



# The Value of Mental Health

Strengthening personal  
resilience across people, productivity,  
and protection systems

Country snapshot: **Chile**



# 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<sup>3</sup> mental and behavioral disorders captured in the Global Burden of Disease (GBD) study.<sup>4</sup> 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.

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 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.



## 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.

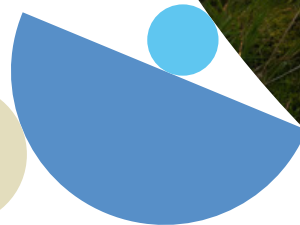
## Data sources and limitations

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.

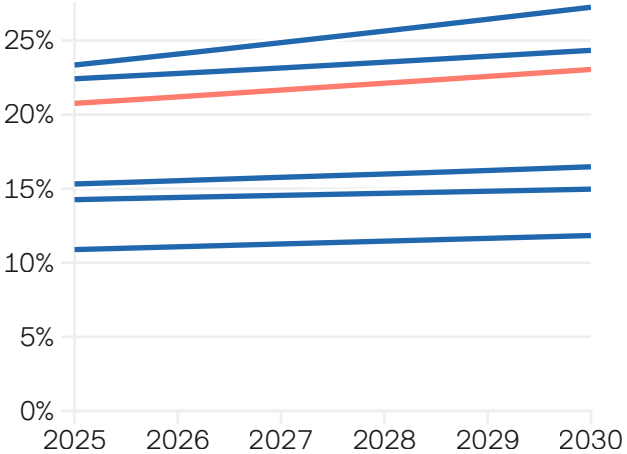


# Chile

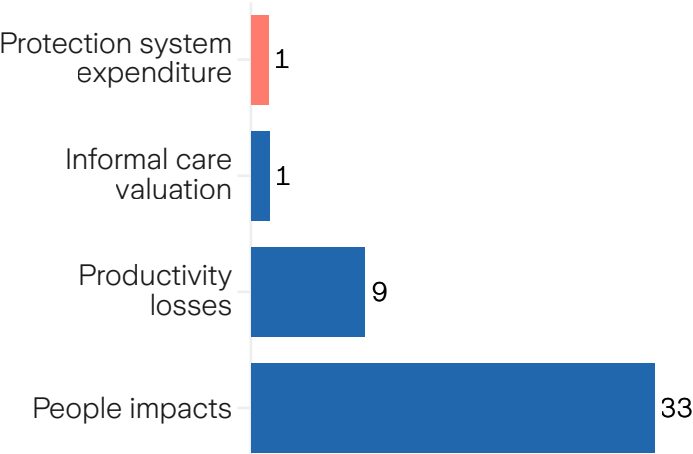
## A critical window for action

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<sup>1</sup> – underscoring how stigma, limited geriatric mental health capacity, and lower help-seeking delay recognition until symptoms meaningfully interfere with daily functioning.

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'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,<sup>2</sup> 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.

## 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)



- Individuals with a mental health condition
- Attention deficit hyperactivity disorder
- Bulimia nervosa
- Idiopathic developmental intellectual disability
- Schizophrenia
- Anorexia nervosa
- Conduct disorder
- Autism spectrum disorders
- Dysthymia
- Other mental disorders
- Anxiety disorders
- Bipolar disorder
- Major depressive disorder

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.



