ZURICH

The Value of Mental Health

Strengthening personal resilience across people, productivity, and protection systems

Country snapshot: **Malaysia**

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.

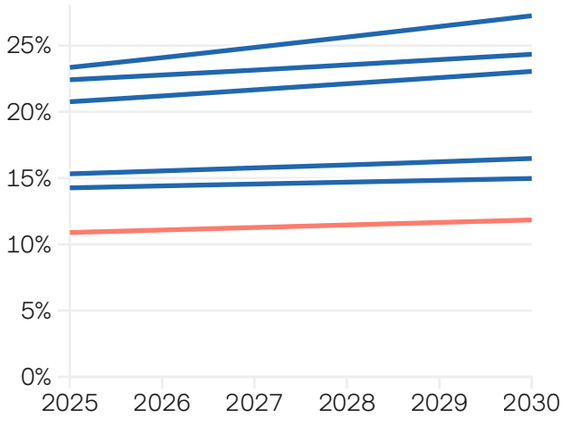
Refer to Data and methodology for a full overview of data sources, assumptions and calculations.

Malaysia

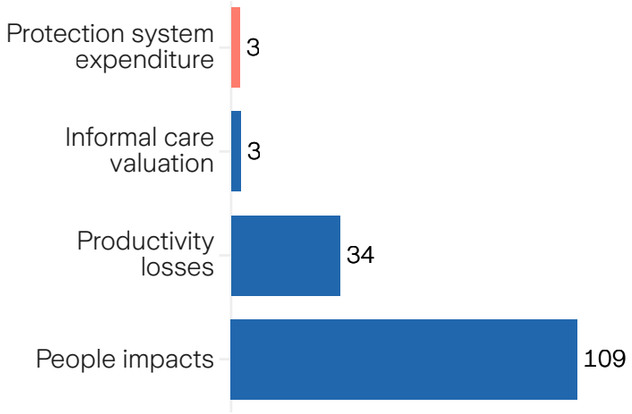
A private problem

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

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



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



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

Lower days of healthy life lost

62 days
of healthy life lost

Higher average employment gap

18%
employment gap

Lower average sick days

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

Higher out-of-pocket expenditure

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

Low annual hours of informal care

35 hours
of informal care received per year

Malaysia

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

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

Structural factors shape this pattern:

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

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

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

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

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

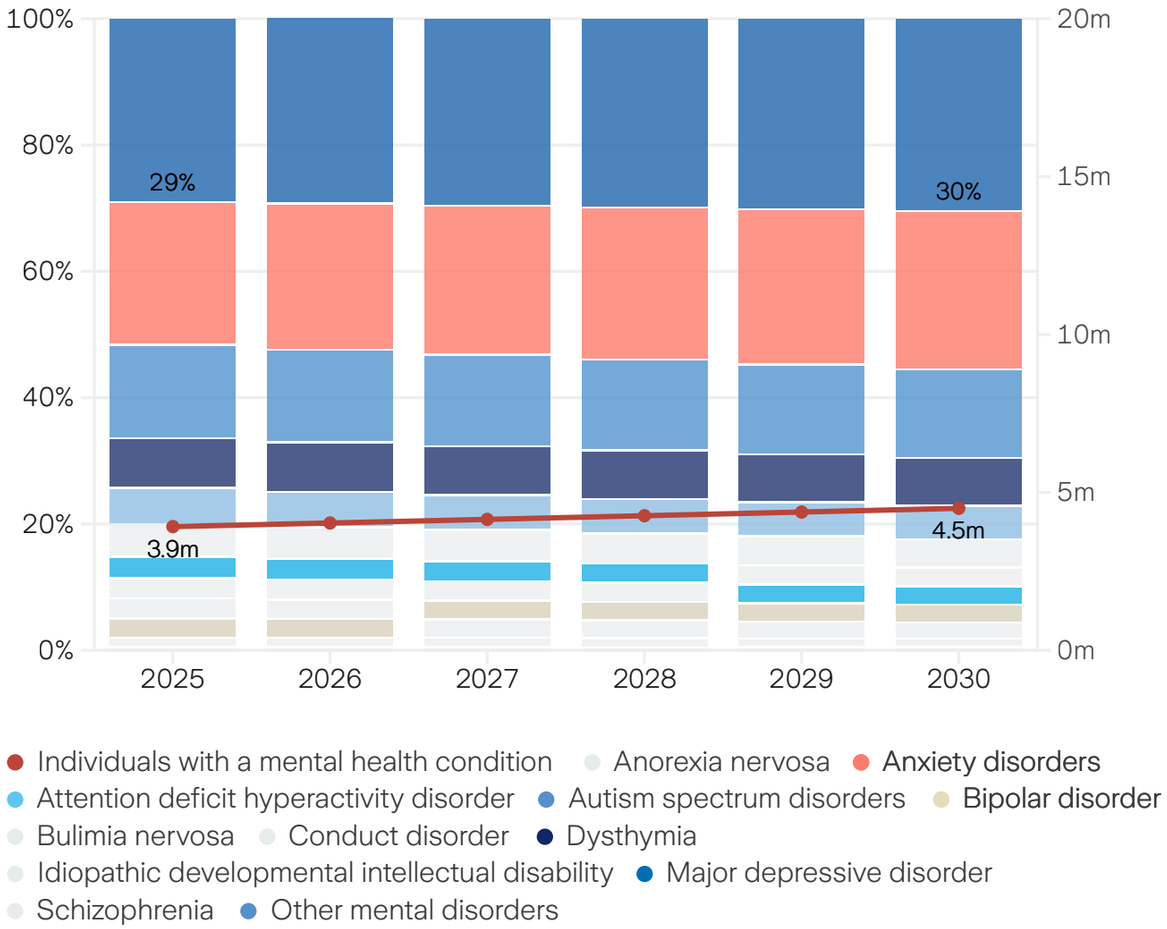
But a countervailing trend is now emerging. Reflecting recent policy emphasis on stigma reduction and expanded access beyond traditional clinical settings, digital and tele-mental health care services have expanded rapidly, enabling online counselling, tele-psychology and crisis support.[3] These models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

