Cultural values that emphasize family cohesion, multigenerational households, and strong social networks create a supportive environment where individuals feel comfortable

9. OECD. Health at a Glance 2023 (2023).
10. WHO. Mental health atlas 2024 (2025).

turning to relatives and trusted connections for care and guidance. This pattern is visible across both Emirati and expatriate communities – including Indian, Arab, and many others – where close family ties often serve as the first line of support, offering understanding and resilience in times of need.

These close-knit relationships reflect the everyday reality of life in the UAE, where support begins at home and is shared collectively. Encouragingly, awareness and openness around mental health continues to grow, with more people seeking professional care when needed and often involving family members as part of their treatment journey. Culture and spiritual wellbeing also remain integral to the overall approach.

To a degree, these unique aspects of the UAE society foster holistic wellbeing – one where mental health is nurtured through strong connections, shared responsibility, and growing openness to mental health.

Informal mental health care is valued at nearly AED 34 billion in 2026, rising to close to AED 39 billion in 2030 – far exceeding formal system spending.

Reliance on informal networks carries several implications:

- **Timely, trusted support:** Families can provide early, flexible assistance, but heavy reliance on households may shift emotional and economic pressures away from formal services and insurers – often falling disproportionately on women in multigenerational homes.

- **Impact on caregivers:** Caregiving responsibilities can reduce the caregiver's own workforce participation, creating additional productivity losses beyond those already quantified.

As mental health care needs increase, demand on both formal and informal systems will grow. Recent investments signal efforts to strengthen early intervention and broaden access, and with 2026 declared the UAE's "Year of the Family," family cohesion and community wellbeing are at the forefront of national attention. Continuing to expand accessible outpatient care and early-support pathways will be essential to sustain families as a core pillar of the UAE's preventative wellbeing model, while avoiding over-reliance on unpaid support.

1.7 billion hours

of unpaid mental health care provided by families and informal networks in the UAE by 2030.

> In the UAE, your first support system isn't a clinic – it's the people who know you best. Signs of distress are often managed privately by families and close networks, which delays access to specialist care.

Dr Khatchik Kinoyan, Chief Underwriter, Zurich Middle East

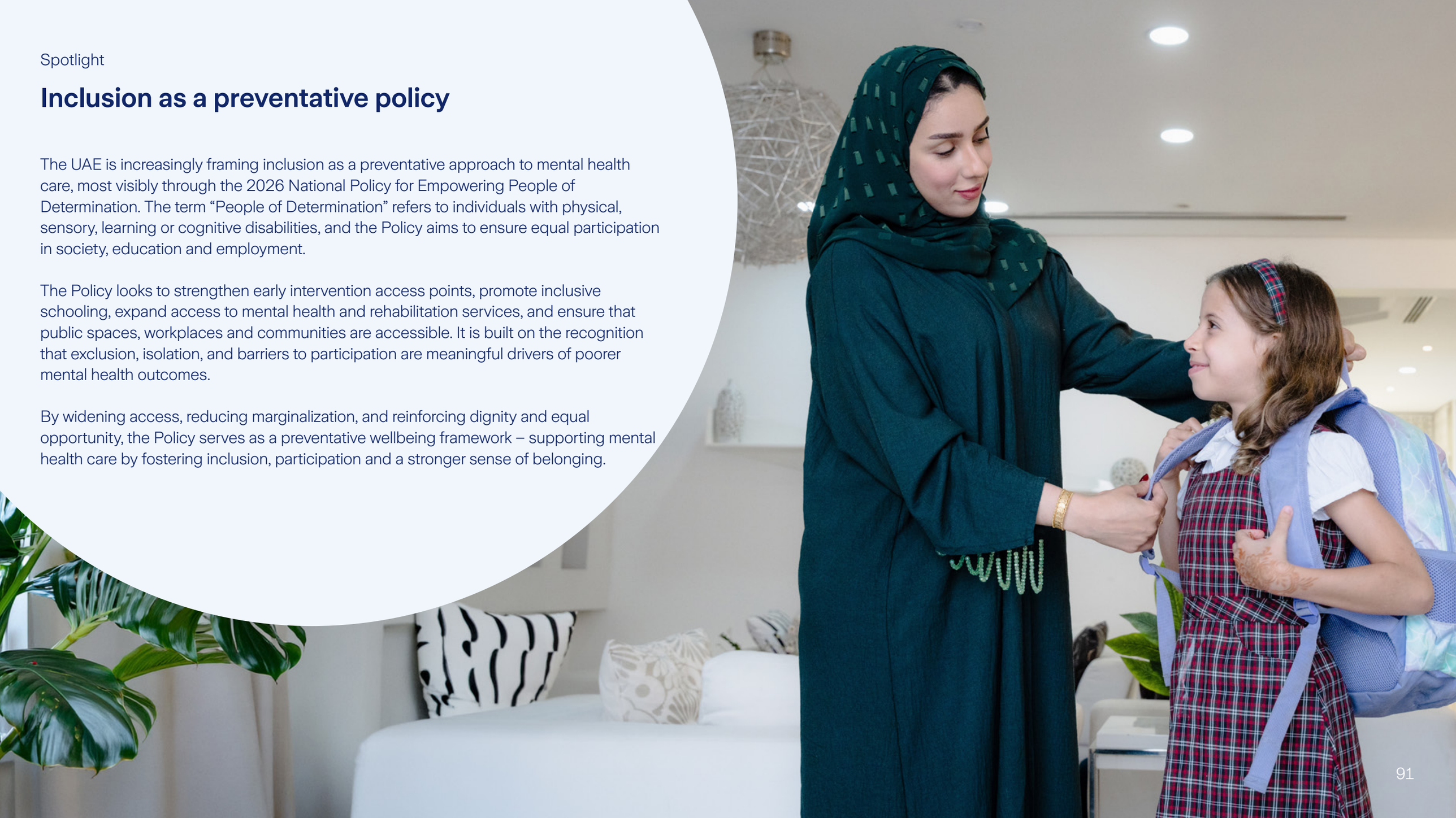
Spotlight

Inclusion as a preventative policy

The UAE is increasingly framing inclusion as a preventative approach to mental health care, most visibly through the 2026 National Policy for Empowering People of Determination. The term “People of Determination” refers to individuals with physical, sensory, learning or cognitive disabilities, and the Policy aims to ensure equal participation in society, education and employment.

The Policy looks to strengthen early intervention access points, promote inclusive schooling, expand access to mental health and rehabilitation services, and ensure that public spaces, workplaces and communities are accessible. It is built on the recognition that exclusion, isolation, and barriers to participation are meaningful drivers of poorer mental health outcomes.

By widening access, reducing marginalization, and reinforcing dignity and equal opportunity, the Policy serves as a preventative wellbeing framework – supporting mental health care by fostering inclusion, participation and a stronger sense of belonging.



From awareness to connection:
Where the UAE's next opportunity lies

The UAE has clear strengths in responding to growing mental health care needs: a rapidly evolving health care system, a strong wellbeing policy foundation, and the ability to act quickly when priorities are defined. Employer-funded insurance provides a broad platform for scaling access, while family and community networks strengthen social support.

The next step is translating this awareness into consistent, scalable capacity. In a system where employers and private insurers are primary access points for much of the population, the intersection between prevalence, workforce participation and protection systems is particularly important. In an expatriate-heavy labor market, prolonged absence can escalate into loss of employment and residency, underscoring the importance of early support. This means:

1. **Intervene early – ideally while the person is still working.** Support should begin before exit from employment, with primary care and workplace touchpoints able to screen, triage, and refer to covered outpatient mental health care services. Employer case-management can coordinate benefits, clinical care, and work adjustments.

2. **Normalize partial capacity and graded return-to-work.** Flexible duties, reduced hours, and time-limited accommodations help maintain attachment to the workforce and reduce the risk of visa-linked exit. Extending flexibility to caregivers where feasible can also reduce secondary productivity losses.

3. **Track the right outcomes.** In a high-mobility workforce, metrics such as time-to-first-support, time-to-return, sustained at-work rates and repeat episodes provide a more accurate picture than headline absence days. Low recorded absenteeism can mask underlying need; participation and retention are more meaningful indicators of success.

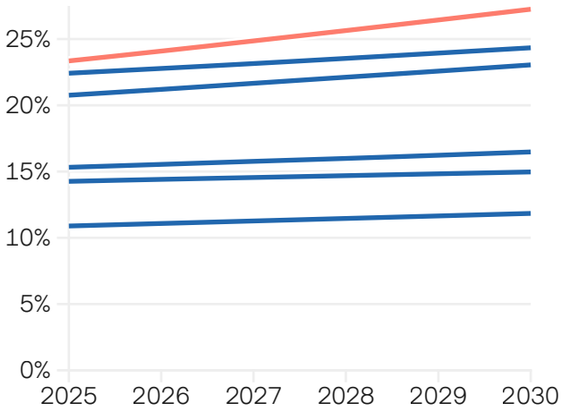
Aligning employer procedures, benefit pathways, and community-based clinical capacity around early support and graded return-to-work can ease pressures on households, reduce reliance on unpaid care and preserve workforce participation. In the UAE, where employers, providers and insurers already intersect at the point of work – the opportunity now is to make that intersection earlier, clearer and more predictable so that temporary mental health challenges do not become long-term disconnection from employment.

The UK

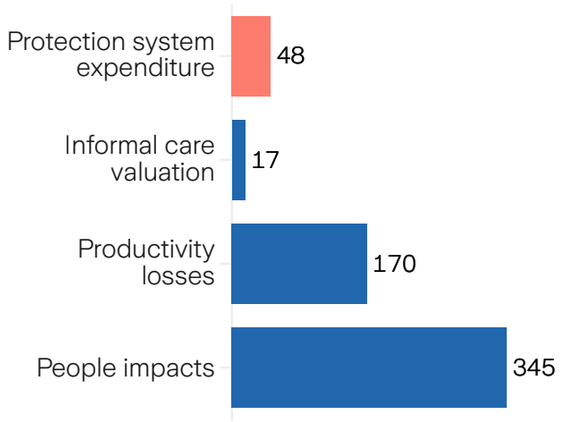
A disrupted transition from education to employment

This section brings together the latest data, modeling, and policy analysis to understand the scale, drivers, and implications of mental health conditions in the UK. We focus on three pillars: People (the human impact), productivity (economic consequences), and protection systems (system pressures, and policy landscape), that are shaping prevention, early intervention, access to support, and long-term recovery. The goal is to offer a clear, evidence-based view of the nation's mental health outlook and highlight select opportunities for strategic action to strengthen wellbeing, resilience, and inclusion in the years ahead.

By 2030, mental health conditions are projected to affect more than 1 in 4 people living in the UK (27%)



Estimated impacts on people, productivity and protection systems (2030)
GBP billion



By 2030, an average person living in the UK with a mental health condition is projected to face...

Lower days of healthy life lost

63 days
of healthy life lost

High average employment gap

29%
employment gap

Lower average sick days

0.6 days
of excess sick leave for mental health reasons per year

Lower out-of-pocket expenditure

18%
of treatment costs covered by out-of-pocket expenditure

Lower annual hours of informal care

51 hours
of informal care received per year

UK

Prevalence: Mental illness is emerging before work begins

Mental health conditions are among the UK's most significant public health and economic pressures. By 2030, an estimated 32% of working-age adults will be living with a mental health condition – the highest prevalence of any of the six markets analyzed.

In part, this reflects earlier recognition across a broader spectrum of severity, supported by long-established primary care pathways, widespread screening, strong cultural openness, and expanding routes into support through schools, workplaces, and digital platforms.

Earlier recognition brings clear benefits for treatment. But in the UK, mental health conditions are being detected at younger ages and growing faster among adolescents than any other group. If current trends continue, by 2030, nearly two in three (64%) of 15- to 19-year-olds are projected to be living with a mental health condition, alongside three in ten (30%) of 10- to 14-year-olds.

Conditions are increasingly diagnosed before individuals even enter the labor market, and the consequences are already visible. Nearly one million young people (13% of those aged 16 to 24) are currently not in education, employment, or training (or "NEETs")[1] – the highest level in five years. Many young people now experience mental health challenges that prevent labor market entry altogether, meaning they never build skills, confidence, and work experience that support long-term participation. This dynamic is reshaping the foundations of the future workforce and amplifying long-term productivity losses.

Policy attention has shifted accordingly. The *Keep Britain Working Review* has placed economic inactivity at the center of the mental health agenda, alongside expanded access to NHS Talking Therapies and early intervention programs.