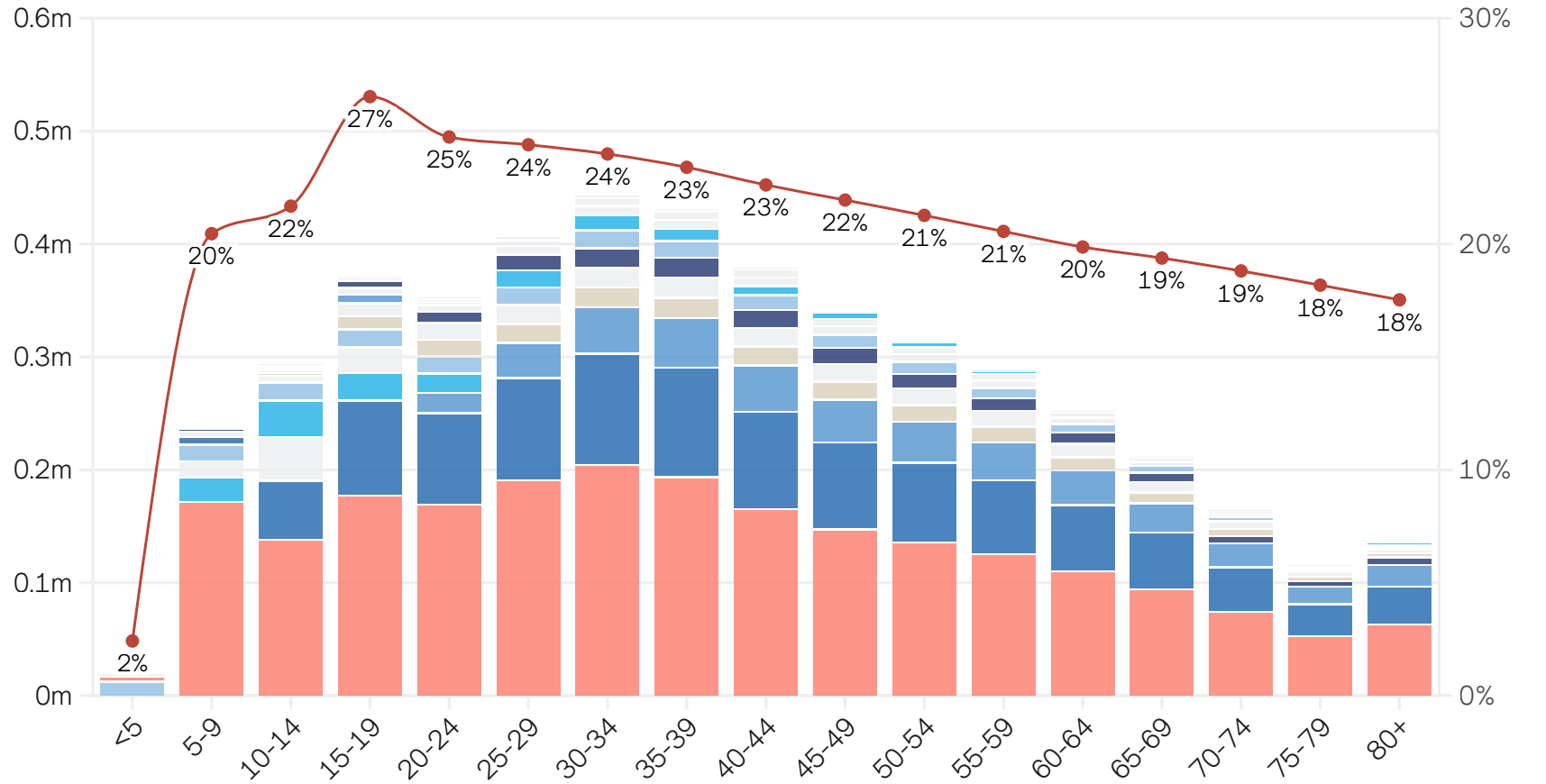
Major depressive disorder accounts for a further 22% of cases but stands out as the fastest growing condition in Chile, growing at about 4.3% per year – a pattern not observed in other markets, where anxiety remains the dominant growth driver. Growth accelerates from age 35 to 39 onward, indicating that 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, Head of Life and Health, Zurich Chile**

**Chile: Projected prevalence of mental health conditions by age (2026)**  
 Number of mental health conditions (million) and prevalence rate (%), by age group



- Prevalence (% of age group)
- 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 \(2025\)](#).