1 in 9

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

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

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



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

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

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

Hidden severity behind low prevalence

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

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

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

Generational divides

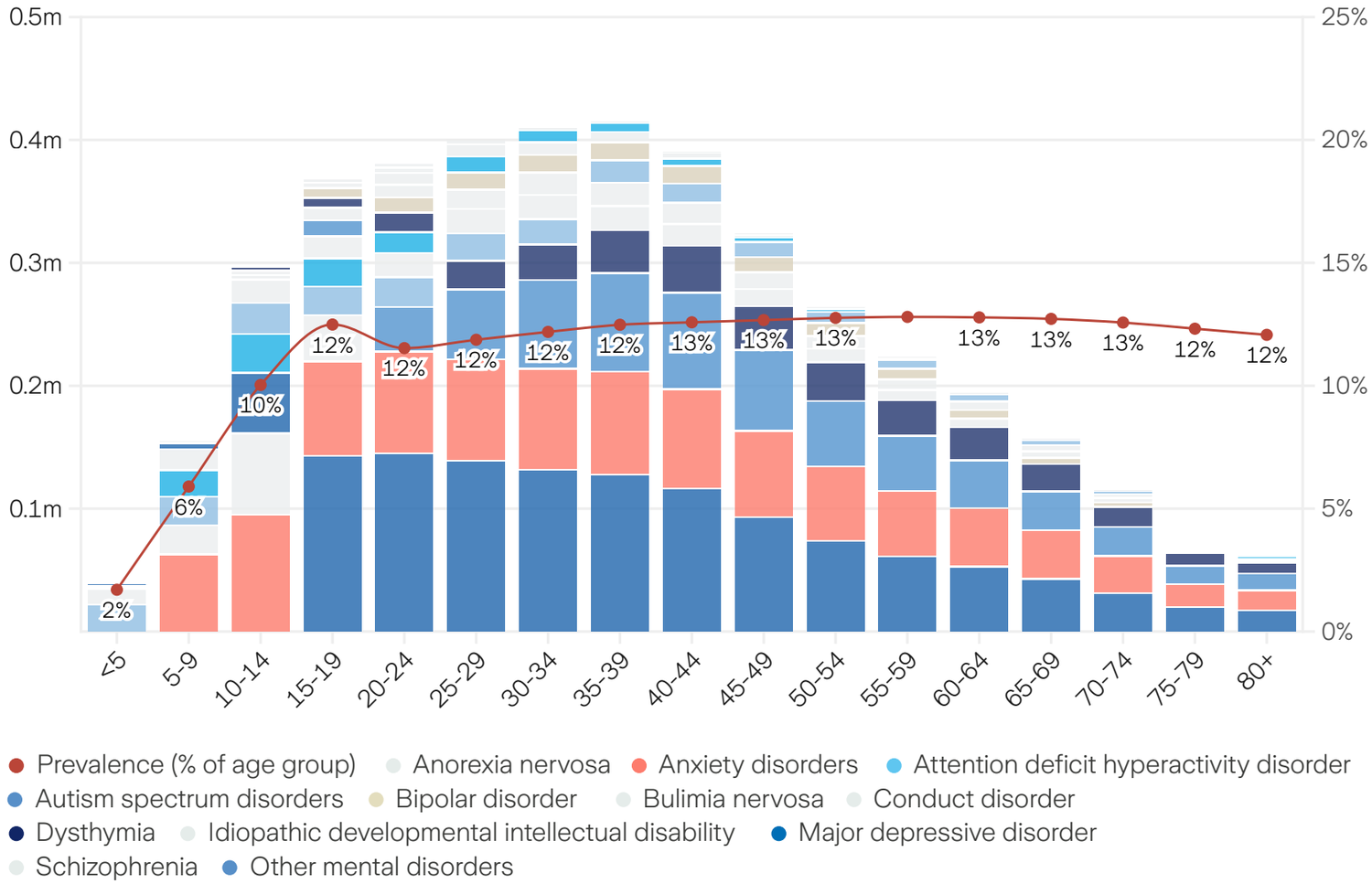
Despite widespread concern about the high prevalence of mental health conditions in children and young people, Malaysia does not yet show a sharp peak in prevalence among young adults. Recorded rates remain relatively consistent across age groups, reflecting similar access and stigma dynamics that limit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

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

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

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

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



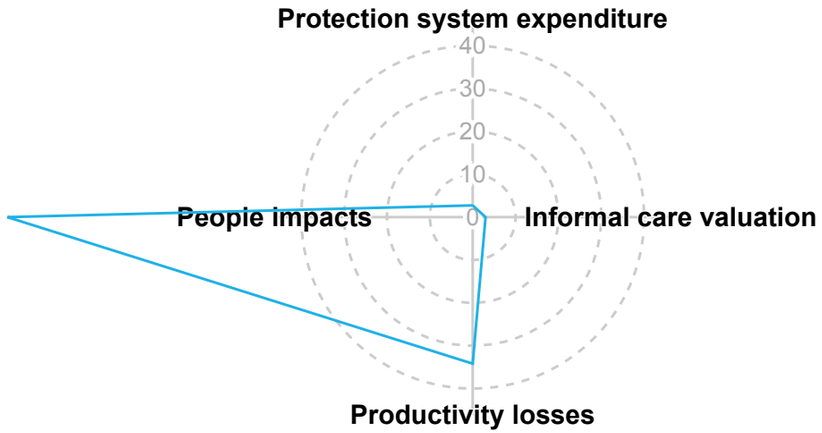
Primary sources: IHME (2025), World Bank (2025).