The UK's main challenge is no longer about recognizing mental illness,[2] but ensuring that early identification does not become early exclusion, by linking recognition to pathways that preserve participation before disruption hardens into long-term inactivity.

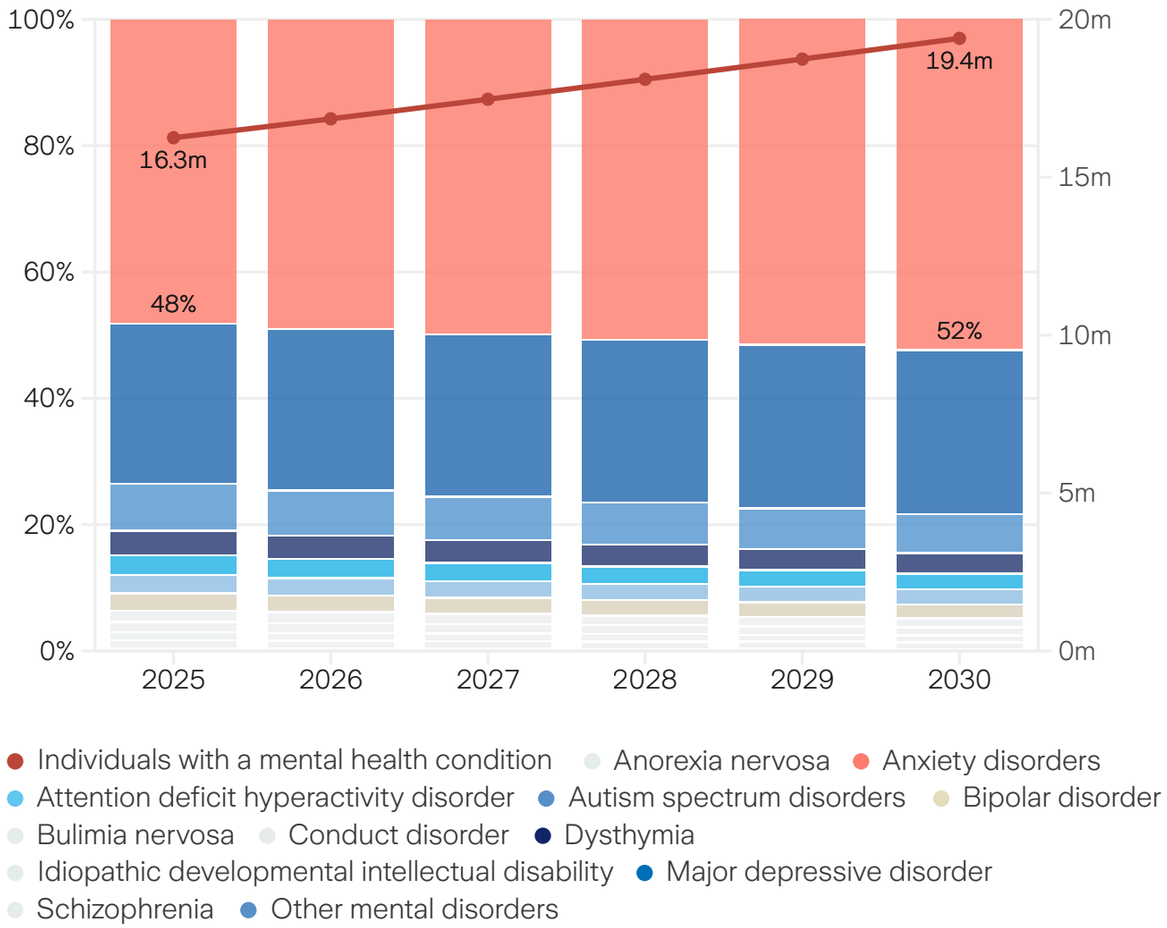
1 in 4

people in the UK (27%) are projected to be living with a mental health condition by 2030.

1. Office for National Statistics (ONS). Young people not in education, employment or training (NEET) (2026).
2. Recognizing that up to a third of adults in certain segments of the population, including men, minority ethnic groups, and low-income households, remain undiagnosed: Morris, S. et al. (2025) Adult Psychiatric Morbidity Survey – Survey of Mental Health and Wellbeing, England, 2023/4.

UK: Projected prevalence of mental health conditions (2025-2030)

Projected share of cases by condition (%) and total number of individuals with a mental health condition (million)



Primary sources: IHME (2025), World Bank (2025).

Total number of individuals with a mental health condition accounts for co-morbidities.

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Anxiety is driving functional disruption

Nearly 17 million people (24% of the total population) are estimated to currently live with a mental health condition, rising to over 19 million (27%) by 2030 – the fastest average annual growth rate among all markets analyzed at 3.6%.

This acceleration likely reflects both heightened risk drivers, such as sustained socioeconomic pressure, as well as improved detection of long-standing and neurodevelopmental conditions.

Anxiety disorders (49%) and major depressive disorder (26%) account for most recorded cases in 2026. This pattern is characteristic of high-visibility systems, where early help-seeking, a strong primary care role, and cultural openness draw mild, episodic, and situational distress into formal pathways alongside more persistent conditions.

As in Australia, anxiety therefore functions as a marker of how early and broadly the system identifies need. This broad visibility is a strength in principle, enabling stabilization before deterioration. But it also drives sharp increases in demand for psychological therapies, contributing to rising wait times and uneven access.

The UK's youth profile is the most pronounced of the countries examined

Prevalence is highest in late adolescence and early adulthood, driven by a combination of reduced stigma, social media exposure, academic pressure, economic uncertainty, and strong engagement through schools and universities. Young people are reaching services before or during key life-stage transitions: education to work, early employment, and first independent living.

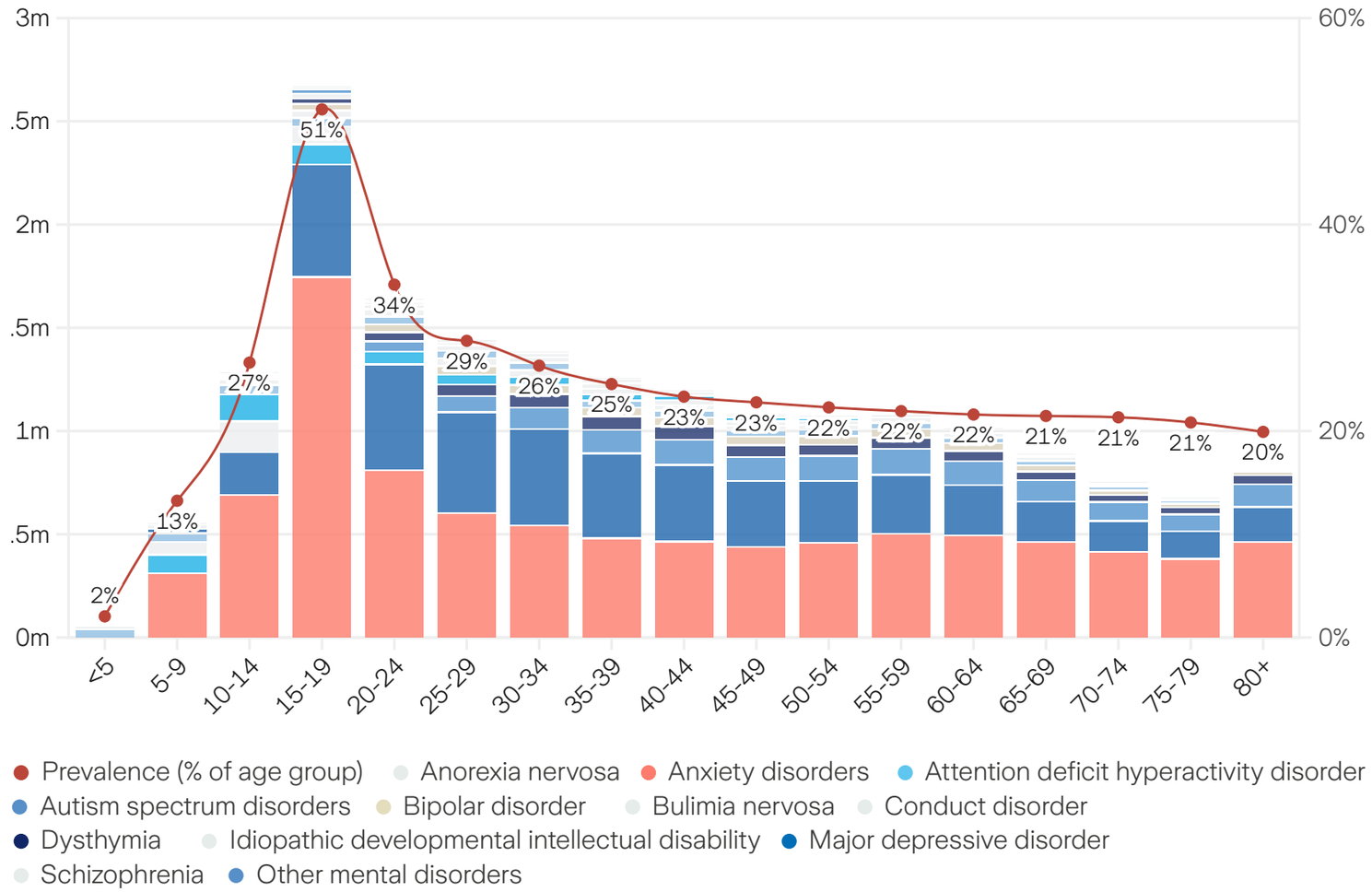
When support at these moments is delayed or fragmented, early symptoms can easily turn into disrupted participation, prolonged recovery, or repeated cycles of disengagement.

> The rise in youth mental health care needs is the start of a wave that will shape the UK's workforce for a generation. Acting early is the only way to stop today's challenges from becoming tomorrow's crisis.

Peter Hamilton, Head of Market Engagement, Zurich UK Life

UK: Projected prevalence of mental health conditions by age (2026)

Number of mental health conditions (million) and prevalence rate (%), by age group



Primary sources: IHME (2025), World Bank (2025).

Projected prevalence by age group (%) includes comorbidities.

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

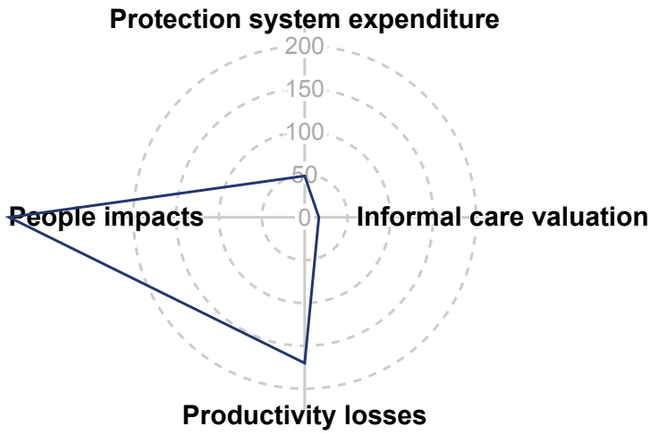
A high awareness, early identification market

These dynamics give the UK a distinct prevalence signature: high visibility, high anxiety burden, sharply rising youth demand, and clinical capacity that is struggling to expand at the same pace.

The challenge is not only recognizing need – which the UK does earlier and more comprehensively than most peers – but connecting recognition to timely, proportionate pathways that prevent early-stage distress from derailing participation.

Because prevalence alone does not capture how mental health conditions shape daily functioning and long-term system demand.

UK: Estimated impacts on people, productivity and protection systems (2030)
GBP billion



Refer to ⇨ Data and methodology for a full set of data sources, assumptions and calculations.

By 2030, despite an estimated GBP 48 billion (1.5% of GDP) in combined public and private expenditure on mental health support and protection, mental health conditions are projected to result in around:

GBP 345 billion
in wellbeing losses related to morbidity and mortality.

GBP 170 billion
in reduced workforce participation and increased absenteeism.