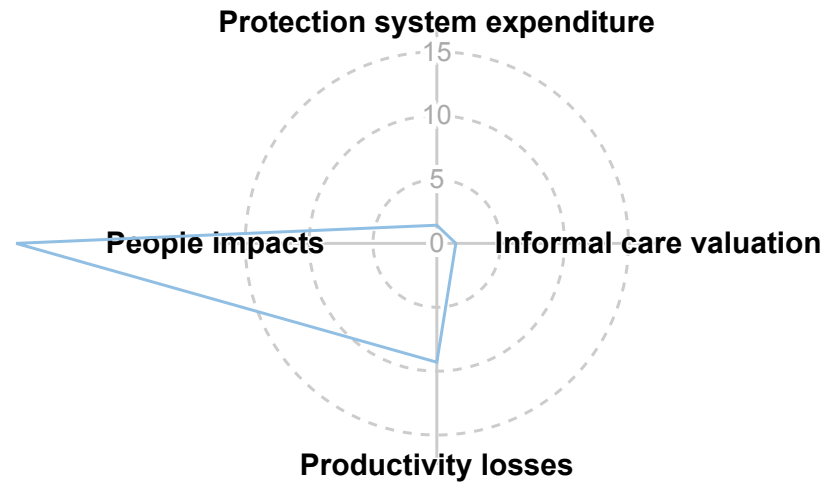
Projected prevalence by age group (%) includes comorbidities.

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.

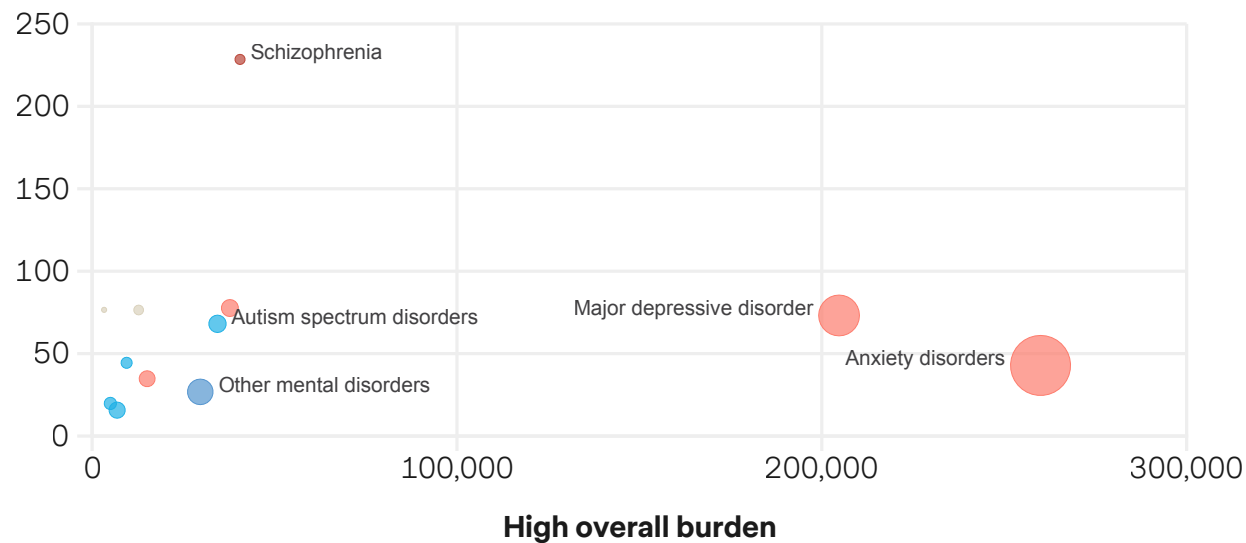
## People: Scale and severity both matter

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.<sup>3</sup>

### 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

#### High individual burden



- Anxiety, depressive and mood disorders
- Neurodevelopmental and conduct disorders
- Other mental disorders
- Eating disorders
- Psychotic disorders