Projected prevalence by age group (%) includes comorbidities.

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

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

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



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

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

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

RM 34 billion
in reduced workforce participation and increased absenteeism.

RM 3 billion
in the value of informal care.

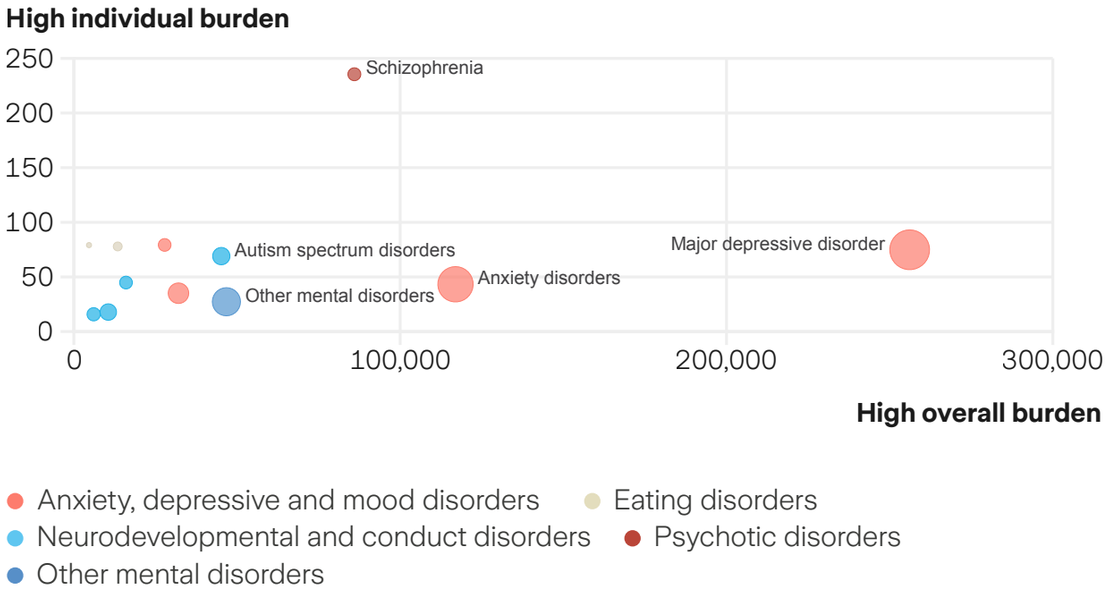
These figures represent the value that could be recaptured through more effective prevention, early intervention and sustained, continuous support.

