ZURICH

The Value of Mental Health

Strengthening personal resilience across people, productivity, and protection systems

Country snapshot: **Australia**

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.

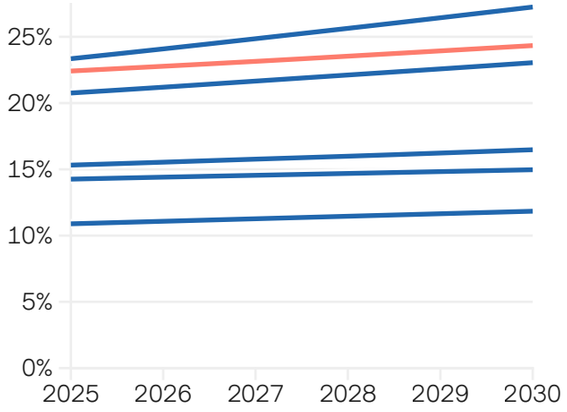
Refer to Data and methodology for a full overview of data sources, assumptions and calculations.

Australia

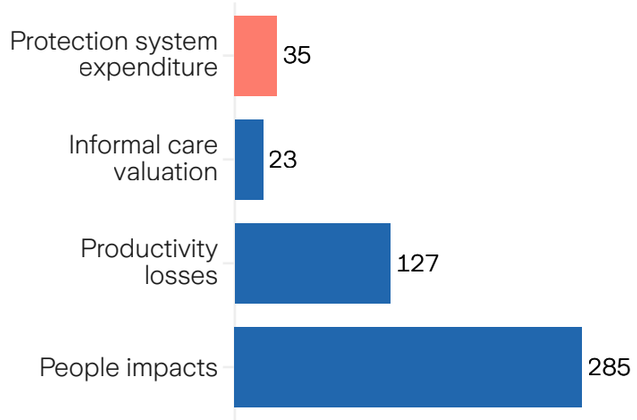
A system under pressure as early identification grows

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.

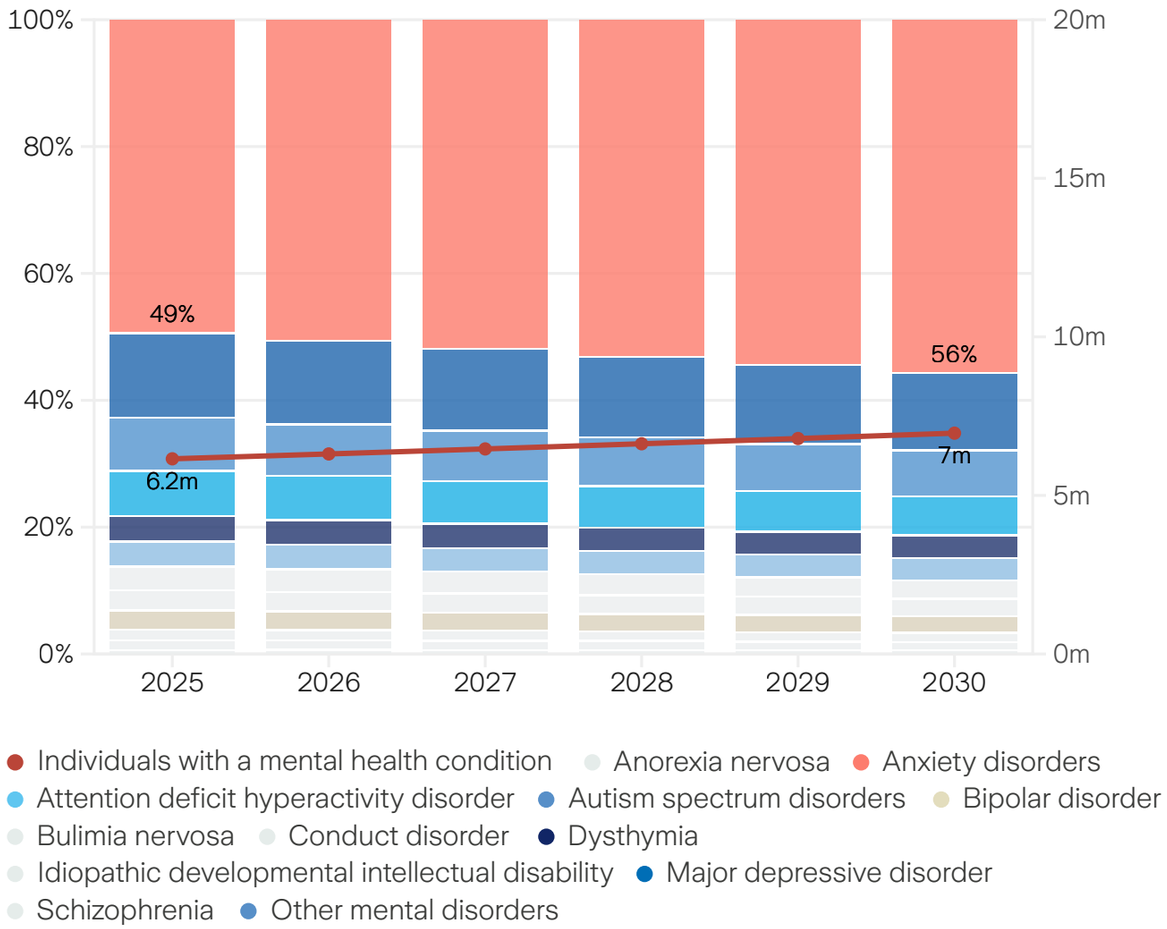
Rising prevalence therefore likely reflects recognition as much as deterioration. A broader spectrum of health-related experiences – from severe and persistent illness to milder, episodic or situational distress – is now visible in the data. Psychological distress that may remain family-managed or unrecorded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