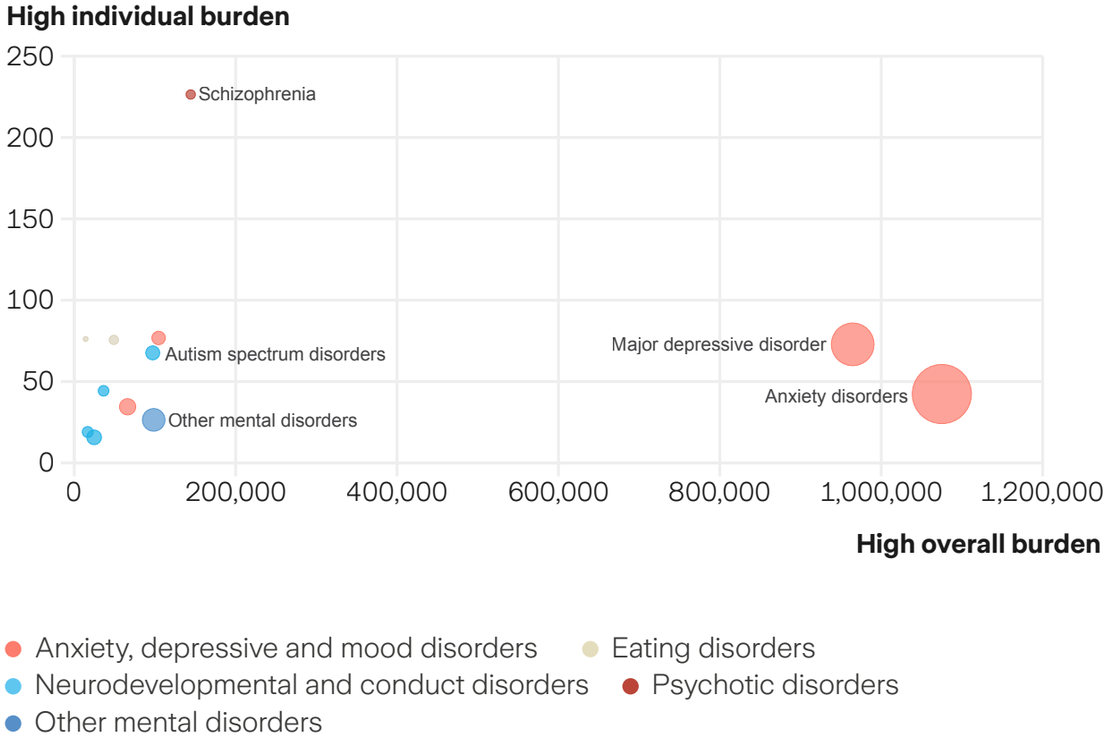
GBP 17 billion
in the value of informal care.

These projected losses illustrate the scale of value foregone each year as mental health conditions limit participation, productivity, and wellbeing – and underline the potential returns from early intervention, strong youth-focused support, and sustained return-to-work support.

People: Common conditions dominate cumulative loss

Wellbeing loss captures the personal impact of mental health: the days when a person cannot function at their usual capacity, the years spent managing persistent symptoms, and the moments when mental health challenges disrupt work, learning, relationships, and daily life.

UK: Impact of mental health conditions on morbidity (2026)
Estimated individual impairment (days living with disability), morbidity impact (total YLDs) and share of cases (%), by condition



Primary sources: IHME (2025), World Bank (2025).

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

In 2026, the average person living with a mental health condition or self-harm is estimated to lose 62 days of healthy life annually, contributing to nearly 3 million years of healthy life lost nationwide, valued at GBP 298 billion.[3] The vast majority of this is driven by morbidity (92% in 2026).

Two patterns shape the UK's profile:

- **Higher prevalence conditions:** Anxiety disorders are the single largest contributor, responsible for over 1 million years lived with disability in 2026. Alongside major depressive disorder – which affects fewer people but with a higher average daily impairment – these conditions account for three-quarters (76%) of total morbidity.

- **Higher severity conditions:** Autism, bipolar disorder, eating disorders, and schizophrenia make up around 8% of cases, but contribute 15% of total morbidity, reflecting their highly impairing nature.

Mirroring prevalence patterns, wellbeing loss is highest among younger working-age adults, peaking at around 64 days lived with disability per year for females aged 25 to 29 (62 days for men). This is when skills, confidence, and labor market attachment normally consolidates – meaning early impairment can have long-lasting effects on earnings, progression, and participation.

The consequences extend beyond health. People with a mental health condition are 9.3 times more likely to find life "difficult financially" and 3.6 times more likely to fall behind on bills.[4] For those already facing housing insecurity or fragmented employment, these pressures can compound.

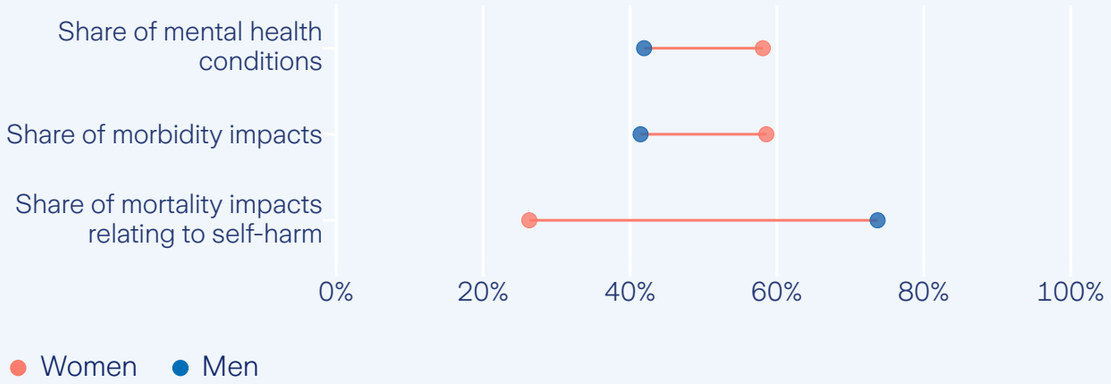
For the UK, managing scale without obscuring severity will be critical – reducing the cumulative impact of common conditions early, while ensuring specialist capacity for those with severe or complex conditions. Left unaddressed, these individual-level losses can harden into lasting disadvantage.

3. A value of a statistical life year of USD 144,000 has been applied and converted into GBP to reflect local conditions.
4. Money and Mental Health Policy Institute. Always on your mind (2024).

Gender divides in the UK

Women exhibit higher overall prevalence of mental health conditions (27% compared with 20% among men), faster average annual growth (4% versus 3%), and account for a larger share of the total disease burden and wellbeing impacts. Men, by contrast, experience more severe downstream consequences, bearing a disproportionate share of mortality impacts linked to suicide.

UK: Projected impacts of mental health conditions by gender (2026)
% of total cases, YLDs and YLLs, by gender



Primary sources: IHME (2025), World Bank (2025).

Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Productivity: Employment impacts set to exceed 5% of UK GDP by 2030

Mental health conditions represent one of the most serious and sustained threats to UK productivity. Combined lost wages from reduced participation and higher absenteeism are estimated at GBP 141 billion in 2026 (around 4.5% of GDP), rising to GBP 170 billion by 2030.

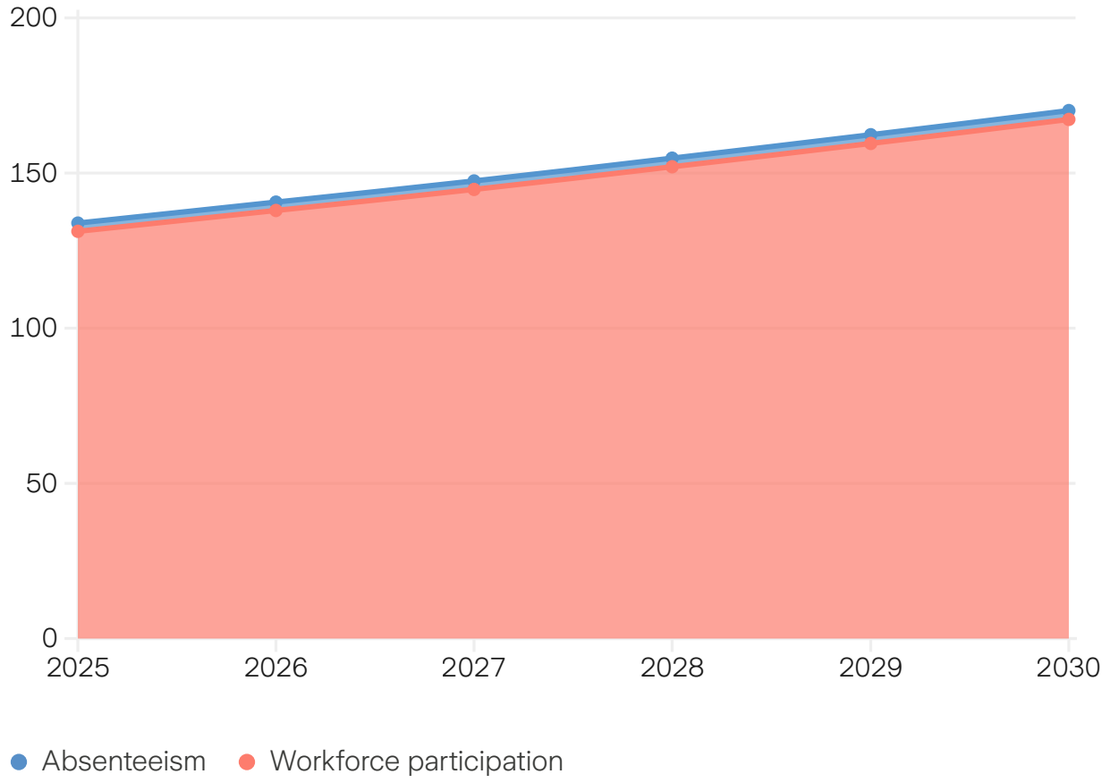
Individuals affected by mental health face a 29 percentage point employment gap

The dominant driver of these losses is long-term workforce absence, not short-term sick leave. In 2026, 98% of employment related losses (GBP 138 billion) stem from reduced workforce participation. This reflects a 29 percentage point employment gap between those with and without a mental health condition: 82% employment among those without mental health conditions, versus 53% employment for those with one.

This gap is one of the most consequential findings in the UK dataset, and materially larger than in comparator markets such as Germany and Australia, where employment gaps are closer to 17 or 18 percentage points.

The UK's gap may be driven by entry barriers, not just early exits. With mental health conditions disproportionately concentrated in younger age groups, and youth unemployment at its highest level in five years,[5] a growing share of young people are unable to secure their first foothold in work.

UK: Projected economic impact of mental health conditions (2025-2030)
Absenteeism and workforce participation losses associated with mental health conditions, GBP billion



Refer to Data and methodology for a full set of data sources, assumptions and calculations..

5. Office for National Statistics (ONS). Young people not in education, employment or training (NEET) (2026).

As entry routes become more limited – partly due to automation and AI-reducing routine roles and raising skill requirements – early distress can delay or disrupt these first steps. This makes it harder to build confidence and financial stability, which in turn can increase vulnerability. And when people never establish a stable connection to the labor market, the consequences compound across the life course.

Performance remains a secondary pressure

Absenteeism remains an operational challenge, particularly for smaller employers. In 2026, the average UK worker is estimated to take 0.6 days of mental health-related sick leave,[6] amounting to 18 million lost workdays, the equivalent of nearly GBP 3 billion in wages.

Hybrid and remote work can make early signs harder to spot, reducing day-to-day visibility and delaying intervention – increasing the risk that short-term distress becomes extended absence or exit.

Reducing absenteeism therefore matters not only for operational stability, but because time away from work quickly hardens into long-term inactivity. According to the *Keep Britain Working Review*, people who have been out of work for less than a year are nearly five times more likely to return than those absent longer.[7] This underscores the need for rapid employer-led intervention and structured return-to-work plans.

18 million days

of sick leave associated with mental health conditions are estimated to be taken by UK workers in 2026.

> Good return-to-work support restores more than income – it restores confidence, connection, and a sense of possibility. That's what early, coordinated intervention can deliver.

Nick Homer, Head of Market Management – Corporate Risk, Zurich UK

6. Absenteeism is expressed as the average excess sick days per worker related to mental health. The figure includes both workers with and without a mental health condition. Variances in recorded sick leave likely reflect both reporting regimes (for example, the seven day employee self-certification present in the UK), as well as labor-market incentives and constraints that shape whether distress appears as absence, long-term leave, or exit from work.
7. Department for Work and Pensions Keep Britain Working Review: Discovery (2025)

Spotlight

A New Role for UK Employers

Mental health has become a defining workforce challenge in the UK, and employers now sit at the front line of the national response. The *Keep Britain Working Review* signals a clear shift: when employers act earlier – and are supported to do so – more people stay healthy in work, recover faster and return sooner.

Employers see issues first, can adjust job design, and can integrate treatment with phased, supported returns. They are also closest to life stage events that often trigger mental health challenges – whether returning from maternity leave or coping with bereavement. This places employers at the earliest point of detection and in the strongest position to intervene before problems escalate.