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

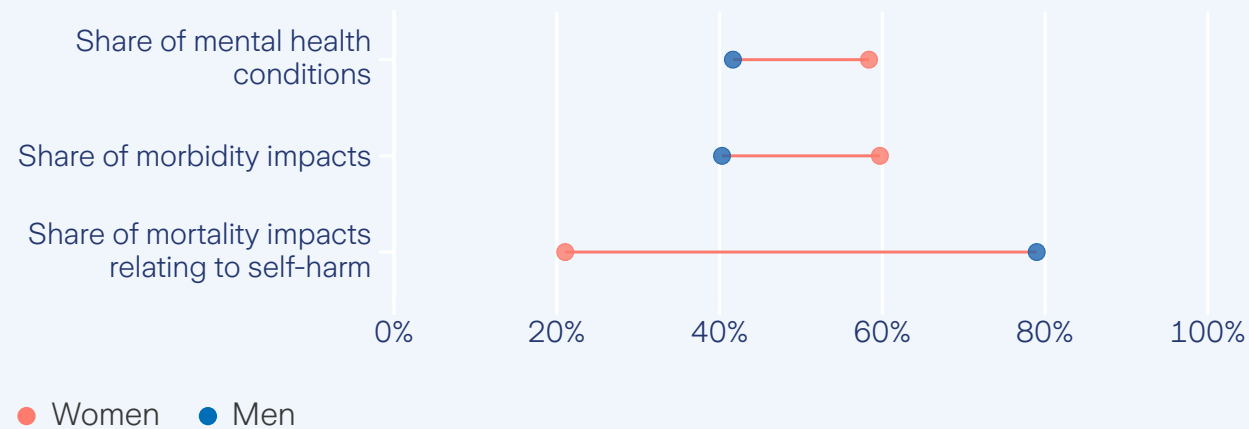
The prevalence of mental health conditions in Chile display a persistent gender divide.

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

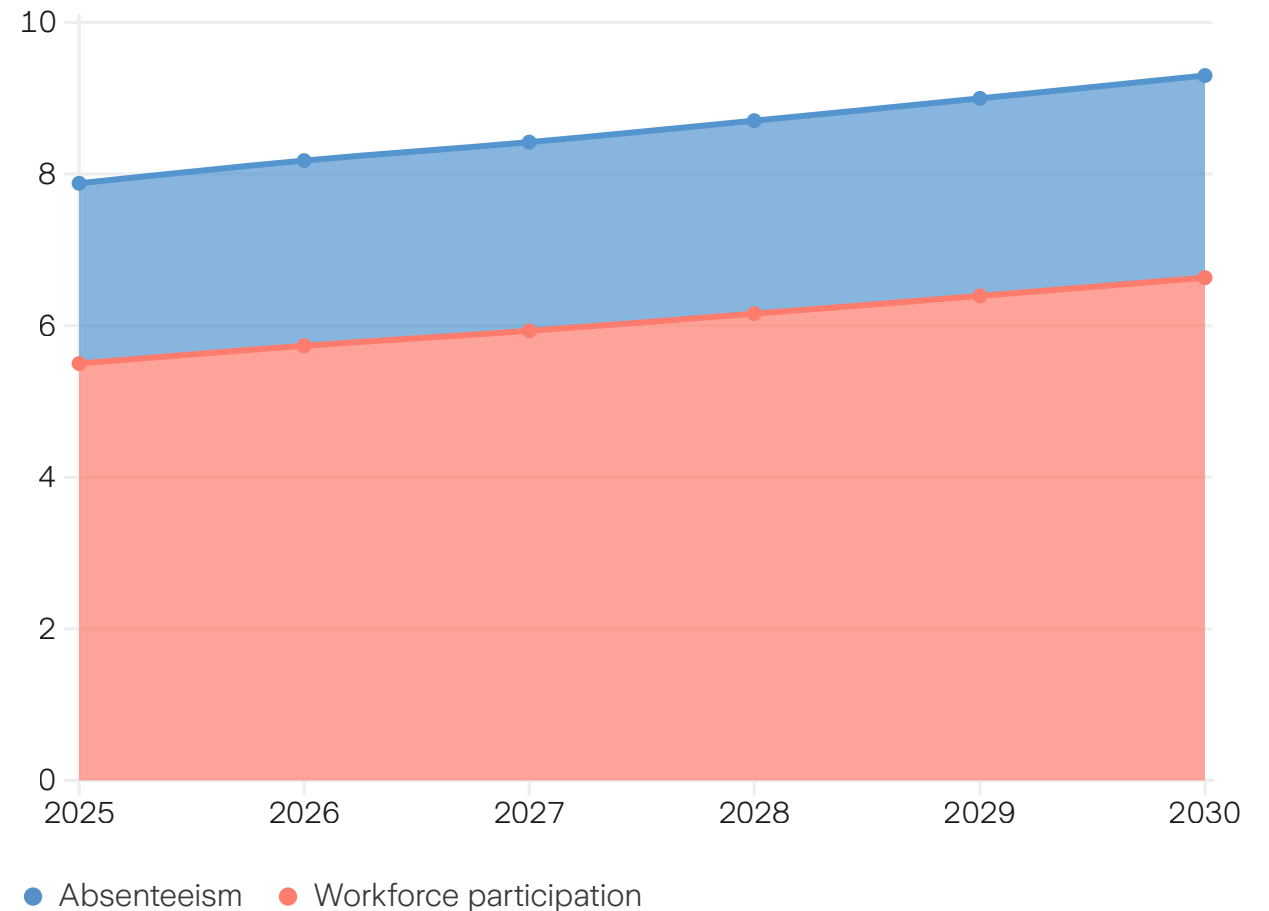
The largest share of productivity loss in Chile – about 70% of the 2026 total – comes from reduced workforce participation. This represents almost CLP 6 trillion, equivalent to 1.6% of GDP, driven by a 14 percentage point<sup>4</sup> employment gap (54% employment among those with a mental health condition, 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.