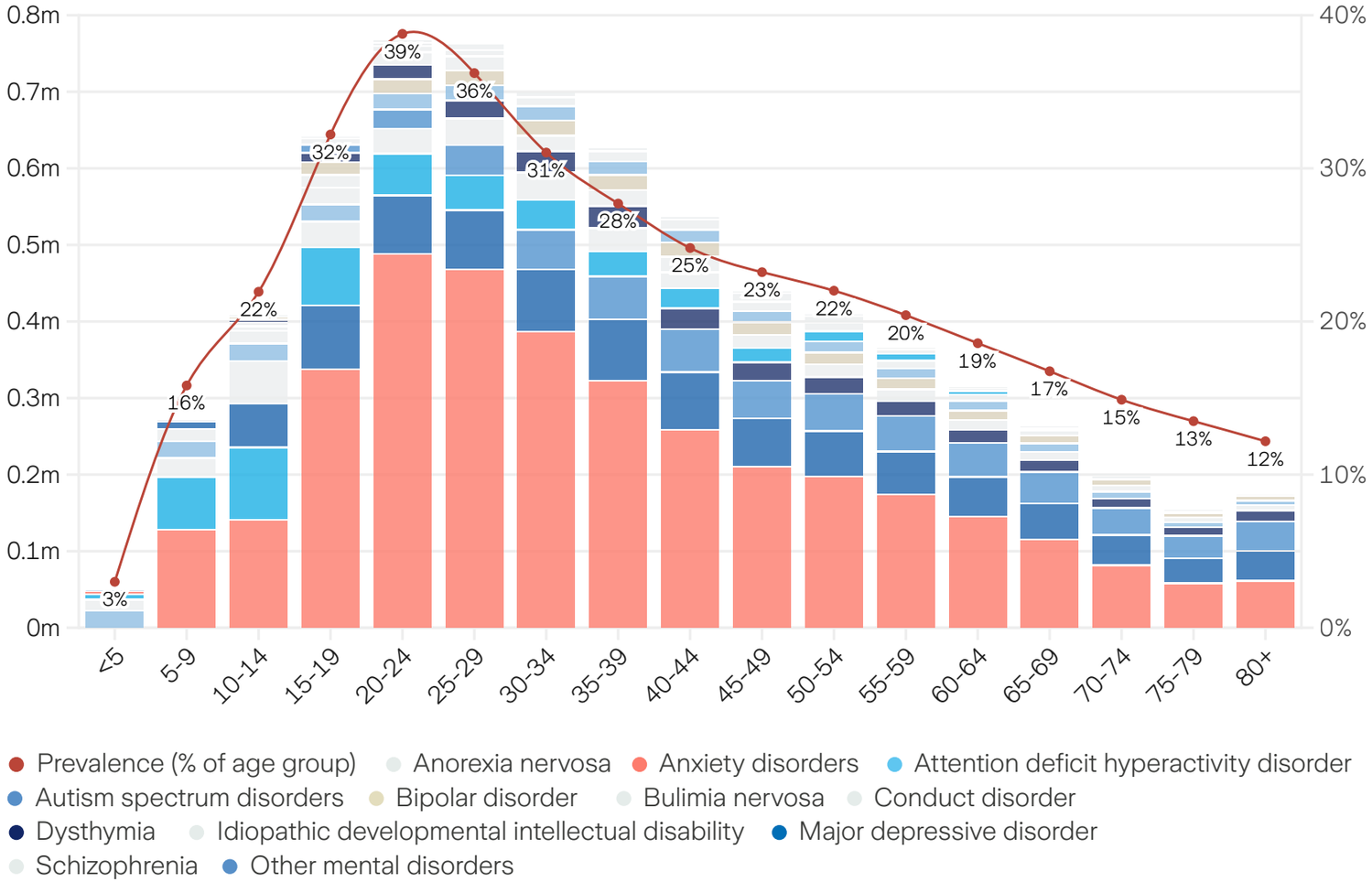
Mental health conditions are most common among people aged 15 to 34, with close to one in three estimated to be living with a condition, and prevalence peaking at around 39% among those aged 20 to 24.