A three-year "Vanguard" phase (2026–2029) brings over 150 employers together to create a workplace health standard focused on recruitment and onboarding, prevention, staying in work, return-to-work and redeployment. Zurich UK already applies a prevention-first approach with a network of 130 Mental Health First Aiders, regular "Time to Talk" sessions, workforce tools that track wellbeing, and expanded support for neurodiverse employees – including assessments, sensory-aware workplace design, flexible hiring practices, and reverse mentoring. Outside the workplace, Zurich UK and the Z Zurich Foundation work with the charity Ambitious About Autism on the *'Autistic and OK'* program – an initiative supporting autistic young people's mental health in high schools, including a downloadable toolkit for educators and students.

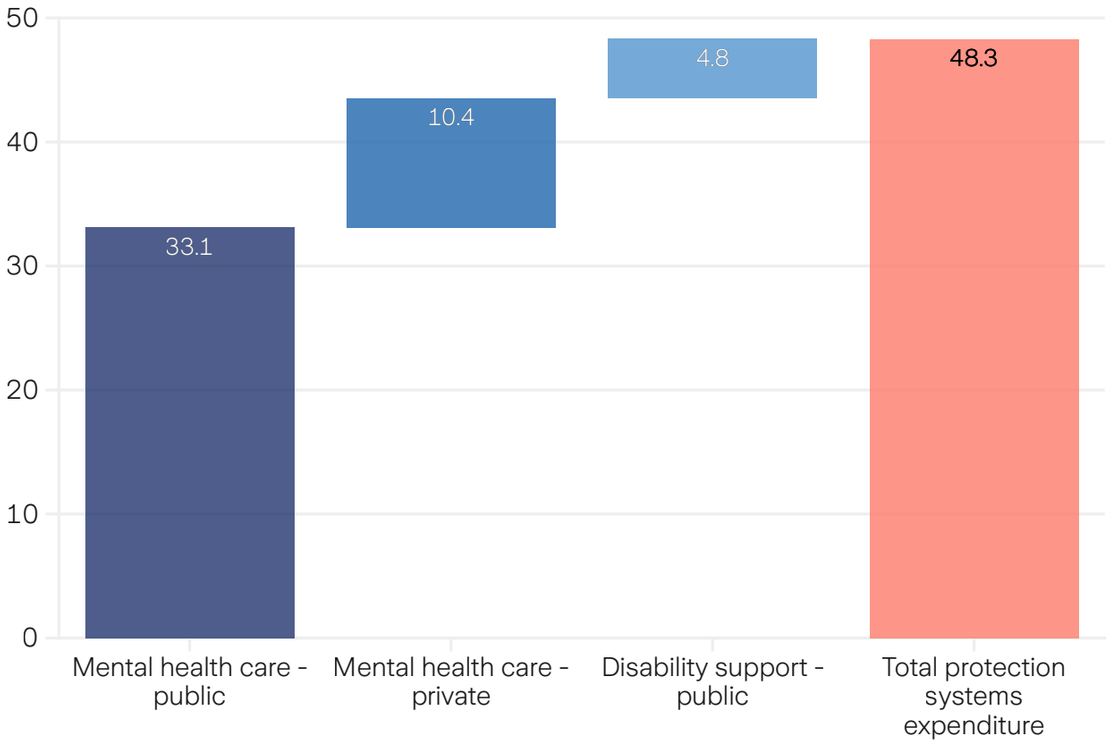
The Keep Britain Working Review is also considering what support could be provided to employers and employees. One element already making a difference is individual and group protection schemes, which can cover life insurance, critical illness, and income protection, and increasingly act as enablers of prevention and recovery, supporting:

- **Wellbeing and prevention:** such as mental health helplines, suicide prevention support, early psychological support, online wellbeing workshops, and Employee Assistance Programs (EAPs), providing confidential counselling and crisis support services.
- **Earlier identification and intervention:** Claims data and early notifications can reveal patterns before long-term absence develops, while fast-tracked assessments, virtual GP access, trauma, bereavement and crisis counselling, vocational rehabilitation support, and psychological therapy may be provided when symptoms first emerge.
- **Structured pathways back to work:** including case management, workplace adjustments, coaching, and phased returns.

These mechanisms help individuals to access support early, preventing short-term disruption from becoming long-term disengagement. Together, policy direction, employer practice and enabling structures can shift workplaces from "endpoints of sickness" to active sites of prevention and recovery – where return-to-work functions as a core tool for sustaining participation.

Protection systems:
Universal access under growing strain

UK: Mental health care protection systems (2030)
Projected expenditure, GBP billion



Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Mental health support in the UK is delivered through a mixed protection system, spanning publicly-funded health care, private health care expenditure, insurance-enabled provision and unpaid informal care. In 2026, total mental health spending is estimated at GBP 42 billion (around 1.4% of GDP), rising to GBP 48 billion by 2030. Most formal spend remains publicly-funded (78%).

Spending levels alone, however, are not a proxy for system effectiveness. How these components interact matters as much as how much is spent – particularly in a system where rising demand is placing growing pressure on primary care, specialist services, and families.

For most people, general practice is the main entry point into the mental health system. GPs assess symptoms, provide initial support, prescribe medication where appropriate, and refer patients to community or specialist services. They are also the clinicians who most frequently issue Statements of Fitness for Work for mental health-related sickness absence, placing them at the intersection of health and work. Whether they are best placed to perform this role is one of the questions considered by the *Keep Britain Working Review*.

While GPs can connect patients with non-clinical support – such as peer groups, financial wellbeing services, and community resources – rising demand, limited consultation time, and waiting lists for specialist treatment mean GPs often operate as the gatekeepers of a system under pressure. Specialist capacity constraints deepen these pressures. In 2023, the UK had 10.1 psychiatrists per 100,000 people, far below Australia (16) and Germany (28.9).[8] These gaps underscore the need for early support beyond primary care, including employer- and insurer-led pathways.

8. Royal College of Psychiatrists. Workforce figures (2023); AIHW. Mental health workforce (2023); Eurostat. Physicians by category (2025).

Private burden remains high

Despite the UK's universal health care model, nearly one-quarter (22%) of mental health care spending is private, with about 85% coming from out-of-pocket payments for counselling, therapy and other support accessed outside the NHS. Private insurance covers the remaining share and helps people access faster treatment, structured pathways, and work-focused rehabilitation. This split highlights an important tension within the system: private provision often improves speed and choice, but access remains uneven, reinforcing differences by income, employment status, and employer support.

A further layer of support sits largely outside formal markets altogether. In 2026, an estimated 470,500 informal mental health caregivers will provide over 13 million hours of unpaid care each week – equivalent to 683 million hours a year – valued at GBP 15 billion. This reflects the scale of support carried by families and communities even within a universal system, and while the proportionate share of informal care in the UK is lower than other in-scope markets, it remains a crucial, and often overlooked, component of the protection system.

Spotlight

Supporting caregivers

Caring for a child or relative with a mental health condition can be emotionally demanding, unpredictable, and difficult to balance alongside full-time work. Without flexibility, many mental health caregivers face rising stress, burnout, and, ultimately, the risk of leaving the workforce altogether. Employers can play a vital role by offering flexible, stigma-free working practices that allow caregivers to stay in work while managing complex and often fluctuating caregiving responsibilities.

For example, all new vacancies at Zurich UK have been advertised as open to part-time, job-share or full-time applicants since 2019. This gives mental health caregivers genuine choice in structuring work without penalty or the need for special exemptions. Zurich also embeds flexible working policies across all roles, enabling caregivers to accommodate crises, appointments, and unpredictable support needs while maintaining career progression. Caregivers are also offered the option of taking up to one week of unpaid leave in any 12-month period, structured in a way to meet their needs.

Managers are trained to hold early, supportive conversations, and teams plan workloads collaboratively so flexibility is shared fairly. These measures help protect caregivers' mental health, reduce stress, and prevent avoidable exits from work – strengthening participation while supporting those who shoulder some of the most demanding caring roles in society.

From early warning to early action:
Where the UK's next opportunity lies

The UK is confronting a landscape of mental health conditions that are defined by early-life disruption, widening gaps, and mounting pressure on primary care and workplaces. Rising prevalence – especially among young people – is reshaping transitions into training and employment and placing employers at the front line of detection and support.

The UK has clear strengths to build on: universal access to mental health care; expanding early intervention models; and sustained policy focus on prevention, workplace-based support, and better coordination across health, employment and rehabilitation systems.

It does not need to build a new system from scratch; it needs to connect what already exists – earlier, faster, and more consistently. This means:

1. **Strengthen early support in the transition from education to employment:** With mental illness emerging before work begins, rapid access support across schools, colleges, apprenticeships, and youth employment programs is essential. In practice, this can mean offering flexible or phased start arrangements for new hires, supported transitions from education or training into work, and early access to workplace adjustments, such as reduced initial hours, or additional supervision during periods of vulnerability. These measures help prevent early-life distress from becoming a barrier to labor market entry.

2. **Expand the availability and reach of effective psychological support:** A large share of the UK's wellbeing loss comes from anxiety and depressive disorders, which cause long-duration impairment when left untreated. Pressure on GPs requires alternative routes to help. Employer services, insurer-enabled rehabilitation, community mental health hubs, and digital triage pathways can shorten the time to first support and ease the load on primary care.

3. **Equip employers to act earlier and more effectively:** Employers are now the earliest and most reliable point of detection. Clear guidance, evidence-based early intervention models, and rapid access psychological support can prevent short-term challenges from escalating into long-term inactivity. Government can accelerate progress by aligning standards, incentives, and data.

The task now is to connect early identification, timely support, and inclusive work design so mental health challenges do not lead to permanent detachment from the labor market. In doing so, the UK can move from identification to integration and strengthen participation across the working-age population.

Data and methodology

Data analysis for this report was undertaken by Mandala Partners, a specialist econometrics firm, in consultation with Zurich experts. This section should be read in conjunction with How to read the report. The following sections outline the primary assumptions, calculations, and data sources for the key inputs and metrics outlined in the report.

General assumptions and limitations

- Projected calculations assume constant growth based on historical rates. Employment gaps and sick day estimates are held constant over the 2026-2030 projection period.
- Where forecasts are estimated by third parties (e.g., World Bank for population, IMF for GDP etc.), projections may rely on different assumptions for future years.
- Where impacts are converted between USD and local currencies, point estimates for exchange rates in January 2026 are assumed to represent exchange rates for the entire 2026 year.
- Where figures are expressed as a proportion of GDP, it is based on real GDP. Nominal GDP forecasts were converted into real GDP using IMF CPI projections.[1]

1. IMF. World Economic Outlook: Global Economy in Flux, Prospects Remain Dim (2025).

Prevalence

Projections of the total number of individuals with a mental health condition (MHC) are based on:

- Prevalence rate (%) of MHC by age and sex in 2023.
- Projected annual increase in prevalence rate of MHC by age and sex to 2030.
- Total population projections by age and sex to 2030.

Inputs	Definition	Methodology notes	Primary source(s)
Prevalence rate of MHC by age and sex (%) in 2023	The prevalence rate is the total number of cases of a given MHC as a proportion of a specified population at a designated time.	• Available by age, sex, and condition. • GBD disability weights (severity of MHC) are applied uniformly across countries. • Comorbidities between MHC are estimated in the Global Burden of Disease (GBD) study and subtracted from the overall total of 'mental health disorders.' The total is projected independently, rather than by summing individual categories.	Global Burden of Disease Collaborative Network, Institute for Health Metrics and Evaluation (IHME). Global Burden of Disease Study 2023 (GBD) (2025).
Projected annual increase in prevalence rate of MHC by age and sex (%) to 2030	Geometric annual growth rate (CAGR) of prevalence rate of MHC in 2012-2023.	• Growth rates are determined by condition, age, and sex, then applied individually to forecast values through 2030. • Our analysis uses data from a 10-year period (2012 to 2023). The growth rate is assumed to be constant in all future years.	IHME (2025).
Total population projections by age and sex to 2030	Total population is based on the de facto definition of population, which counts all residents regardless of legal status or citizenship.	• Forecasts undertaken by the World Bank.	World Bank. Population Estimates and Projections (2025).

Personal

Projections of total wellbeing impact are based on:

- Valued morbidity impact: calculated using years lived with disability (YLDs) and the value of a statistical life-year (VLY).
- Valued mortality impact: calculated using deaths and the value of a statistical life (VSL).