People: Substantial wellbeing loss despite low recorded prevalence

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

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

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



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

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

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

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

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

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

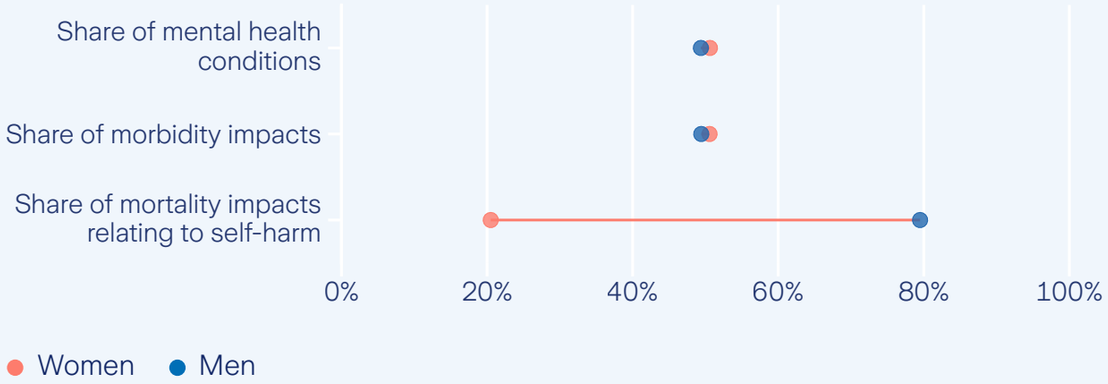
Gender divides in Malaysia

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

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

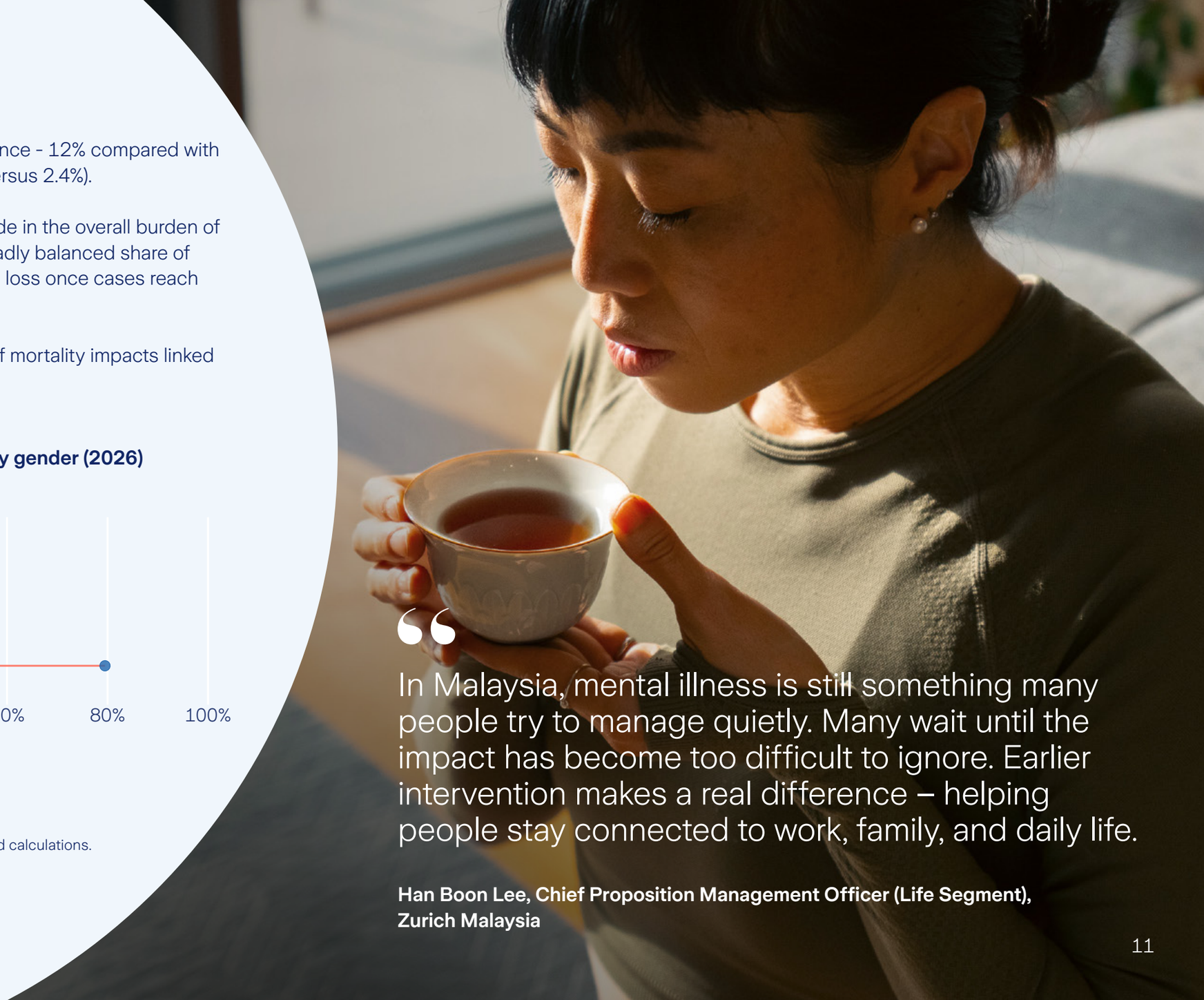
At the same time, men experience a disproportionate share of mortality impacts linked to suicide, mirroring trends observed in many markets.