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).

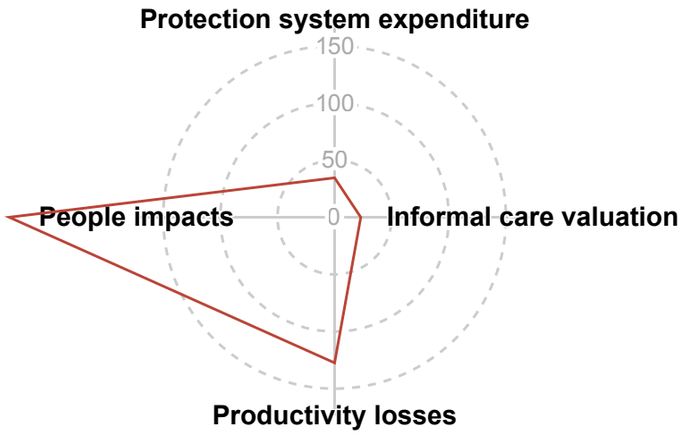
Projected prevalence by age group (%) includes comorbidities.

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.

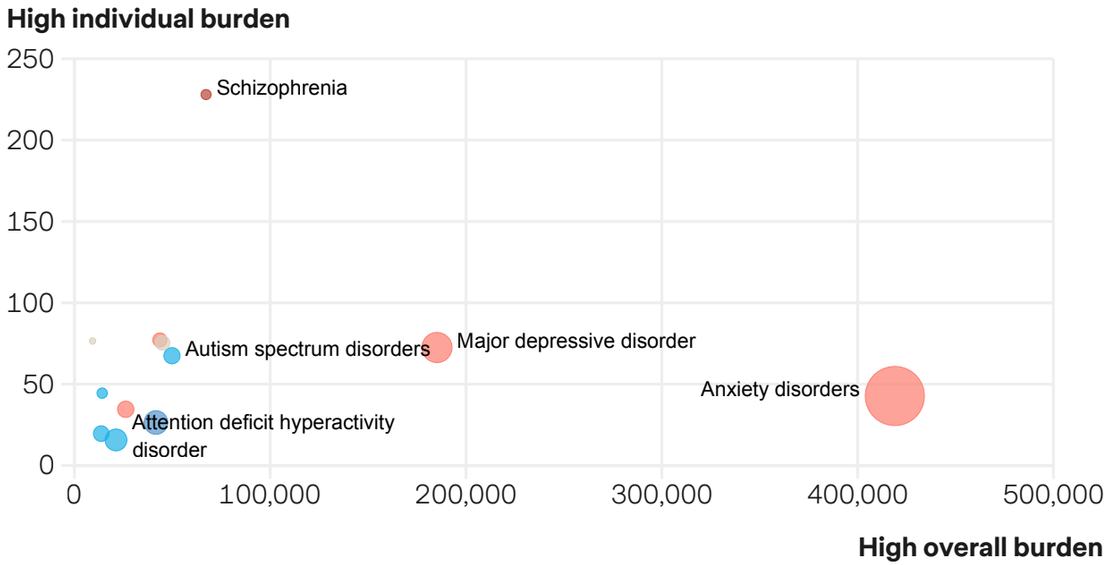
AUD 127 billion
in reduced workforce participation and increased absenteeism.

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.

