ZURICH

The Value of Mental Health

Strengthening personal resilience across people, productivity, and protection systems

Country snapshot: **Germany**

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.

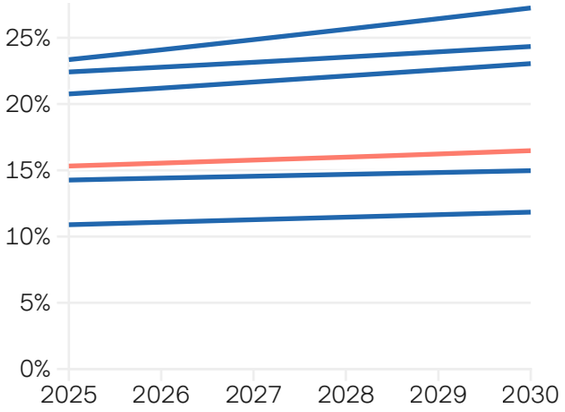
Refer to Data and methodology for a full overview of data sources, assumptions and calculations.

Germany

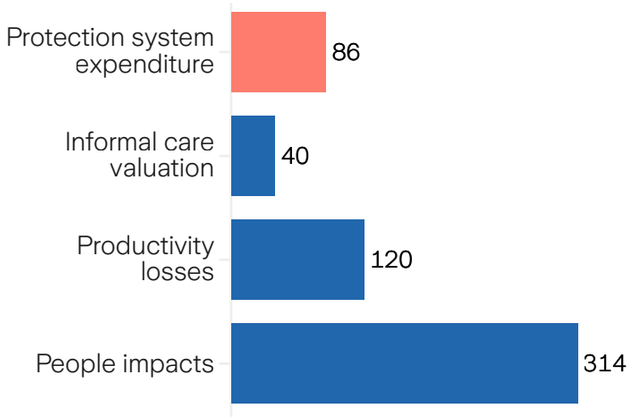
A comprehensive system with a widening youth burden

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

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



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



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

High days of healthy life lost

67 days
of healthy life lost

Lower average employment gap

17%
employment gap

Higher average sick days

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

Lower out-of-pocket expenditure

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

Higher annual hours of informal care

89 hours
of informal care received per year

Germany

Prevalence: A growing burden behind a strong system

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

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

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

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

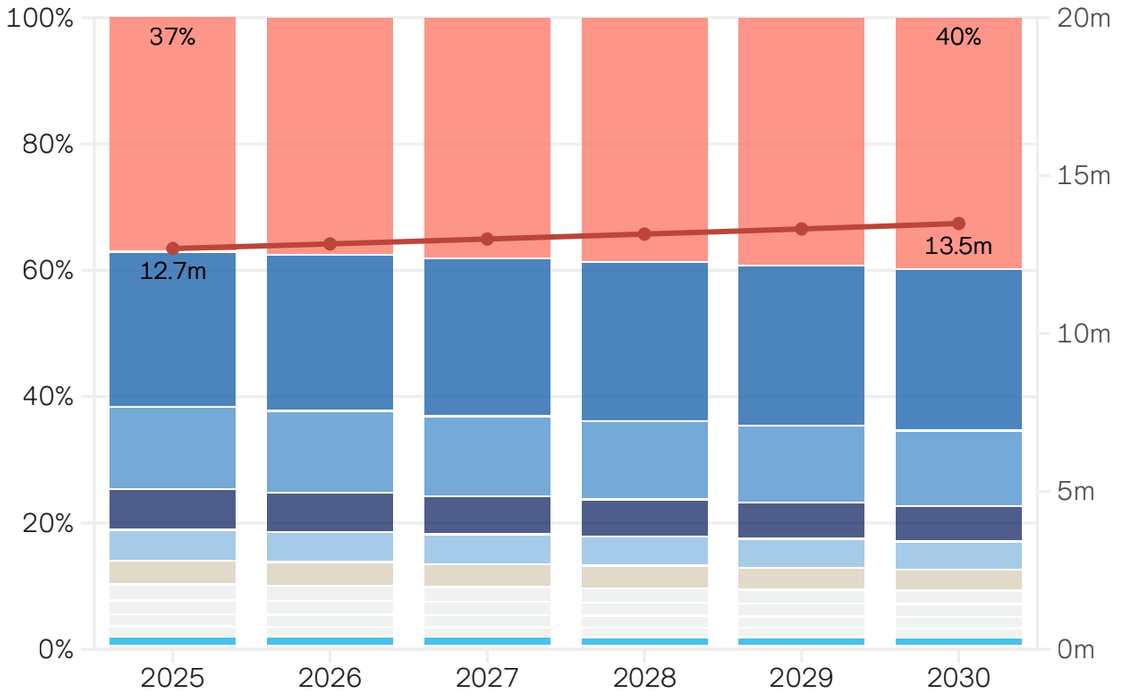
These structural dynamics shape the country's wider mental health burden. Germany's strong access pathways mean many individuals reach support earlier, but workforce pressures, rising youth distress, and growing demand for psychological therapies are stretching capacity in key areas. Cultural norms,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