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



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

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



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

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

Productivity: Economic losses driven by labor market disengagement

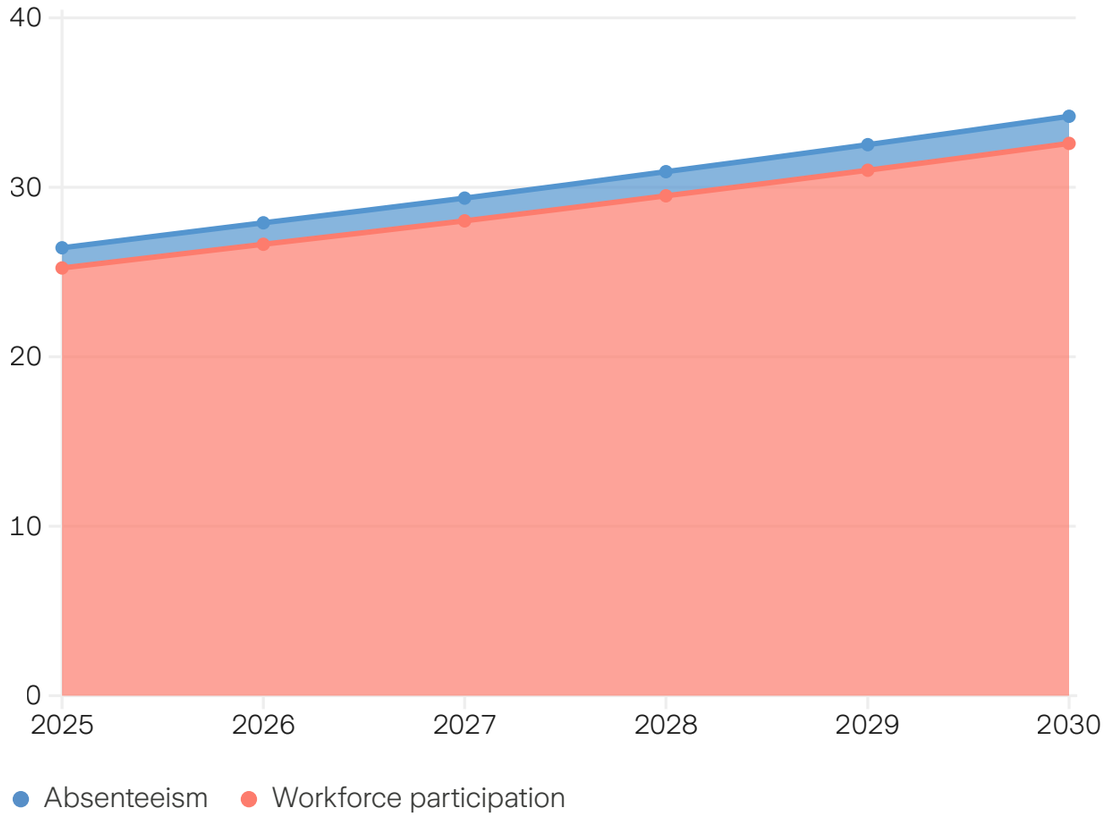
In 2026, mental health conditions are estimated to result in RM 28 billion in lost productivity due to absenteeism and reduced workforce participation, rising to around RM 34 billion by 2030 – equivalent to 1.4% of GDP.