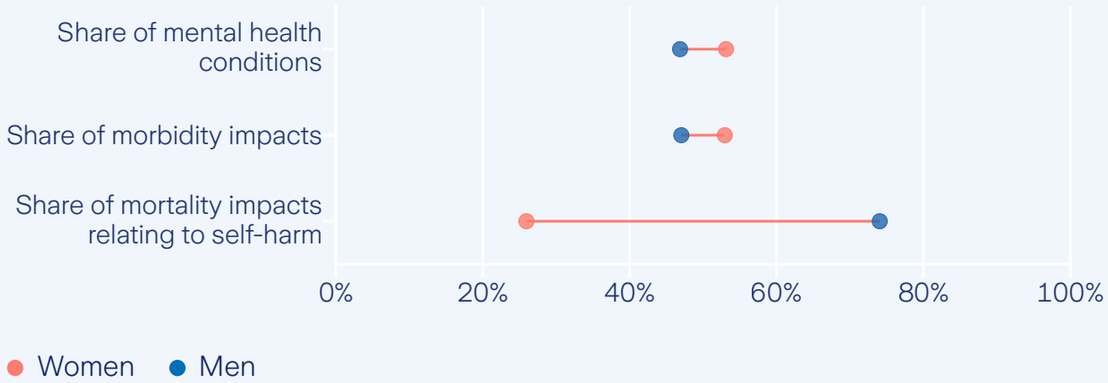
Managing this balance is the central challenge: large volumes of milder needs can absorb system capacity, highlighting the importance of triage and proportionate response to avoid crowding out care for those with the greatest need.

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.

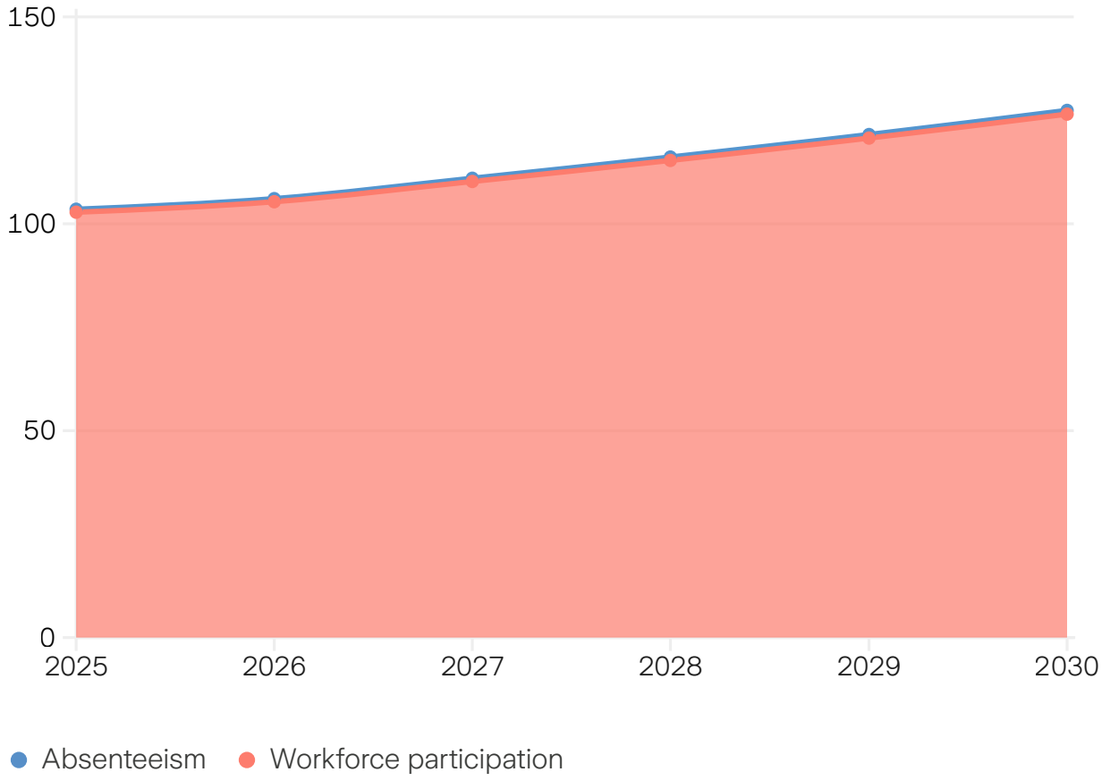
Lost wages – combining reduced workforce participation and absenteeism – are estimated at AUD 106 billion in 2026, (equivalent to 3.5% of GDP). By 2030, productivity-related losses are projected to exceed AUD 127 billion per year, or about 4.0% of GDP. These losses far outweigh formal mental health spending (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