Inputs	Definition	Methodology notes	Primary source(s)
Years lived with disability (YLDs)	The annual total of healthy years lost as a result of living with a disability, calculated for all individuals affected during that year.	• Projected using prevalence rates (see Data and methodology: Prevalence). • YLDs include “Self-Harm”.	IHME (2025).
Value of a statistical life-year (VLY)	A monetized, statistical value of a year of healthy life. This is an estimate of the value society places on a year of healthy life. It measures the extent to which society is willing to pay to reduce the risk of death. It may not represent an individual’s willingness to pay, nor will it be representative of each person’s situation.	• Valuations are standardized using a single estimate to ensure comparability across markets, using Abelson (2007) as the reference for the value of a healthy year of life in Australia. • The Australian value of a life year (VLY) was adjusted using GDP per capita, following OECD (2025) guidance. GDP was calculated based on historical and projected data from the IMF, with population statistics from the World Bank. • VLYs for each country are forecast using relative Gross National Income (GNI) that are independently projected and interacted with income elasticities, which are stable. Estimates are based on OECD guidelines, with income elasticity relative to Australia set at 1. • Market exchange rates are then used to convert the value of life across countries.	Abelson, Establishing a monetary value for lives saved: Issues and controversies (2007). Australian Department of the Prime Minister and Cabinet. Value of a statistical life and value of a statistical life year (2024). OECD. Mortality Risk Valuation in Policy Assessment (2025). World Bank (2025). IMF (2025).

Deaths	Deaths attributed directly to a condition each year.	• Projected using prevalence rates (see Data and methodology: Prevalence). The only MHC to which the GBD attributes deaths is anorexia. • Mortality attributed to suicide is classified under “Self-Harm.” This category is included in the People metric but excluded from Prevalence, as the figures may capture individuals without a formal diagnosis.	IHME (2025). World Bank (2025).
Value of a statistical life (VSL)	A monetized, statistical value of the remaining years of healthy life for an individual.	• Net present value of VLY, based on remaining life expectancy taken directly from UN life tables. This net present value is derived using an intertemporal discount factor of 3%, as applied by Abelson (2007). • The intertemporal discount factor (or quantification of the degree to which individuals discount their future personal value of life) is assumed to be constant across all markets. • The Australian wage-price index (WPI), rebased to 100 for the year 2009 in alignment with Abelson (2007), was used to adjust VLY estimates. WPI projections follow a 10-year geometric mean approach, using the latest available value as the endpoint and the earliest available value within the past decade as the starting point. • VSL is converted to local currencies at market value using designated exchange rates.	United Nations. World population prospects 2024: Life expectancy at exact age (2024). Abelson (2007). Australian Bureau of Statistics. Wage Price Index, Table 2a: Total hourly rates of pay excluding bonuses, all sectors, all industries, Australia (2025).

Australia

Productivity

Projections of employment-related impacts are based on:

- Valued participation impact: calculated using projected prevalence, an estimated employment rate gap, and average wages per year;
- Valued absenteeism impact: calculated using an estimate of the employed population with a mental health condition (MHC), excess days of sick leave taken by those workers with a MHC, and average wages per day.

Inputs	Definition	Methodology notes	Primary source(s)
Employment rate gap	The gap between the employment rate of individuals with a MHC and the employment rate of individuals without a MHC.	• Relative employment gaps between people with and without MHC are assumed constant and applied via fixed wedges derived from historical (2017 + 2021) HILDA data. Aggregate employment rates are anchored to external ILO employment forecasts and distributed across sex and age groups using the 2023 HILDA structure. • Employment gaps reflect association rather than causation. Due to data limitations, we do not distinguish between MHC causing non-employment and non-employment itself exacerbating MHC. We also do not distinguish discrimination from health-related work capacity. • Those in employment are implicitly more likely to receive a mental health diagnosis due to healthcare access, which may understate the true employment gap. Furthermore, estimates exclude informal employment.	ILO. ILO Modelled Estimates and Projections Database (ILOEST) (2025). ILO. ILOSTAT Database: Labour Force Statistics (2024). Melbourne Institute of Applied Economic and Social Research. Household, Income and Labour Dynamics in Australia (HILDA) Survey (2025).

Average wages per annum / day		• HILDA data at a weekly level is collected for each respondent reporting employment. No distinction is made between part-time and full-time workers. • The data is not specific to MHC and is reported on a weekly basis. Calculations assume a standard of five working days per week and 52 weeks per year. • A proxy projection of real wage growth is generated using real GDP from the IMF World Economic Outlook and real employment growth for populations aged 15 and above from the ILO's ILOEST database. This approach is empirically supported by OECD analysis (OECD (2018). The methodology assumes that changes in hours worked or labor effort are minimal compared to employment and productivity shifts over the projection period. The resulting relationship serves as a baseline approximation for aggregate growth, rather than as a model for short-term or structural wage setting. • Wages are adjusted to 2026 values using the Australian Bureau of Statistics Wage Price Index (ABS WPI). Projected wage growth is applied to baseline HILDA wage levels, disaggregated by sex and age.	Melbourne Institute of Applied Economic and Social Research (2025). Solow, A Contribution to the Theory of Economic Growth (1956). Lucas, On the mechanics of economic development (1988). Romer, Endogenous Technological Change (1990). OECD. Decoupling Wages from Productivity (2018).
Employed population with a MHC		• Calculated based on the prevalence projections within the working-age population from IHME (2025), as well as the employment rate of individuals with a MHC from HILDA (2025).	IHME (2025). Melbourne Institute of Applied Economic and Social Research. (2025).

Excess days of sick leave taken by those with MHC	The difference in the proportion of sick leave days taken by workers with MHC compared to those without MHC.	• Total average days of sick leave are estimated for those with MHC using historical HILDA estimates by sex and age. This average is estimated from those respondents that self-report a mental health diagnosis. • We then apply proportions from Lalluka et al. (2021) to determine the number of mental-health-attributable sick days of those that have MHC. • The authors measure the number of days of sick leave attributable to mental health among those with mental health distress. Adopting this approach assumes that proportional rates are consistent between populations experiencing mental distress and those diagnosed with a MHC. We assume that self-reported psychological distress is a proxy for MHC. • Differences between people with and without MHC are assumed constant over the projection period.	Melbourne Institute of Applied Economic and Social Research (2025). Lallukka et al. Recurring pain, mental health problems and sick leave in Australia (2021).

Protection systems

Projections of expenditure on mental health care protection systems are based on:

- Mental health care expenditure, with calculations including public health and pharmaceutical expenditure, individual out-of-pocket expenses, and private health and other insurer expenditure.

- Other social services expenditure, with calculations including total National Disability Insurance Scheme (NDIS) payments relating to MHC and disability support pension payments relating to MHC.

Period adjustments were applied for projections to 2030. In addition, the value of informal care was estimated based on the number of informal MHC caregivers, and the total cost per informal MHC caregiver.

Inputs	Definition	Methodology notes	Primary source(s)
Period adjustment (for projections to 2030)	Period adjustment (%) to extrapolate most recent data to 2030.	• Calculated based on projected prevalence and inflation. Inflation rate is calculated using historical CPI and inflation projections. • Expenditure projections assume a constant growth trajectory; estimates assume no change in the business cycle.	IHME (2025). World Bank (2025). IMF (2025).
Public health and pharmaceutical expenditure	Australian Government federal and state-level expenditure on Medical Benefits Schedule (MBS) claims, public hospital funding, community and residential care, Pharmaceutical Benefits Scheme (PBS) expenditure, grants to NGOs, and funding for programs related to MHC.	• We only include expenditure items related to mental health care or treatment.	Australian Institute of Health and Welfare. Expenditure on mental health-related services (2025).

Individual out-of-pocket expenses	Consumer out-of-pocket contributions for MBS and PBS items related to mental health treatment and medicines.		
Private health and other insurer expenditure	Private health and other third-party insurer expenditure on health derived by the Department of Health and Aged Care, using total revenue less Australian Government sources.		
Total NDIS payments relating to MHC	Australian Government National Disability Insurance Scheme (NDIS) payments and supports for psychosocial disability.		National Disability Insurance Agency. Psychosocial (2025)
Disability Support Pension (DSP) payments related to MHC	Australian Government Disability Support Pension (DSP) payments.	• Calculated based on the average DSP payment per person and the total number of people on DSP with a primary psychological or psychiatric condition. • Average DSP payment was estimated using the average of maximum fortnightly payment rates for single and coupled persons, weighted by number of single and coupled persons on DSP.	Services Australia. Payment rates (2025). Department of Social Services. DSS Payment Demographic Data (2025).
Number of informal mental health caregivers	Total number of primary and non-primary informal caregivers for people with MHC.	• Estimated using the total number of informal caregivers from the Australian Bureau of Statistics' Survey of Disability, Ageing and multiplied by the proportion of informal caregivers that care for a recipient with mental illness (8.6%).	Australian Bureau of Statistics. Disability, Ageing and Carers, Australia: Summary of Findings (2022). Diminic et al. The economic value of informal mental health caring in Australia: Technical report (2017).

Total cost per informal MH caregiver	The value of unpaid care using the replacement cost approach. Valued at the cost of employing a formal carer to replace an informal carer.	• Calculated using the rate of pay for social and community services employees. Estimated as the average of Social, Community, Health and Disability Services Industry Award (SCHAD) Level 1-4 hourly pay rate plus additional salary on-costs (23%) and organizational overheads (20%). SCHAD pay rates were forecasted using real wage growth, estimated by IMF WEO and ILO ILOEST. • The total hours per week of informal care delivered by an informal caregiver to a person with a MHC was estimated using the average hours worked per week for primary and non-primary carers, weighted by number of primary and non-primary carers for people with a MHC.	Diminic et al. (2017). Fair Work Ombudsman. Pay Guide – Social, Community, Home Care and Disability Services Industry Award (2025). IMF (2025). ILO (2025).

Additional assumptions and limitations

- An exchange rate of USD-AUD of 1.47 was applied (January 2-30 2026 period average).[1]
- A VLY of USD 176,000 was applied.
- In addition to the above, Australian calculations for Personal and Productivity impacts rely on the Household, Income and Labour Dynamics in Australia (HILDA) Survey.[2] The analysis estimates mental health impacts across three comparison groups ("Mental Health Condition," "No Mental Health Condition," and "Population"). MHC include diagnosed depression, anxiety, or other mental illnesses. Populations have been restricted to working-age individuals (15 to 64 years old). Results are stratified by five demographic dimensions (age, sex, occupation, industry, and remoteness). For remoteness, industry and occupation, we estimate impacts by applying the observed proportions from HILDA to our national-level forecasts. In certain demographic strata, there is substantial variation in results. This is driven by the small number of respondents. Results will, in part, be driven by COVID-19.

1. IMF. Representative Exchange Rates for Selected Currencies for January 2026 (2026).
2. Melbourne Institute of Applied Economic and Social Research. Household, Income and Labour Dynamics in Australia (HILDA) Survey (2025).

Chile

Productivity

Projections of employment-related impacts are based on:

- Valued participation impact: calculated using projected prevalence, an estimated employment rate gap, and average wages per year;
- Valued absenteeism impact: calculated using an estimate of the employed population with a mental health condition (MHC), excess days of sick leave taken by those workers with a MHC, and average wages per day.

Inputs	Definition	Methodology notes	Primary source(s)
Employment rate gap	The gap between the employment rate of individuals with a mental health condition (MHC) and the employment rate of individuals without a MHC.	• The employment rate across the working-age population was modeled as a weighted mean across mental health status, incorporating the employment rates of those with no mental distress, those with severe mental distress, and those with moderate mental distress. These identities allow employment rates for MHC and non-MHC populations to be inferred using observed aggregate employment, prevalence, and an externally estimated employment gap. • Diagnosed MHC were approximated using an equal (50:50) ratio of moderate to severe mental distress. The weighted employment gap, estimated from OECD-aggregated data for severe and moderate mental distress, is considered broadly representative of employment differences among individuals with diagnosed MHC. • Employment gaps are likely conservative in high stigma contexts.	OECD, Fitter minds, Fitter Jobs (2021). ILO. ILO Modelled Estimates and Projections Database (ILOEST) (2025). IMF (2025).