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

1 in 3

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

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



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

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

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

A more stable burden?

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

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

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

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

A high burden among adolescents

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

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

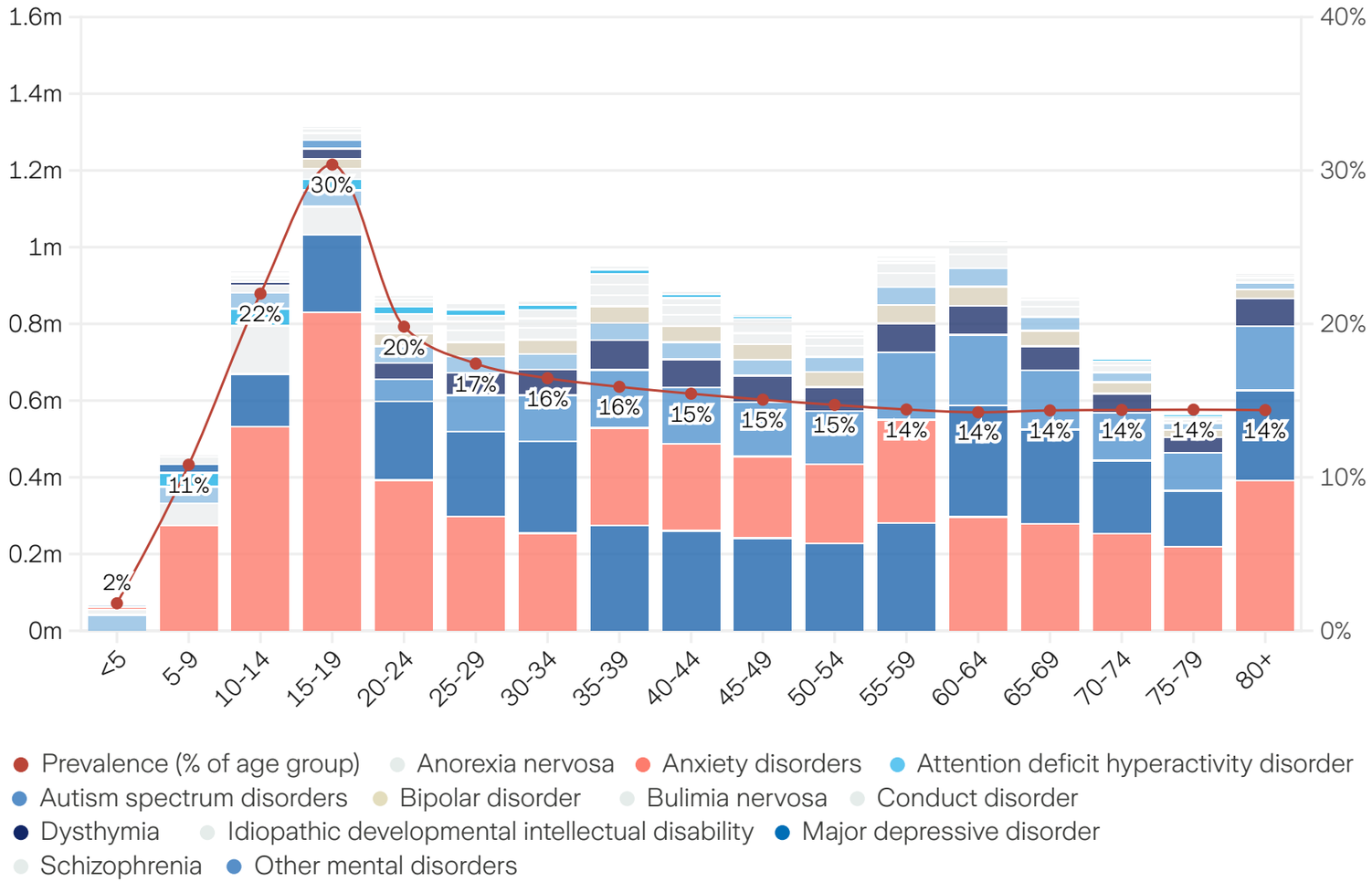
1. More than 60 days of healthy life lost on average per individual per year.