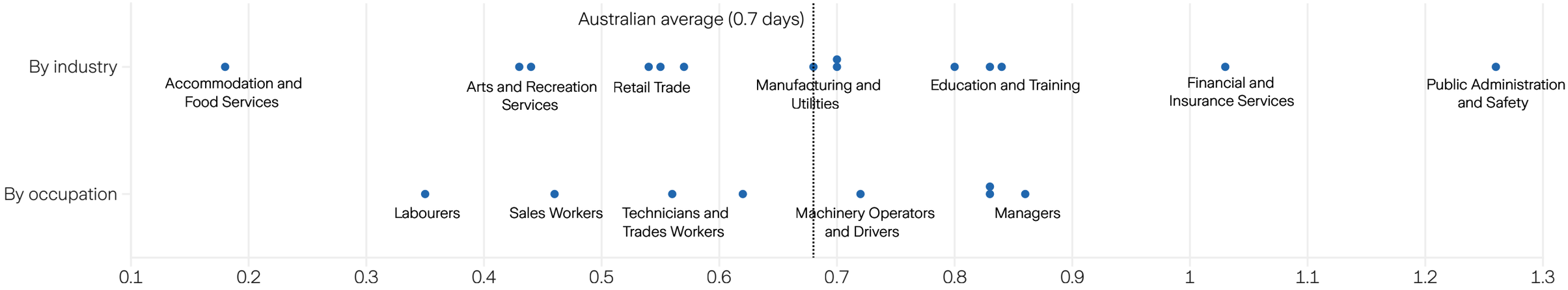


Refer to Data and methodology for a full set of data sources, assumptions and calculations.

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.

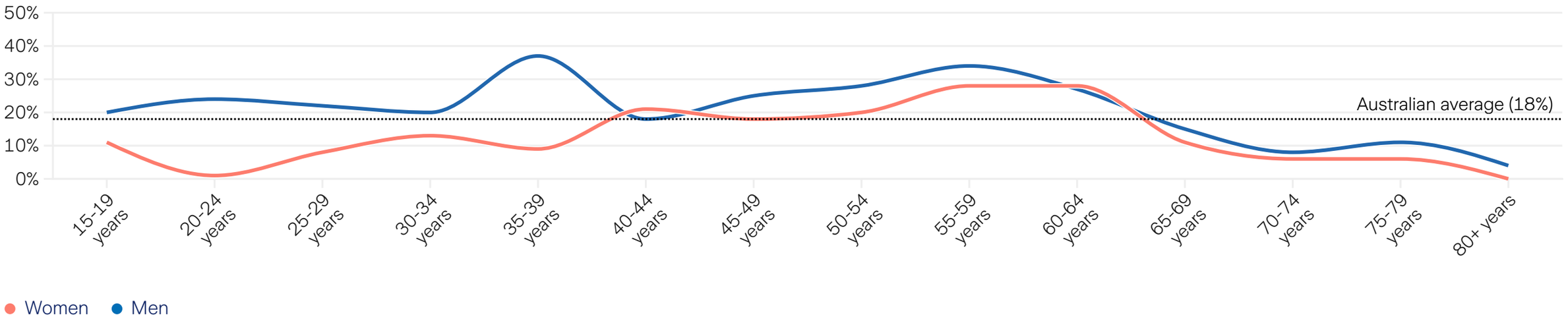
Short-term withdrawal can become long-term exit if:

- 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)