4. Without rounding error.

## 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.

## 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.<sup>5</sup> 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,<sup>6</sup> reflecting sustained pressure on specialist services. With only 8.5 psychiatrists per 100,000 people,<sup>7</sup> 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.

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).

## A distinct system trade-off

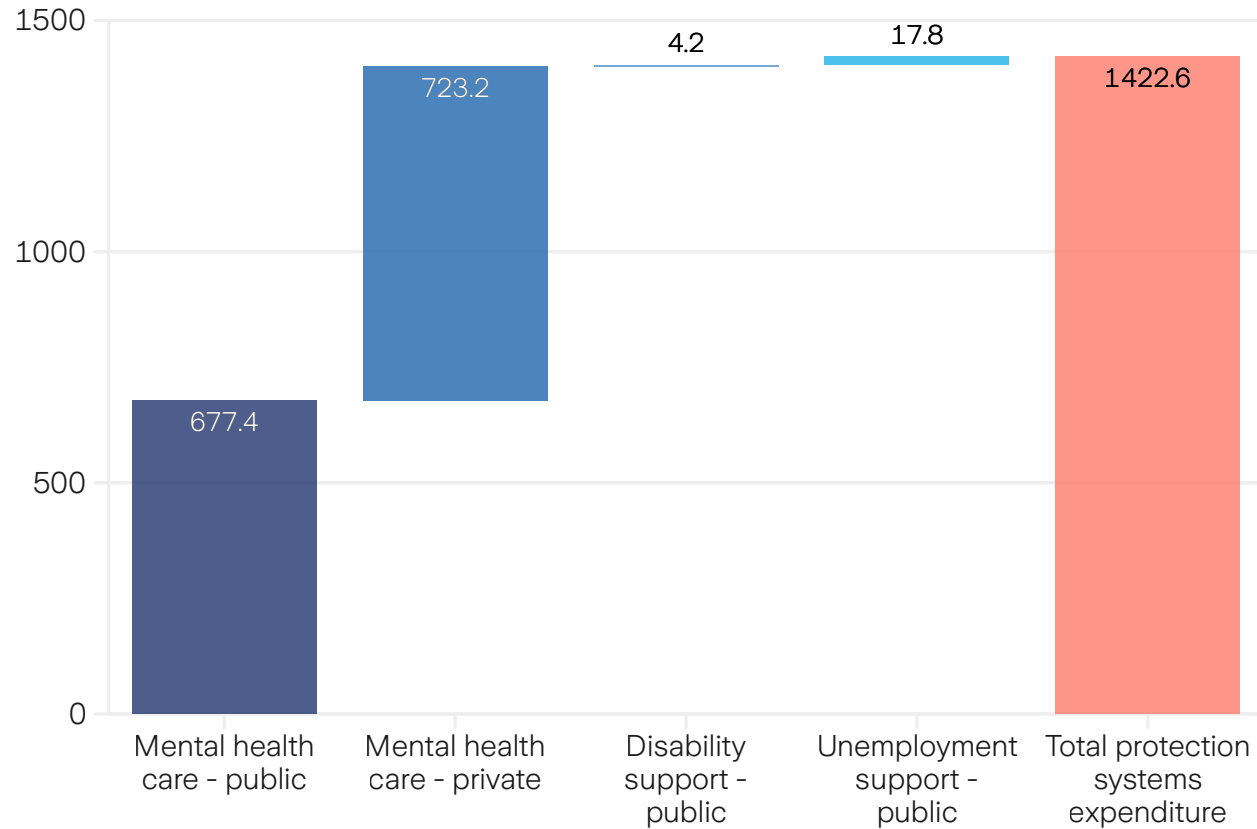
Compared with markets where mental health conditions more often lead to labor force exit, Chile's social insurance-based sick leave framework can help keep people formally connected to employment, but it struggles to shorten the time it takes to recover and re-engage. Earlier, coordinated action – combining 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.



# 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.<sup>8</sup>

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.<sup>9</sup> 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.<sup>10</sup>

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.

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).

## 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,<sup>11</sup> 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.<sup>12</sup> 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.

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.



**CLP 1.5 trillion**

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

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.<sup>13</sup>

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