Average wages per annum / day	Average wages agnostic of MHC status.	• A proxy projection of real wage growth is generated using real GDP from the IMF World Economic Outlook and real employment growth for populations aged 15 and above from the ILO's ILOEST database. This approach is empirically supported by OECD analysis (OECD (2018). The methodology assumes that changes in hours worked or labor effort are minimal compared to employment and productivity shifts over the projection period. The resulting relationship serves as a baseline approximation for aggregate growth, rather than as a model for short-term or structural wage setting. • Wage growth rates are applied to historical data from the ILO and inflated. As there is no internationally harmonized wage-price index, CPI was instead used. CPI data is available to 2024, after which a 10-year geometric mean is used to project to 2030. • Wages are converted from international dollars to local currency units using market rate data.	ILO. ILOSTAT Database: Labour Force Statistics (2024). ILO (2025). IMF (2025). Solow, A Contribution to the Theory of Economic Growth (1956). Lucas, On the mechanics of economic development (1988). Romer, Endogenous Technological Change (1990). OECD. Decoupling Wages from Productivity (2018).
Employed working-age population	The employed population aged of 15 to 64.	• Historical employment data for individuals aged 15 to 64 is sourced from ILO labor force statistics and serves as the baseline for projections. ILO-modeled employment growth rates for ages 15 and above are applied through 2026. For the period 2027–2030, projections use the average growth rate observed from 2024 to 2026.	ILO. Labour Force Statistics: Employed 15-64 population (2024). ILO (2025).

Annual mental health sick days per worker	The difference in the proportion of sick leave days taken by workers with MHC compared to those without MHC.	• Calculated based on the total number of FONASA (public health insurer) and of ISAPRE (private health insurer) licenses issued for mental health absence, and the weighted number of calendar days of leave taken on FONASA/ISAPRE sick leave licenses. As estimates are based on medical certificates, a 5/7 calendar-to working-day conversion is assumed. • It is assumed that the number of days of leave per mental health license aligns with the sick leave license averages for FONASA and ISAPRE. This approach captures only medically certified, paid sick leave, excluding informal absences. • Total number of FONASA and ISAPRE mental health days per worker are assumed constant over the forecast period.	Superintendencia de Seguridad Social. Estadísticas de la Seguridad Social 2024 (2025).

Protection systems

Projections of expenditure on mental health care protection systems are based on:

- Mental health care expenditure, with calculations including health services expenditure apportioned to MHC, pharmaceutical services, individual out-of-pocket expenses, and private health and other insurer expenditure.

- Other social services expenditure, with calculations labor disability subsidies for MHC and unemployment support for MHC.

Period adjustments were applied for projections to 2030. In addition, the value of informal care was estimated based on the number of informal MHC caregivers, and the total cost per informal MHC caregiver.

Inputs	Definition	Methodology notes	Primary source(s)
Period adjustment (for projections to 2030)	Period adjustment (%) to extrapolate most recent data to 2030.	• Calculated based on projected prevalence and inflation. Inflation rate is calculated using historical CPI and inflation projections. • Expenditure projections assume a constant growth trajectory; estimates assume no change in the business cycle.	IHME (2025). World Bank (2025). IMF (2025).
Total health services expenditure apportioned to MHC	Total government budgeted expenditure on health services apportioned to MHC.	• Calculated based on the proportion of mental health cases as a share of all health cases in the FONASA / ISPRE systems. • Estimated using the total cases of schizophrenia (esquizofrenia), depression (depresión en personas de 15 años y más), alcohol dependence (consumo perjudicial y dependencia de alcohol y drogas en menores de 20 años), and bipolar disorder (trastorno bipolar en personas de 15 años y más), classified as mental health cases by Superintendencia de Salud.	Ministerio de Salud. Ley De Presupuestos Ano 2024 (2024). Superintendencia de Seguridad Social. Estadistica Trimetral De Casos Ges (Auge) De FONASA Y Sistema ISAPRE (2025).

Pharmaceutical services	Total pharmaceutical expenditure for mental health-related medications at ATC level 3 classification.	• Estimated using the total expenditure on the following items: Anxiolytics (N05B-Ansioliticos), Hypnotics and sedatives (N05C Hipnóticos y sedantes), and Antidepressants (N06A-Antidepresivos).	Universo de las estadísticas. Serie Histórica Gasto Constantes ATC (2025).
Individual out-of-pocket expenses	Total out-of-pocket health expenditure reported by IES Minsal, apportioned to MHC.	• The apportionment method used for health services expenditure was applied.	IES Minsal (accessed 2025).
Private health and other insurer expenditure	Average expenditure on private health insurance per person annually, apportioned to MHC and multiplied by the Total number of people in the private (ISAPRE) system.	• Average expenditure was calculated based on the average monthly spend per affiliate in the private (ISAPRE) system, assumed to remain constant at CLP94,000. The apportionment method used for health services expenditure was applied. • The total number of individuals in the system was estimated by multiplying the total population of Chile, as reported by the World Bank, by the proportion enrolled in the private (ISAPRE) system, estimated at 20% according to Isapres en Chile.	Isapres en Chile. Valores Isapres. (2025).
Labor disability subsidies for MHC	Total payments for worker disability subsidies for employees of private companies, public services, and independent workers, apportioned to MHC	• Calculated using the proportion of AFP (Administradoras de Fondos de Pensiones) and PBS (Pensión Básica Solidaria) pension approvals for psychiatric support as a share of total AFP and PBS pensions approvals.	Gobierno de Chile. Minesterio del Trabajo y Prevision Social (2025). Superintendencia de Pensiones. Solicitudes y dictámenes del proceso de invalidez (2025).
Unemployment support for MHC	Total unemployment benefit payments in the Unemployment Insurance Database, reported by Superintendencia de Pensiones, apportioned to MHC	• The apportionment method used for labor disability subsidies was applied.	Superintendencia de Pensiones (2025).

Number of informal mental health caregivers	Total number of primary and non-primary informal carers for people with MHC.	• Estimates are based on the total population in Chile aged 15 and above, using historical and forecast data from the World Bank, combined with the proportion of individuals providing informal mental health care as a share of the overall population. • The proportion of informal mental health caregivers was estimated by multiplying the percentage of individuals engaged in unpaid care work (38%) by the proportion of care recipients who receive informal care for a MHC (5.9%).	World Bank (2025). Agence Francaise de Development. Cuidadoras de personas mayores: sobrecargadas y mal pagadas: evidencia de una encuesta del Banco Interamericano de Desarrollo en América Latina y el Caribe (2024).
Total cost per informal MH caregiver	The value of unpaid care using the replacement cost approach. Valued at the cost of employing a formal carer to replace an informal carer.	• The cost of a replacement caregiver was calculated using the hourly value of unpaid care for individuals aged 15 and above, as well as those experiencing functional dependency. This value reflects the average pay rate, supplemented by additional salary on-costs (23%) and organizational overheads (20%). Pay rates were projected based on real wage growth estimates from the IMF World Economic Outlook (WEO) and the ILO's ILOEST database. • The total hours per week of informal care delivered by an informal caregiver to a person with a MHC was estimated using the average hours of unpaid care work reported by the Ministry of Finance.	Diminic et al. The economic value of informal mental health caring in Australia: Technical report (2017). IMF (2025). ILO (2025). Ministerio de Hacienda. Estimación del Valor Económico del Trabajo Doméstico y de Cuidados no Remunerados en Chile (2025).

Additional assumptions and limitations

- An exchange rate of USD-CLP of 883.81 was applied (January 2-30 2026 period average).[1]
- A VLY of USD 48,000 was applied.

1. IMF. Representative Exchange Rates for Selected Currencies for January 2026 (2026).

Germany

Productivity

Projections of employment-related impacts are based on:

- Valued participation impact: calculated using projected prevalence, an estimated employment rate gap, and average wages per year;
- Valued absenteeism impact: calculated using the employed working-age population, the annual mental health sick days per worker, and average wages per day.

Inputs	Definition	Methodology notes	Primary source(s)
Employment rate gap	The gap between the employment rate of individuals with a mental health condition (MHC) and the employment rate of individuals without a MHC.	• The employment rate across the working-age population was modeled as a weighted mean across mental health status, incorporating the employment rates of those with no mental distress, those with severe mental distress, and those with moderate mental distress. These identities allow employment rates for MHC and non-MHC populations to be inferred using observed aggregate employment, prevalence, and an externally estimated employment gap. • Diagnosed MHC were approximated using an equal (50:50) ratio of moderate to severe mental distress. The weighted employment gap, estimated from OECD-aggregated data for severe and moderate mental distress, is considered broadly representative of employment differences among individuals with diagnosed MHC. • Employment gaps are likely conservative in high stigma contexts.	OECD, Fitter minds, Fitter Jobs (2021). ILO. ILO Modelled Estimates and Projections Database (ILOEST) (2025). IMF (2025).

Average wages per annum / day	Average wages agnostic of MHC status.	• Proxy projections of real wage growth are developed using real GDP data from the IMF World Economic Outlook and real employment growth for populations aged 15 and above from the ILO's ILOEST database in target markets. This methodology is supported by OECD analysis (2018). The approach assumes that changes in hours worked or labor effort are minimal compared to employment and productivity shifts over the projection period. The resulting relationship provides a baseline approximation for aggregate growth, rather than a short-term or structural wage-setting model. • Wage growth rates are applied to historical data from the ILO and inflated. As there is no internationally harmonized wage-price index, CPI was used. CPI data is available to 2024, after which a 10-year geometric mean is used to project to 2030. • Wages are converted from international dollars to local currency units using market rate data.	ILO (2025). ILO. ILOSTAT Database: Labour Force Statistics (2024). IMF (2025). Solow, A Contribution to the Theory of Economic Growth (1956). Lucas, On the mechanics of economic development (1988). Romer, Endogenous Technological Change (1990). OECD. Decoupling Wages from Productivity (2018).
Employed working-age population	The employed population aged 15 to 64.	• Historical employment data for individuals aged 15 to 64 is sourced from ILO labor force statistics and serves as the baseline for projections. ILO-modeled employment growth rates for ages 15 and above are applied through 2026. For the period 2027–2030, projections use the average growth rate observed from 2024 to 2026.	ILO. Labour Force Statistics: Employed 15-64 population (2024). ILO (2025).

Average annual mental health sick days per worker	The difference in the proportion of sick leave days taken by workers with MHC compared to those without MHC.	• Calculated based on the recorded calendar days of sick leave granted per year for DAK members, apportioned to MHC. • We assume the recorded level of MHC for a DAK member matches the level of sick leave for employees at a national level in Germany. • Captures only medically certified, paid sick leave, and excludes informal absences. • As estimates are based on medical certificates, a 5/7 calendar-to working-day conversion is assumed.	DAK. Gesundheitsreport 2025 (2025).

Protection systems

Projections of expenditure on mental health care protection systems are based on:

- Mental health care expenditure, with calculations including government health expenditure apportioned to MHC, pharmaceutical services, individual out-of-pocket expenses, and other private spending relating to MHC.

- Other social services expenditure, with calculations including social care and services for MHC and unemployment support for MHC.

Period adjustments were applied for projections to 2030. In addition, the value of informal care was estimated based on the number of informal MHC caregivers, and the total cost per informal MHC caregiver.

Inputs	Definition	Methodology notes	Primary source(s)
Period adjustment (for projections to 2030)	Period adjustment (%) to extrapolate most recent data to 2030.	• Calculated based on projected prevalence and inflation. Inflation rate is calculated using historical CPI and inflation projections. • Expenditure projections assume a constant growth trajectory; estimates assume no change in the business cycle.	IHME (2025). World Bank (2025). IMF (2025).
Government health expenditure apportioned to MHC	Total general government expenditure on health excluding security funds, and statutory health insurance, apportioned to MHC.	• Estimated using the cost of illness proportion for 'Mental and behavioral disorders' as a share of total diagnoses.	DeStatis. Health expenditure by sources of funding (2024). DeStatis. Krankheitskosten: Deutschland, Jahre, Krankheitsdiagnosen (ICD-10 Kapitel), Geschlecht, Altersgruppen (2023).

Individual out-of-pocket expenses	Total expenditure on health by private households and private non-profit organizations, apportioned to MHC.	• The apportionment method used for health services expenditure was applied.	DeStatis (2024).
Other private spending related to MHC	Total expenditure by private health insurers on health and total expenditure by employers on health, apportioned to MHC.		
Social care and services for MHC	Australian Government National Disability Insurance Scheme (NDIS) payments and supports for psychosocial disability.		
Unemployment support for MHC	Total expenditure on social long-term insurance and statutory pension insurance related to health, apportioned to MHC.		
Number of informal caregivers	Total number of informal caregivers for people with MHC.	• Estimated using the total number of informal caregivers estimated by Fuchs et al., multiplied by the proportion of care recipients with a MHC as a reason for long-term care (14.77%) from Wetzel et al.	DeStatis (2024). World Bank (2025). Fuchs et. al. Informal caregivers in Germany – who are they and which risks and resources do they have? (2023). Wetzel et. al. Reasons for long-term care need: analyzing combinations of health limitations in Germany (2025).