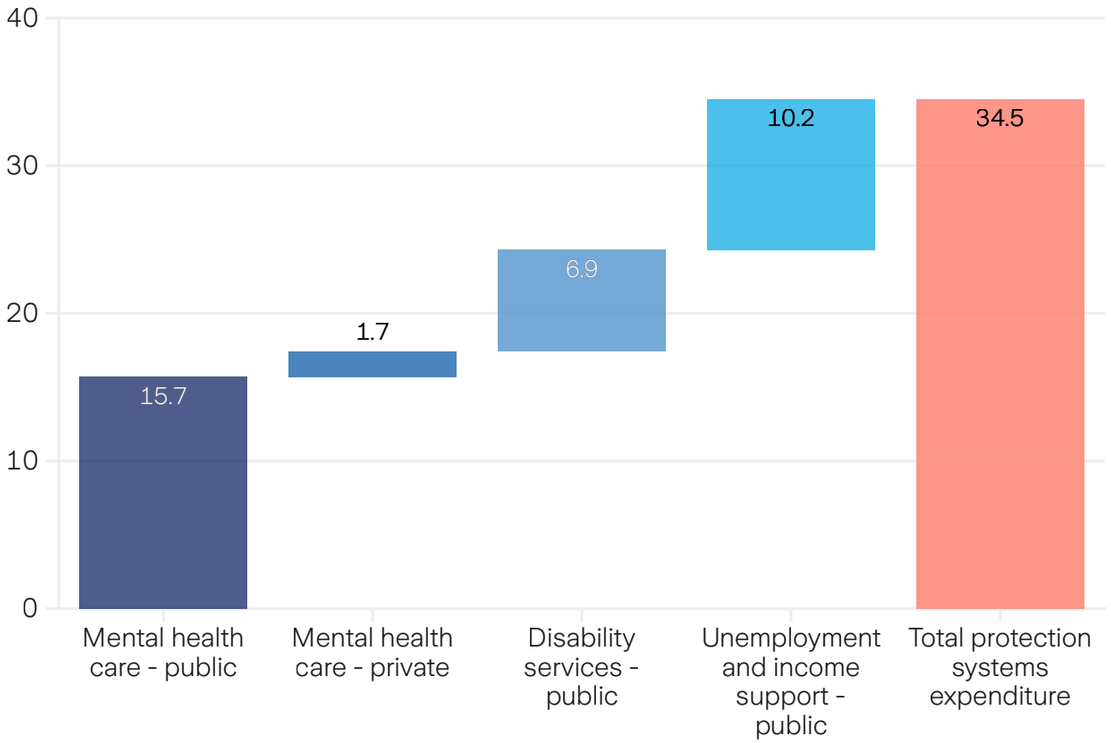
Percentage point gap in employment rate between those with a mental health condition and those without, by gender and age group



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.

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).

Acknowledgments

This report was produced by Zurich Insurance Group, supported by Mandala Partners. It was developed under the efforts and guidance of Rosanna Cubelli, Sophie Heading, Sean McAllister, and Rebecca Pihlapuro, with design by Joël Giroud. This report has also greatly benefited from the insight and expertise of:

Jose Ernesto Aguero, Deputy Head of Data Analytics, Zurich Chile; Susanne Cupic, Mental Health Prevention Coach, Prevention & Health Care Consulting, Zurich Switzerland; Reka Deak, Head of People Resilience and Inclusion, Zurich Insurance Group; Sofyen Khalfaoui, Head of Improving Mental Wellbeing, Z Zurich Foundation; Dr Khatchik Kinoyan, Chief Underwriter, Zurich Middle East; Olfa Khechine, Health & Wellbeing Proposition Lead, Zurich Insurance Group; Han Boon Lee, Chief Proposition Management Officer, Zurich Malaysia; Peter Hamilton, Head of Market Engagement – UK Life, Zurich UK; Michele Häusler, Head of Customer Experience and Growth, Corporate Life & Pensions, Zurich Insurance Group; Nick Homer, Head of Market Management – Corporate Risk, Zurich UK; Heike Hommel, Head of Underwriting Life, Zurich Germany; Alison Martin, CEO Life, Health and Bank Distribution, Zurich Insurance Group; Toby May, Head of Sustainability Integration, Zurich Insurance Group; Laura McAlpine, Head of Public Affairs, Zurich UK; Maite Mouraille, Head of Marketing & Communication, Zurich Middle East; Angeles Quintana, Head of Life and Health, Zurich Chile; Andrea Alejandra Perez, Commercial Manager, Group Health, Zurich Chile; Sally Phillips, Head of Zurich Medical Administration, Life, Health and Bank Distribution, Zurich Insurance Group; Martin Scanlon, Senior Protection Proposition Manager, Protection & Data Analytics, Zurich Insurance Group; Harriet Taylor, Head of Zurich Global Employee Benefits, Zurich Insurance Group; Antony Vriens, Head Of Health Services, Zurich Australia; and Felipe Andres Yañez, Deputy Head of Group Health Commercial, Zurich Chile; Igor Rogach, Data and Analytics Manager, Zurich Insurance Group.

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