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

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

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

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



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

Projected prevalence by age group (%) includes comorbidities.

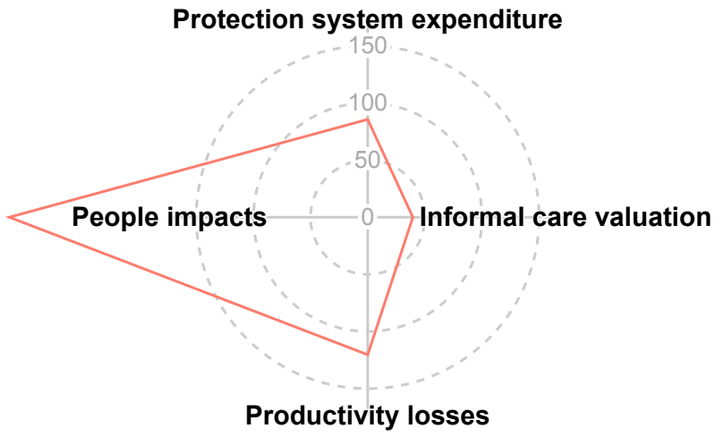
Refer to Data and methodology for a full set of data sources, assumptions and calculations.

A legacy of informal management

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

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

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



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

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

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

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

EUR 120 billion
in reduced workforce participation and increased absenteeism.

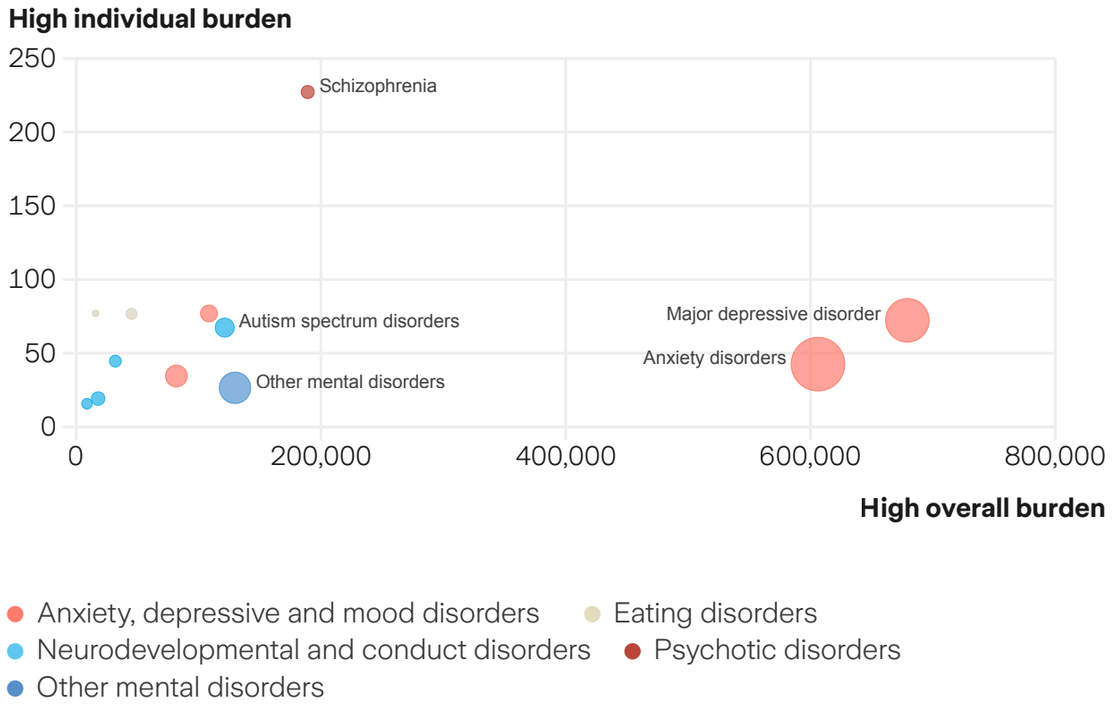
EUR 40 billion
in the value of informal care.