Total cost per informal MHC carer	The value of unpaid care using the replacement cost approach. Valued at the cost of employing a formal carer to replace an informal carer.	• Replacement carer cost was estimated using the gross full-time wage for nursing and social care. • Replacement caregiver cost was estimated as the average pay rate plus additional salary on-costs (23%) and organizational overheads (20%). Pay rates were forecasted using real wage growth, estimated from IMF WEO and ILO ILOEST. • The total weekly hours of informal care provided to individuals with MHC were estimated using average hours reported by survey respondents. Categorical survey responses (e.g., "=10 hours") were interpreted using the midpoint of the range. For unbounded categories, the midpoint was assumed to be 50% higher than the lower bound.	Diminic et al. The economic value of informal mental health caring in Australia: Technical report (2017). IMF (2025). ILO (2025). DeStatis (2024). Schutz and Wetzel, Who has Informal Caregivers – And if so, how many?, (2024).

Additional assumptions and limitations

- An exchange rate of USD-EUR of 0.85 was applied (January 2-30 2026 period average).[1]
- A VLY of USD 156,000 was applied.

1. IMF. Representative Exchange Rates for Selected Currencies for January 2026 (2026).

Malaysia

Productivity

Projections of employment-related impacts are based on:

- Valued participation impact calculated using projected prevalence, an estimated employment rate gap, and average wages per year;
- Valued absenteeism impact: calculated using the employed working-age population, the annual mental health sick days per worker, and average wages per day.

Inputs	Definition	Methodology notes	Primary source(s)
Employment rate gap	The gap between the employment rate of individuals with a mental health condition (MHC) and the employment rate of individuals without a MHC.	• Limited data on employment rates by MHC is available in Malaysia. Gaps in Malaysia have been approximated using the OECD average. • The employment rate across the working-age population was modeled as a weighted mean across mental health status, incorporating the employment rates of those with no mental distress, those with severe mental distress, and those with moderate mental distress. These identities allow employment rates for MHC and non-MHC populations to be inferred using observed aggregate employment, prevalence, and an externally estimated employment gap. • Diagnosed MHC were approximated using an equal (50:50) ratio of moderate to severe mental distress. The weighted employment gap, estimated from OECD-aggregated data for severe and moderate mental distress, is considered broadly representative of employment differences among individuals with diagnosed MHC. • Employment gaps are likely conservative in high stigma contexts.	OECD, Fitter minds, Fitter Jobs (2021). ILO. ILO Modelled Estimates and Projections Database (ILOEST) (2025). IMF (2025).

Average wages per annum / day	Average wages agnostic of MHC status.	• Proxy projections of real wage growth are developed using real GDP data from the IMF World Economic Outlook and real employment growth for populations aged 15 and above from the ILO's ILOEST database in target markets. This methodology is supported by OECD analysis (2018). The approach assumes that changes in hours worked or labor effort are minimal compared to employment and productivity shifts over the projection period. The resulting relationship provides a baseline approximation for aggregate growth, rather than a short-term or structural wage-setting model. • Wage growth rates are applied to historical data from the ILO and inflated. As there is no internationally harmonized wage-price index, CPI was used. CPI data is available to 2024, after which a 10-year geometric mean is used to project to 2030. • Wages are converted from international dollars to local currency units using market rate data.	ILO (2025). ILO. ILOSTAT Database: Labour Force Statistics (2024). IMF (2025). Solow, A Contribution to the Theory of Economic Growth (1956). Lucas, On the mechanics of economic development (1988). Romer, Endogenous Technological Change (1990). OECD. Decoupling Wages from Productivity (2018).
Employed working-age population	The employed population aged 15 to 64.	• Historical employment data for individuals aged 15 to 64 is sourced from ILO labor force statistics and serves as the baseline for projections. ILO-modeled employment growth rates for ages 15 and above are applied through 2026. For the period 2027–2030, projections use the average growth rate observed from 2024 to 2026.	ILO. Labour Force Statistics: Employed 15-64 population (2024). ILO (2025).

Average annual mental health sick days per worker	The difference in the proportion of sick leave days taken by workers with MHC compared to those without MHC.	• The average annual sick days per worker (employed population) are modelled as a weighted average across mental health status and assumed constant across the forecast period. • The OECD reports average annual sick days among workers, by mental distress rate. Calculations assume the sick day gap estimated using data aggregated by the OECD for mental distress is representative of diagnosed mental illnesses. • The OECD sick-day data measures days absent conditional on taking any sick leave. This is calibrated to an unconditional per-worker measure (i.e. averaged across all employed workers, including those with zero sick days) and the calibration is assumed to be appropriate. • Proportional sick-leave differentials are based on OECD definitions of mental distress and may not reflect gaps for diagnosed disorders. • The estimated differences reflect excess absenteeism associated with mental health status rather than causal effects.	AIA Vitality. Malaysia's Healthiest Workplace (2017).

Protection systems

Projections of expenditure on mental health care protection systems are based on:

- Mental health care expenditure, with calculations including government health expenditure apportioned to MHC, pharmaceutical services, individual out-of-pocket expenses, and other private spending relating to MHC.

- Other social services expenditure, with calculations including disability payments for MHC and pension payments.

Period adjustments were applied for projections to 2030. In addition, the value of informal care was estimated based on the number of informal MHC caregivers, and the total cost per informal MHC caregiver.

Inputs	Definition	Methodology notes	Primary source(s)
Period adjustment (for projections to 2030)	Period adjustment (%) to extrapolate most recent data to 2030.	• Calculated based on projected prevalence and inflation. Inflation rate is calculated using historical CPI and inflation projections. • Expenditure projections assume a constant growth trajectory; estimates assume no change in the business cycle.	IHME (2025). World Bank (2025). IMF (2025).
Mental health care services	Total government budgeted expenditure on mental health services including psychiatry and mental health emoluments, services, and supplies.		Kementerian Kesihatan. Angarran Perbelanjaan Persekutuan (2025).

Pharmaceutical services related to MHC	Total pharmaceutical expenditure on MHC medicines and treatments.	• Calculated using the reported Total Pharmaceuticals Expenditures (TPE) estimation by the Ministry of Health. • The apportionment of spent to MHC is based on the proportion of psychiatry and mental health spending as a share of total budgeted health spending.	Kementerian Kesihatan. Estimation of Total Pharmaceutical Expenditure (TPE) Using National Health Accounts Framework Report 2018-2023 (2025).
Individual out-of-pocket expenses	Total out-of-pocket expenditure on general health, apportioned to MHC.	• The apportionment method used for pharmaceutical services was applied.	Kementerian Kesihatan. Malaysia National Helath Accounts, Health Expenditure Report 2011-2022 (2023).
Other private spending related to MHC	Total private spending by insurers, private entities and similar entities, corporations, and non-profit institutions serving households (NGOs) on general health, apportioned to MHC.		
Disability payments for MHC	Total disability payments apportioned to MHC.	• Total disability payments toward “disabled worker allowance,” “assistance for person with disability (PWD’s) incapable of work,” and “assistance for the carer of the bedridden PWD/chronically ill patients” (including non-MHC). • The proportion of mental health-related JKM OKU registrations as a share of total JKM OKU registrations was estimated using the cumulative number of registered persons with “Mental” disabilities in each state.	Kementerian Ekonomi. Person with disability statistics (2022).
Pension payments for MHC	Total benefit payments for Invalidity pensions and survivor’s pensions for all reasons (including non-MHC), apportioned to MHC.	• Estimated using the total Invalidity and Survivor’s cases reported for Mental Disorders.	Perkeso. Annual Report 2023 (2023).

Number of informal mental health caregivers	Total number of informal caregivers in Malaysia caring for people with MHC.	• Estimated using the share of adult population providing informal care (5.10%), multiplied by the proportion of care recipients that receive informal care due to a MHC (8.65%)	World Bank (2025). Jawahir et al. The impacts of caregiving intensity on informal caregivers in Malaysia: findings from a national survey (2021).
Total cost per informal MH caregiver	Replacement caregiver cost was estimated using the hourly value of unpaid care for people aged 15+ and people in situations of functional dependency.	• Estimated as the average pay rate plus additional salary on-costs (23%) and organizational overheads (20%). Pay rates were forecasted using real wage growth, estimated from IMF WEO and ILO ILOEST. • The total hours per week of informal care delivered by an informal caregiver to a person with a MHC was estimated using the average hours of informal care provided reported by survey respondents. • Categorical survey responses, such as "1–19 hours" or "20+ hours," were interpreted using the midpoint of each range. For unbounded categories, the midpoint was assumed to be 50% higher than the lower bound.	Kementerian Ekonomi. Banci Ekonomi 2023 – Statistik Pekerja Dan Gaji & Upah (2025). IMF (2025). ILO 2025). Jawahir et al. (2021).

Additional assumptions and limitations

- An exchange rate of USD-MYR of 4.03 was applied (January 2-30 2026 period average).[1]
- A VLY of USD 35,000 was applied.

1. IMF. Representative Exchange Rates for Selected Currencies for January 2026 (2026).

Productivity

Projections of employment-related impacts are based on:

- Valued participation impact, calculated using projected prevalence, an estimated employment rate gap, and average wages per annum;
- Valued absenteeism impact, calculated using the employed working-age population, the annual mental health sick days per worker, and average wages per day.

Inputs	Definition	Methodology notes	Primary source(s)
Employment rate gap	The gap between the employment rate of individuals with a mental health condition (MHC) and the employment rate of individuals without a MHC.	• Limited data on employment rates with mental distress is available in the UAE. Gaps in the UAE have been approximated from a simple arithmetic average in Switzerland and Japan. • Employment rates for the working-age population were modeled as a weighted mean by mental health status, incorporating rates for individuals with no mental distress, severe mental distress, and moderate mental distress. This approach enables the inference of employment rates for populations with and without MHC using observed aggregate employment, prevalence data, and externally estimated employment gaps. • Diagnosed MHC were approximated using an equal (50:50) ratio of moderate and severe mental distress. The weighted employment gap, estimated from OECD-aggregated data for severe and moderate mental distress, is considered broadly representative of employment differences among individuals with diagnosed MHC. • Employment gaps are likely conservative in high stigma contexts.	OECD, Fitter minds, Fitter Jobs (2021). ILO. ILO Modelled Estimates and Projections Database (ILOEST) (2025). IMF (2025).

Average wages per annum / day	Average wages agnostic of MHC status.	• Proxy projections of real wage growth are developed using real GDP data from the IMF World Economic Outlook and real employment growth for populations aged 15 and above from the ILO's ILOEST database in target markets. This methodology is supported by OECD analysis (2018). The approach assumes that changes in hours worked or labor effort are minimal compared to employment and productivity shifts over the projection period. The resulting relationship provides a baseline approximation for aggregate growth, rather than a short-term or structural wage-setting model. • Wage growth rates are applied to historical data from the ILO and inflated. As there is no internationally harmonized wage-price index, CPI was used. CPI data is available to 2024, after which a 10-year geometric mean is used to project to 2030. • Wages are converted from international dollars to local currency units using market rate data.	ILO (2025). ILO. ILOSTAT Database: Labour Force Statistics (2024). IMF (2025). Solow, A Contribution to the Theory of Economic Growth (1956). Lucas, On the mechanics of economic development (1988). Romer, Endogenous Technological Change (1990). OECD. Decoupling Wages from Productivity (2018).
Employed working-age population	The employed population aged 15 to 64.	• Historical employment data for individuals aged 15 to 64 is sourced from ILO labor force statistics and serves as the baseline for projections. ILO-modeled employment growth rates for ages 15 and above are applied through 2026. For the period 2027–2030, projections use the average growth rate observed from 2024 to 2026.	ILO. Labour Force Statistics: Employed 15-64 population (2024). ILO (2025).

Average annual mental health sick days per worker	The difference in the proportion of sick leave days taken by workers with MHC compared to those without MHC.	• Baseline sick leave from proxy countries (Saudi Arabia / Qatar) focuses on limited professions and may not reflect the UAE's labor market. • The OECD reports average annual sick days among workers, by mental distress rate. Calculations assume the proportional sick day gap estimated using data aggregated by the OECD for mental distress is broadly representative of diagnosed mental illnesses. • The OECD sick-day data measures days absent conditional on taking any sick leave. This is calibrated to an unconditional per-worker measure (i.e. averaged across all employed workers, including those with zero sick days) and the calibration is assumed to be appropriate. • Proportional sick-leave differentials are based on OECD definitions of mental distress and may not reflect gaps for diagnosed disorders. • The estimated differences reflect excess absenteeism associated with mental health status rather than causal effects.	Elabd et al. Sick Leaves Pattern in a Tertiary Healthcare Facility in Saudi Arabia (2020). Nuaimi et al. Sickness absenteeism among primary health care workers in Qatar before and during the COVID-19 pandemic (2023).