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.



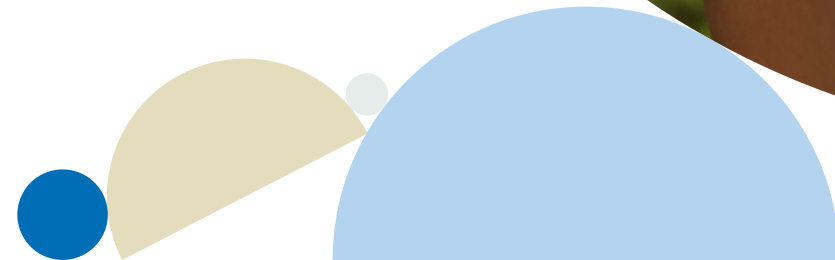
# Data and methodology

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.<sup>1</sup>

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)
<b>Prevalence rate of MHC by age and sex (%) in 2023</b>	The prevalence rate is the total number of cases of a given MHC as a proportion of a specified population at a designated time.	<ul style="list-style-type: none"> <li>• Available by age, sex, and condition.</li> <li>• GBD disability weights (severity of MHC) are applied uniformly across countries.</li> <li>• 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.</li> </ul>	Global Burden of Disease Collaborative Network, Institute for Health Metrics and Evaluation (IHME). <a href="#">Global Burden of Disease Study 2023 (GBD) (2025)</a> .
<b>Projected annual increase in prevalence rate of MHC by age and sex (%) to 2030</b>	Geometric annual growth rate (CAGR) of prevalence rate of MHC in 2012-2023.	<ul style="list-style-type: none"> <li>• Growth rates are determined by condition, age, and sex, then applied individually to forecast values through 2030.</li> <li>• Our analysis uses data from a 10-year period (2012 to 2023). The growth rate is assumed to be constant in all future years.</li> </ul>	IHME (2025).
<b>Total population projections by age and sex to 2030</b>	Total population is based on the de facto definition of population, which counts all residents regardless of legal status or citizenship.	<ul style="list-style-type: none"> <li>• Forecasts undertaken by the World Bank.</li> </ul>	World Bank. <a href="#">Population Estimates and Projections (2025)</a> .