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

People: A high personal cost

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

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



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

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

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

Scale and severity both matter

Germany's mental health burden reflects two realities:

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

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

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

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

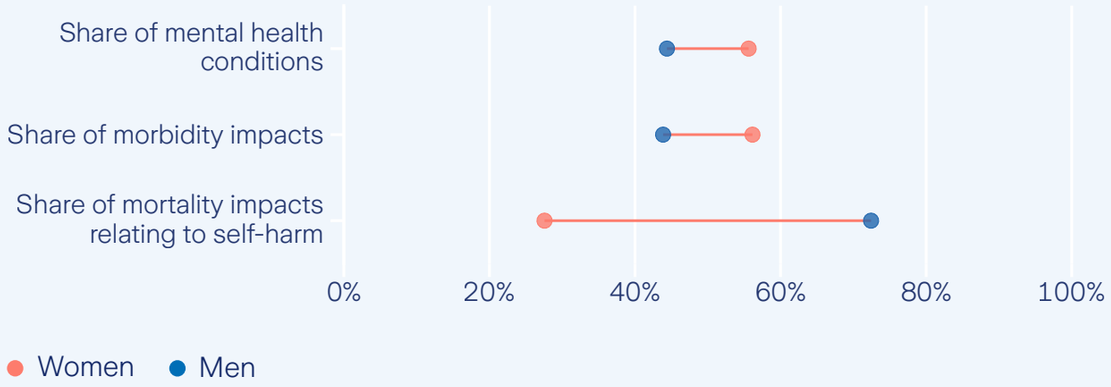
3. The value of a statistical life year of USD 156,000 has been applied and converted into EUR to reflect local conditions.