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

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

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

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



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

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

Spotlight

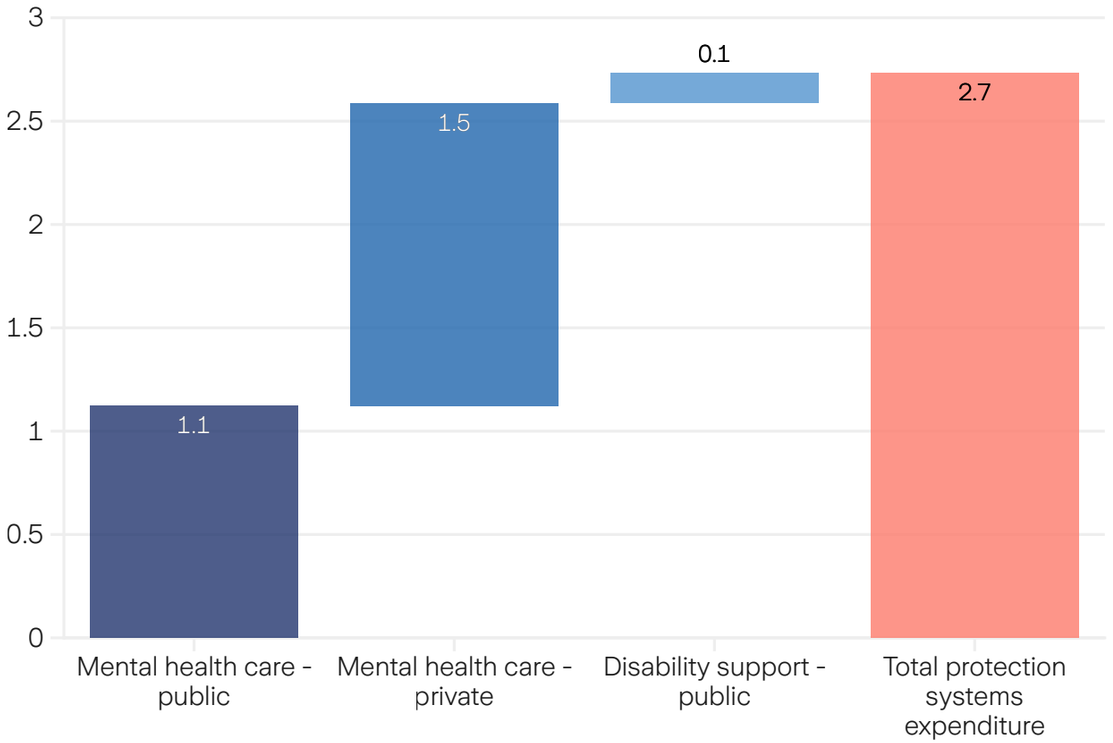
Tele-health as a bridge to earlier intervention

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

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

Protection systems: Public provision is constrained

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



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

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

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

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

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

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

Private spending strengthens a thin formal safety net

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

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

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

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

123 million hours

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

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

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

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

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

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

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

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

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

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).

Malaysia

Productivity

Projections of employment-related impacts are based on:

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

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

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

Average annual mental health sick days per worker	The difference in the proportion of sick leave days taken by workers with MHC compared to those without MHC.	• The average annual sick days per worker (employed population) are modelled as a weighted average across mental health status and assumed constant across the forecast period. • The OECD reports average annual sick days among workers, by mental distress rate. Calculations assume the sick day gap estimated using data aggregated by the OECD for mental distress is representative of diagnosed mental illnesses. • The OECD sick-day data measures days absent conditional on taking any sick leave. This is calibrated to an unconditional per-worker measure (i.e. averaged across all employed workers, including those with zero sick days) and the calibration is assumed to be appropriate. • Proportional sick-leave differentials are based on OECD definitions of mental distress and may not reflect gaps for diagnosed disorders. • The estimated differences reflect excess absenteeism associated with mental health status rather than causal effects.	AIA Vitality. Malaysia's Healthiest Workplace (2017).