# 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)
<p><b>Years lived with disability (YLDs)</b></p>	<p>The annual total of healthy years lost as a result of living with a disability, calculated for all individuals affected during that year.</p>	<ul style="list-style-type: none"> <li>• Projected using prevalence rates (see Data and methodology: Prevalence).</li> <li>• YLDs include “Self-Harm”.</li> </ul>	<p>IHME (2025).</p>
<p><b>Value of a statistical life-year (VLY)</b></p>	<p>A monetized, statistical value of a year of healthy life.</p> <p>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.</p> <p>It may not represent an individual’s willingness to pay, nor will it be representative of each person’s situation.</p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• Market exchange rates are then used to convert the value of life across countries.</li> </ul>	<p>Abelson, <a href="#">Establishing a monetary value for lives saved: Issues and controversies</a> (2007).</p> <p>Australian Department of the Prime Minister and Cabinet. <a href="#">Value of a statistical life and value of a statistical life year</a> (2024).</p> <p>OECD. <a href="#">Mortality Risk Valuation in Policy Assessment</a> (2025).</p> <p>World Bank (2025).</p> <p>IMF (2025).</p>

<p><b>Deaths</b></p>	<p>Deaths attributed directly to a condition each year.</p>	<ul style="list-style-type: none"> <li>• Projected using prevalence rates (see Data and methodology: Prevalence). The only MHC to which the GBD attributes deaths is anorexia.</li> <li>• 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.</li> </ul>	<p>IHME (2025).</p> <p>World Bank (2025).</p>
<p><b>Value of a statistical life (VSL)</b></p>	<p>A monetized, statistical value of the remaining years of healthy life for an individual.</p>	<ul style="list-style-type: none"> <li>• 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).</li> <li>• 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.</li> <li>• 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.</li> <li>• VSL is converted to local currencies at market value using designated exchange rates.</li> </ul>	<p>United Nations. <a href="#">World population prospects 2024: Life expectancy at exact age (2024)</a>.</p> <p>Abelson (2007).</p> <p>Australian Bureau of Statistics. <a href="#">Wage Price Index, Table 2a: Total hourly rates of pay excluding bonuses, all sectors, all industries, Australia (2025)</a>.</p>

## 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)
<b>Employment rate gap</b>	<p>The gap between the employment rate of individuals with a mental health condition (MHC) and the employment rate of individuals without a MHC.</p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• Employment gaps are likely conservative in high stigma contexts.</li> </ul>	<p>OECD, <a href="#">Fitter minds, Fitter Jobs</a> (2021).</p> <p>ILO. <a href="#">ILO Modelled Estimates and Projections Database (ILOEST)</a> (2025).</p> <p>IMF (2025).</p>

<p><b>Average wages per annum / day</b></p>	<p>Average wages agnostic of MHC status.</p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• Wages are converted from international dollars to local currency units using market rate data.</li> </ul>	<p>ILO. <a href="#">ILOSTAT Database: Labour Force Statistics</a> (2024).</p> <p>ILO (2025).</p> <p>IMF (2025).</p> <p>Solow, <a href="#">A Contribution to the Theory of Economic Growth</a> (1956).</p> <p>Lucas, <a href="#">On the mechanics of economic development</a> (1988).</p> <p>Romer, <a href="#">Endogenous Technological Change</a> (1990).</p> <p>OECD. <a href="#">Decoupling Wages from Productivity</a> (2018).</p>
<p><b>Employed working-age population</b></p>	<p>The employed population aged of 15 to 64.</p>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>	<p>ILO. <a href="#">Labour Force Statistics: Employed 15-64 population</a> (2024).</p> <p>ILO (2025).</p>