Protection systems

Projections of expenditure on mental health care protection systems are based on:

- Mental health care expenditure, with calculations including general health expenditure apportioned to MHC, pharmaceutical services, individual out-of-pocket expenses, private health insurer spending, and other private spending relating to MHC.

- Other social services expenditure.

Period adjustments were applied for projections to 2030. In addition, the value of informal care was estimated based on the number of informal MHC caregivers, and the total cost per informal MHC caregiver.

Inputs	Definition	Methodology notes	Primary source(s)
Period adjustment (for projections to 2030)	Period adjustment (%) to extrapolate most recent data to 2030.	• Calculated based on projected prevalence and inflation. Inflation rate is calculated using historical CPI and inflation projections. • Expenditure projections assume a constant growth trajectory; estimates assume no change in the business cycle.	IHME (2025). World Bank (2025). IMF (2025).
General health expenditure	Total government expenditure and compulsory contributory health care financing expenditure, apportioned to MHC.	• Proportion of spending related to mental health care/treatment was estimated using the Dubai Health Authority's reported spending for Major Diagnostic Categories (MDCs).	Federal Competitiveness and Statistics Centre. Health Services 2023 (2023). Dubai Health Authority, Health accounts system of Dubai (2022).

Pharmaceutical services	Total drugs and supplies cost for MHC-related clinical services.	• Includes anxiety disorders, depression, psychosis and attention disorders reported by UNDP, but epilepsy, developmental disorders, conduct disorders, and alcohol use have a reported zero value.	World Health Organization. The cost of health services delivered at primary care facilities in the United Arab Emirates (2023).
Private health insurer spending	Total expenditure from voluntary health insurance and compulsory private insurance related to health, apportioned to MHC.	• The apportionment method used for health services expenditure was applied.	Federal Competitiveness and Statistics Centre (2023).
Out-of-pocket expenses	Total household out-of-pocket expenses for health services and domestic private health expenditure, apportioned to MHC.		
Other social services expenditure	Total budget allocation for social protection, apportioned to MHC.	• The apportionment method used for health services expenditure was applied.	UAE Government – Ministry of Community Empowerment, Social Protection Budget (2024).
Hours of informal care for MHC	Total hours of informal care provided to people with MHC	• Total hours of informal care is estimated using the total population aged 15 and above, multiplied by the average weekly caregiving hours per person estimated by ILO (2019). • Total hours per week of informal care delivered by the average person in the UAE was estimated using the average hours of informal care provided (including community, caregiving, and domestic services) multiplied by the proportion of informal care apportioned to caregiving services only. • Total population in UAE aged 15 and above is based on historical and forecasted values from World Bank. Total number of MH carers is not estimated as the ILO reports caregiving hours as an average across the entire population.	World Bank (2025). ILO. The Unpaid Care Work and the Labour Market. An analysis of time use data based on the latest World Compilation of Time-use Surveys (2019).

Replacement cost per hour	The value of unpaid care using the replacement cost approach. Valued at the cost of employing a formal carer to replace an informal carer.	• Replacement carer cost was estimated using the average salary for caregivers from Indeed (2026), and the Domestic Worker Wage Schedule from MoHRE Tadbeer (2025). • Estimated as the average of pay rates plus additional salary on-costs (23%) and organisational overheads (20%). Pay rates were forecasted using real wage growth, estimated from IMF WEO and ILO ILOEST.	Diminic et al. (2017). Indeed. Caregiver salary in UAE (2026). MoHRE Tadbeer (accessed 2025) IMF (2025). ILO (2025).

Additional assumptions and limitations

- An exchange rate of USD-AED of 3.67 was applied (January 2-30 2026 period average).[1]
- A VLY of USD 127,000 was applied.

1. IMF. Representative Exchange Rates for Selected Currencies for January 2026 (2026).

The UK

Productivity

Projections of employment-related impacts are based on:

- Valued participation impact: calculated using projected prevalence, an estimated employment rate gap, and average wages per year;
- Valued absenteeism impact: calculated using the employed working-age population, the annual mental health sick days per worker, and average wages per day.

Inputs	Definition	Methodology notes	Primary source(s)
Employment rate gap	The gap between the employment rate of individuals with a mental health condition (MHC) and the employment rate of individuals without a MHC.	• The employment rate across the working age population was modelled as a weighted mean across mental health status, incorporating the employment rates of those with no mental distress, those with severe mental distress, and those with moderate mental distress. These identities allow employment rates for MHC and non-MHC populations to be inferred using observed aggregate employment, prevalence, and an externally estimated employment gap. • A simple 50:50 ratio of moderate and severe mental distress was assumed to approximate diagnosed MHC. We assumed the weighted employment gap estimated using data aggregated by the OECD for severe / moderate mental distress is broadly representative of diagnosed MHC. • Employment gaps are likely conservative in high stigma contexts.	OECD, Fitter minds, Fitter Jobs (2021). ILO. ILO Modelled Estimates and Projections Database (ILOEST) (2025). IMF (2025).

Average wages per annum / day	Average wages agnostic of MHC status.	• Proxy projections of real wage growth are developed using real GDP data from the IMF World Economic Outlook and real employment growth for populations aged 15 and above from the ILO's ILOEST database in target markets. This methodology is supported by OECD analysis (2018). The approach assumes that changes in hours worked or labor effort are minimal compared to employment and productivity shifts over the projection period. The resulting relationship provides a baseline approximation for aggregate growth, rather than a short-term or structural wage-setting model. • Wage growth rates are applied to historical data from the ILO and inflated. As there is no internationally harmonized wage-price index, CPI was used. CPI data is available to 2024, after which a 10-year geometric mean is used to project to 2030. • Wages are converted from international dollars to local currency units using market rate data.	ILO (2025). ILO. ILOSTAT Database: Labour Force Statistics (2024). IMF (2025). Solow, A Contribution to the Theory of Economic Growth (1956). Lucas, On the mechanics of economic development (1988). Romer, Endogenous Technological Change (1990). OECD. Decoupling Wages from Productivity (2018).
Employed working-age population	The employed population aged 15 to 64.	• Historical employment data for individuals aged 15 to 64 is sourced from ILO labor force statistics and serves as the baseline for projections. ILO-modeled employment growth rates for ages 15 and above are applied through 2026. For the period 2027–2030, projections use the average growth rate observed from 2024 to 2026.	ILO. Labour Force Statistics: Employed 15-64 population (2024). ILO (2025).
Number of working days lost from sickness	Total number of working days lost from sickness in the UK labor market due to mental health.	• Forecasts are based on the estimated 10-year arithmetic mean of total sick leave days per worker.	Office for National Statistics. Labour force survey - Sickness absence in the UK labour market: 2023 and 2024 (2025).

Protection systems

Projections of expenditure on mental health care protection systems are based on:

- Mental health care expenditure, with calculations including mental health care services, primary care relating to MHC, pharmaceutical services, private health insurer spending, and individual out-of-pocket expenses.

- Other social services expenditure.

Period adjustments were applied for projections to 2030. In addition, the value of informal care was estimated based on the number of informal MHC caregivers, and the total cost per informal MHC caregiver.

Inputs	Definition	Methodology notes	Primary source(s)
Period adjustment (for projections to 2030)	Period adjustment (%) to extrapolate most recent data to 2030.	• Calculated based on projected prevalence and inflation. Inflation rate is calculated using historical CPI and inflation projections. • Expenditure projections assume a constant growth trajectory; estimates assume no change in the business cycle.	IHME (2025). World Bank (2025). IMF (2025).

Mental health care services	Total expenditure on mental health care services in NHS budgets from NHS England, Scotland, Wales and Northern Ireland public accounts	• Proportion of spending related to mental health care/treatment was estimated using the Dubai Health Authority's reported spending for Major Diagnostic Categories (MDCs).	NHS England, NHS mental health dashboard (accessed 2025). NHS Scotland. Mental Health expenditure - financial years 2012/13 to 2023/24 (2025). StatsWales. NHS expenditure by programme budget category, organisation and commissioner (2024). Northern Ireland Assembly. Report on Mental Health Services in Northern Ireland (2024).
Primary care relating to MHC	Total spending on primary care services, for general health, apportioned to MHC.	• England: Estimated MH related GP expenditure obtained from the Centre for Mental Health, extrapolated to 2030 using the period adjustment. • Scotland: Total budget spending (Level 3) on General Medical Services. The proportion of primary care spending related to MHC was based on the MH expenditure as a share of total net NHS expenditure from NHS Scotland (2025). • Wales: Total expenditure on general practice, net of dispensing. The proportion of general practice spending related to MHC was based on the NHS expenditure on 'Mental health problems' and 'Learning disability problems' as a % of total LHB and PHW expenditure from Welsh Government (2025). • Northern Ireland: Total payments towards overall cost of GP services. The proportion of GP services costs related to MHC was based on total investments in MH services as a % of overall health budget from NISRA (2024).	Centre for Mental Health. The economic and social costs of mental ill health (2024). NHS England (2025). NHS Scotland (2025). Scotland Government. Scottish Budget 2025 to 2026 (2024). Welsh Government (2025). StatsWales. Investment in general practice for the 2019 to 2020 financial year to the 2023 to 2024 financial year (2024). Northern Ireland Statistics and Research Agency (2024).

Pharmaceutical services	Total spending on MHC related medications and pharmaceuticals.	• England & Scotland: Net ingredient costs for antidepressants, CNS stimulants, and drugs used in psychosis and hypnotics. • Wales & Northern Ireland: Total pharmaceutical costs (including non-mental health medications). The apportionment method used for primaru care was applied.	NHSBSA – Statistics, Prescription Cost Analytics (2025). Public Health Scotland. Dispenser payments and prescription cost analysis. (2025). StatsWales. Health and social care (2024). Business Services Organization. Pharmaceutical statistics (2025).
Private health insurer spending	Total voluntary health insurance expenditure reported for the UK, for general health, apportioned to MHC.	• The apportionment method used for primary care was applied.	Office for National Statistics, Healthcare expenditure, UK Health Accounts: 2023 and 2024 (2024).
Out-of-pocket expenses	Total consumer out-of-pocket expenses for health services reported for the UK, for general health, apportioned to MHC.		

Other social services expenditure	Total spending on disability support payments and other local social services that are MHC specific.	• England: Expenditure by local authority social services on MHC. • Scotland: Adult, child and pension age payments with “Mental and Behavioural Disorders” listed as a primary disability. • Wales: Direct payments for social services to adults with “mental health needs” and “learning disabilities,” under 65 years old. • Northern Ireland: Total social service payments for “Mental Health” and “Learning Disability.”	Centre for Mental Health (2024) Social Security Scotland (2025). StatsWales (2024). Northern Ireland Assembly (2024).
Number of informal caregivers	Total number of informal caregivers caring for people with MHC.	• Proportion of informal caregivers that care for a recipient with a MH condition, estimated using the share of people who receive care for mental health support in England reported in the Personal Social Services Survey of Adult Carers in England (2024).	NHS England. Personal Social Services Survey of Adult Carers in England (2024). ONS. Unpaid care, England and Wales: Census 2021 (2021).
Total cost per informal MH carer	The value of unpaid care using the replacement cost approach. Valued at the cost of employing a formal carer to replace an informal carer.	• Replacement carer cost was estimated using the rate of pay for care workers and home carers (SOC 6135) and senior care workers (SOC 6136). Estimated as the simple average of pay rates plus additional salary on-costs (23%) and organizational overheads (20%). Pay rates were forecasted using real wage growth, estimated from IMF WEO and ILO ILOEST. • Total hours per week of informal care delivered by an informal carer to a person with a MHC was estimated using the average hours spent providing care per week reported in the Personal Social Services Survey of Adult Carers (PSSAC). Treated categorical survey responses (0-4, 5-19, 20-34, 35-49 hours) by taking the midpoint. Midpoint of unbounded categories (50 or more hours, varies but less than 35 hours, varies but 35 or more hours) assumed to be 50% higher.	Diminic et al. (2017). ONS. Earnings and hours worked, occupation by four-digit SOC: ASHE Table 14 (2025). IMF (2025). ILO (2025).

Additional assumptions and limitations

- An exchange rate of USD-GBP of 0.74 was applied (January 2-30, 2026 period average).[1]
- A VLY of USD 144,000 was applied.

1. IMF. Representative Exchange Rates for Selected Currencies for January 2026 (2026).

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