Protection systems

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

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

- Other social services expenditure, with calculations including disability payments for MHC and pension payments.

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

Inputs	Definition	Methodology notes	Primary source(s)
Period adjustment (for projections to 2030)	Period adjustment (%) to extrapolate most recent data to 2030.	• Calculated based on projected prevalence and inflation. Inflation rate is calculated using historical CPI and inflation projections. • Expenditure projections assume a constant growth trajectory; estimates assume no change in the business cycle.	IHME (2025). World Bank (2025). IMF (2025).
Mental health care services	Total government budgeted expenditure on mental health services including psychiatry and mental health emoluments, services, and supplies.		Kementerian Kesihatan. Angarran Perbelanjaan Persekutuan (2025).

Pharmaceutical services related to MHC	Total pharmaceutical expenditure on MHC medicines and treatments.	• Calculated using the reported Total Pharmaceuticals Expenditures (TPE) estimation by the Ministry of Health. • The apportionment of spent to MHC is based on the proportion of psychiatry and mental health spending as a share of total budgeted health spending.	Kementerian Kesihatan. Estimation of Total Pharmaceutical Expenditure (TPE) Using National Health Accounts Framework Report 2018-2023 (2025).
Individual out-of-pocket expenses	Total out-of-pocket expenditure on general health, apportioned to MHC.	• The apportionment method used for pharmaceutical services was applied.	Kementerian Kesihatan. Malaysia National Helath Accounts, Health Expenditure Report 2011-2022 (2023).
Other private spending related to MHC	Total private spending by insurers, private entities and similar entities, corporations, and non-profit institutions serving households (NGOs) on general health, apportioned to MHC.		
Disability payments for MHC	Total disability payments apportioned to MHC.	• Total disability payments toward “disabled worker allowance,” “assistance for person with disability (PWD’s) incapable of work,” and “assistance for the carer of the bedridden PWD/chronically ill patients” (including non-MHC). • The proportion of mental health-related JKM OKU registrations as a share of total JKM OKU registrations was estimated using the cumulative number of registered persons with “Mental” disabilities in each state.	Kementerian Ekonomi. Person with disability statistics (2022).
Pension payments for MHC	Total benefit payments for Invalidity pensions and survivor’s pensions for all reasons (including non-MHC), apportioned to MHC.	• Estimated using the total Invalidity and Survivor’s cases reported for Mental Disorders.	Perkeso. Annual Report 2023 (2023).

Number of informal mental health caregivers	Total number of informal caregivers in Malaysia caring for people with MHC.	• Estimated using the share of adult population providing informal care (5.10%), multiplied by the proportion of care recipients that receive informal care due to a MHC (8.65%)	World Bank (2025). Jawahir et al. The impacts of caregiving intensity on informal caregivers in Malaysia: findings from a national survey (2021).
Total cost per informal MH caregiver	Replacement caregiver cost was estimated using the hourly value of unpaid care for people aged 15+ and people in situations of functional dependency.	• Estimated as the average pay rate plus additional salary on-costs (23%) and organizational overheads (20%). Pay rates were forecasted using real wage growth, estimated from IMF WEO and ILO ILOEST. • The total hours per week of informal care delivered by an informal caregiver to a person with a MHC was estimated using the average hours of informal care provided reported by survey respondents. • Categorical survey responses, such as "1–19 hours" or "20+ hours," were interpreted using the midpoint of each range. For unbounded categories, the midpoint was assumed to be 50% higher than the lower bound.	Kementerian Ekonomi. Banci Ekonomi 2023 – Statistik Pekerja Dan Gaji & Upah (2025). IMF (2025). ILO 2025). Jawahir et al. (2021).

Additional assumptions and limitations

- An exchange rate of USD-MYR of 4.03 was applied (January 2-30 2026 period average).[1]
- A VLY of USD 35,000 was applied.

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

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