**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)
<b>Period adjustment (for projections to 2030)</b>	Period adjustment (%) to extrapolate most recent data to 2030.	<ul style="list-style-type: none"> <li>• Calculated based on projected prevalence and inflation. Inflation rate is calculated using historical CPI and inflation projections.</li> <li>• Expenditure projections assume a constant growth trajectory; estimates assume no change in the business cycle.</li> </ul>	IHME (2025). World Bank (2025). IMF (2025).
<b>Total health services expenditure apportioned to MHC</b>	Total government budgeted expenditure on health services apportioned to MHC.	<ul style="list-style-type: none"> <li>• Calculated based on the proportion of mental health cases as a share of all health cases in the FONASA / ISPRES systems.</li> <li>• 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.</li> </ul>	Ministerio de Salud. <a href="#">Ley De Presupuestos Año 2024</a> (2024). Superintendencia de Seguridad Social. <a href="#">Estadística Trimestral De Casos Ges (Auge) De FONASA Y Sistema ISAPRE</a> (2025).

<b>Pharmaceutical services</b>	Total pharmaceutical expenditure for mental health-related medications at ATC level 3 classification.	<ul style="list-style-type: none"> <li>Estimated using the total expenditure on the following items: Anxiolytics (N05B-Ansiolíticos), Hypnotics and sedatives (N05C Hipnóticos y sedantes), and Antidepressants (N06A-Antidepresivos).</li> </ul>	Universo de las estadísticas. <a href="#">Serie Histórica Gasto Constantes ATC (2025)</a> .
<b>Individual out-of-pocket expenses</b>	Total out-of-pocket health expenditure reported by IES Minsal, apportioned to MHC.	<ul style="list-style-type: none"> <li>The apportionment method used for health services expenditure was applied.</li> </ul>	IES Minsal ( <a href="#">accessed 2025</a> ).
<b>Private health and other insurer expenditure</b>	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.	<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> </ul>	Isapres en Chile. <a href="#">Valores Isapres (2025)</a> .
<b>Labor disability subsidies for MHC</b>	Total payments for worker disability subsidies for employees of private companies, public services, and independent workers, apportioned to MHC	<ul style="list-style-type: none"> <li>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.</li> </ul>	Gobierno de Chile. <a href="#">Ministerio del Trabajo y Prevision Social (2025)</a> .  Superintendencia de Pensiones. <a href="#">Solicitudes y dictámenes del proceso de invalidez (2025)</a> .
<b>Unemployment support for MHC</b>	Total unemployment benefit payments in the Unemployment Insurance Database, reported by Superintendencia de Pensiones, apportioned to MHC	<ul style="list-style-type: none"> <li>The apportionment method used for labor disability subsidies was applied.</li> </ul>	Superintendencia de Pensiones (2025).

<p><b>Number of informal mental health caregivers</b></p>	<p>Total number of primary and non-primary informal carers for people with MHC.</p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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%).</li> </ul>	<p>World Bank (2025).</p> <p>Agence Francaise de Development. <a href="#">Cuidadoras de personas mayores: sobrecargadas y mal pagadas: evidencia de una encuesta del Banco Interamericano de Desarrollo en América Latina y el Caribe</a> (2024).</p>
<p><b>Total cost per informal MH caregiver</b></p>	<p>The value of unpaid care using the replacement cost approach. Valued at the cost of employing a formal carer to replace an informal carer.</p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul>	<p>Diminic et al. <a href="#">The economic value of informal mental health caring in Australia: Technical report</a> (2017).</p> <p>IMF (2025).</p> <p>ILO (2025).</p> <p>Ministerio de Hacienda. <a href="#">Estimación del Valor Económico del Trabajo Doméstico y de Cuidados no Remunerados en Chile</a> (2025).</p>

## Additional assumptions and limitations

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

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

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