Gender divides in Germany

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

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

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



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

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

Productivity: A strong labor market carrying a rising load

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

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

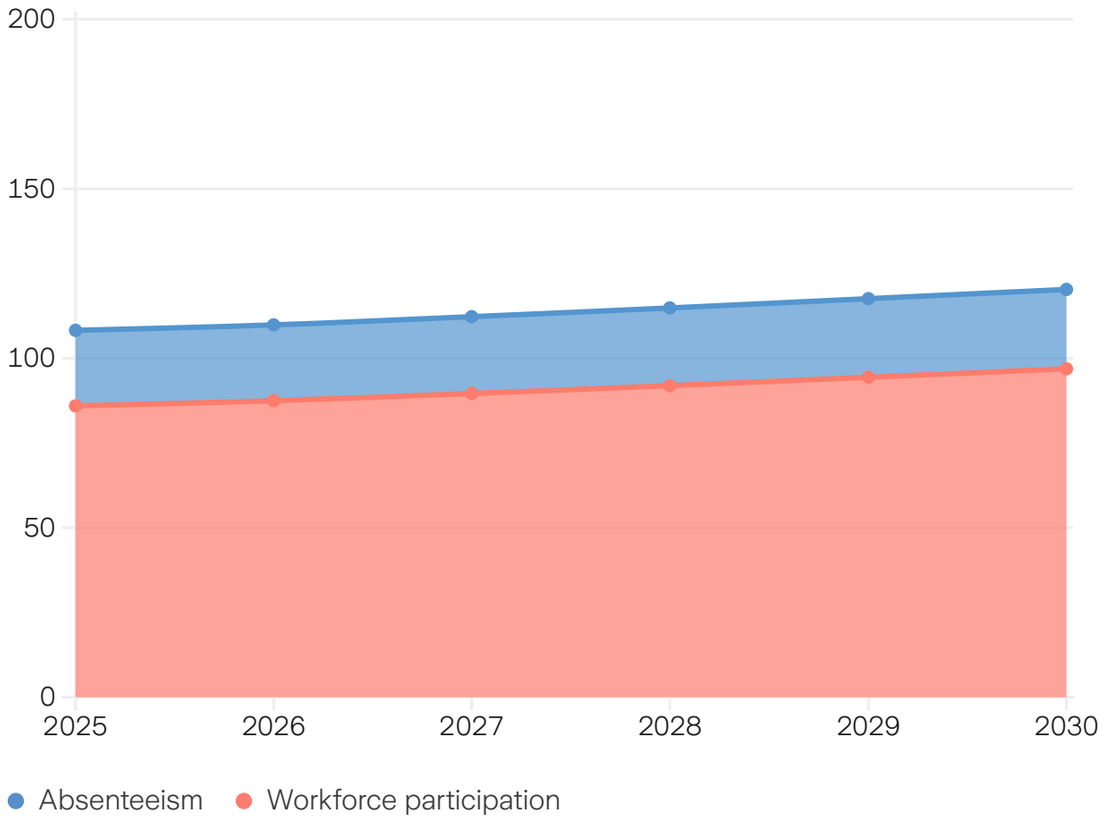
A wide and persistent employment gap

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

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

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

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



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

Absenteeism and presenteeism

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

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

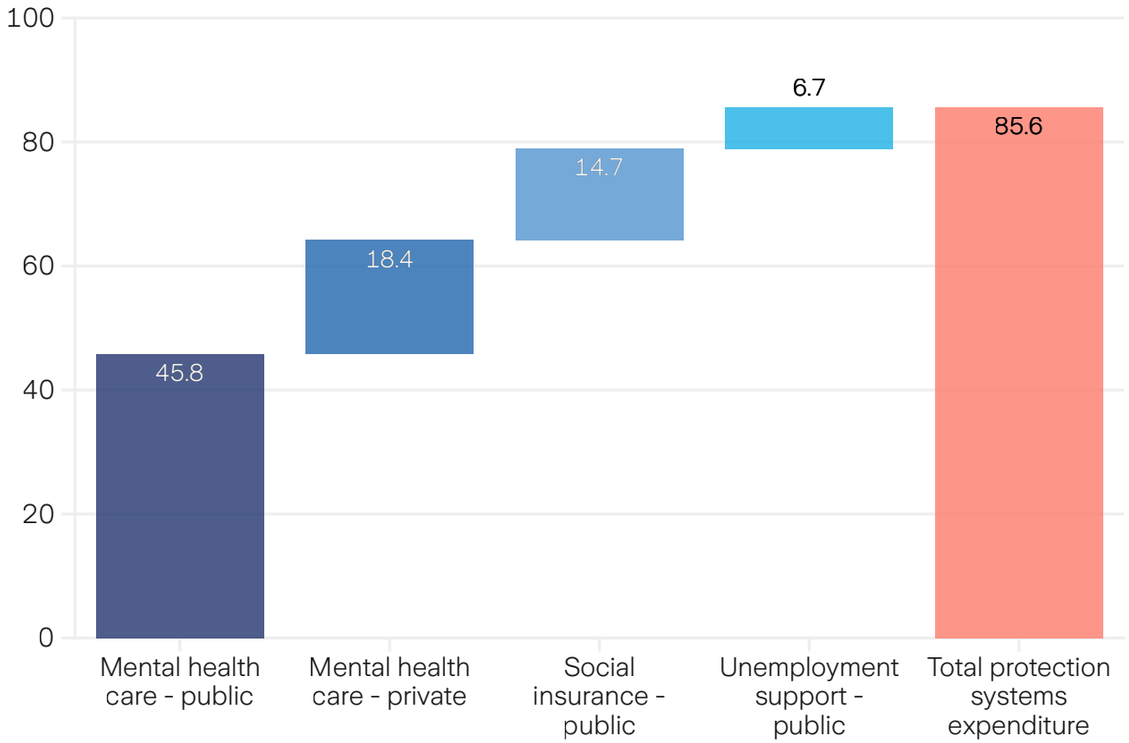
However, these figures do not account for presenteeism – when individuals continue to work while unwell and perform below their capacity. Consistent with patterns observed across the OECD, underreporting of mental illness among some adults suggests that presenteeism likely plays a significant, though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

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

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

Protection systems: Strong institutions but uneven delivery

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



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

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

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

A dual path system

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

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

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

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

Private access

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

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

A two-speed system

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

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

A hidden workforce of caregivers

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

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

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

Spotlight

FIT hospitals

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

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

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

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

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

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

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

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

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

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

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

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).

Germany

Productivity

Projections of employment-related impacts are based on:

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

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

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

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

Protection systems

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

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

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

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

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

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

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

Additional assumptions and limitations

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

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

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