ZURICH

The Value of Mental Health

Strengthening personal resilience across people, productivity, and protection systems

Country snapshot: **The UAE**

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.

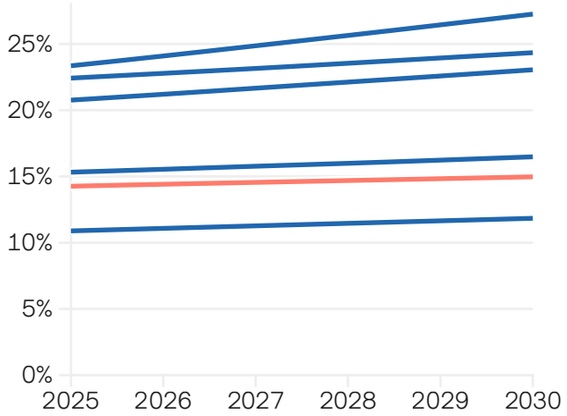
Refer to Data and methodology for a full overview of data sources, assumptions and calculations.

The UAE

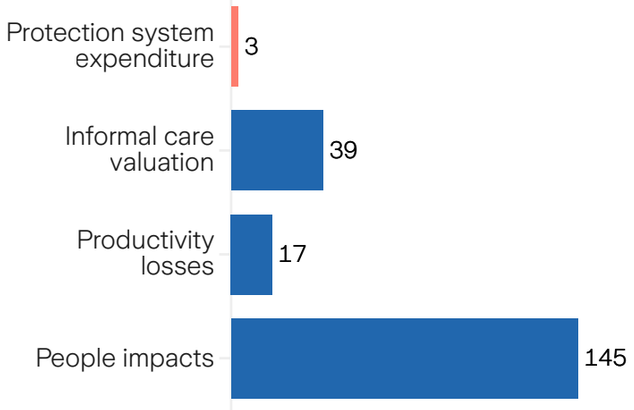
Mental health is more visible, but still managed privately

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

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



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



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

Higher days of healthy life lost

66 days
of healthy life lost

Low average employment gap

8%
employment gap

Low average sick days

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

Higher out-of-pocket expenditure

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

High annual hours of informal care

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

● UAE

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

Prevalence: A strong policy foundation prioritizing early identification and access

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

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

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

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

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

1 in 10

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

This figure does not account for comorbidities.

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

Spotlight

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

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

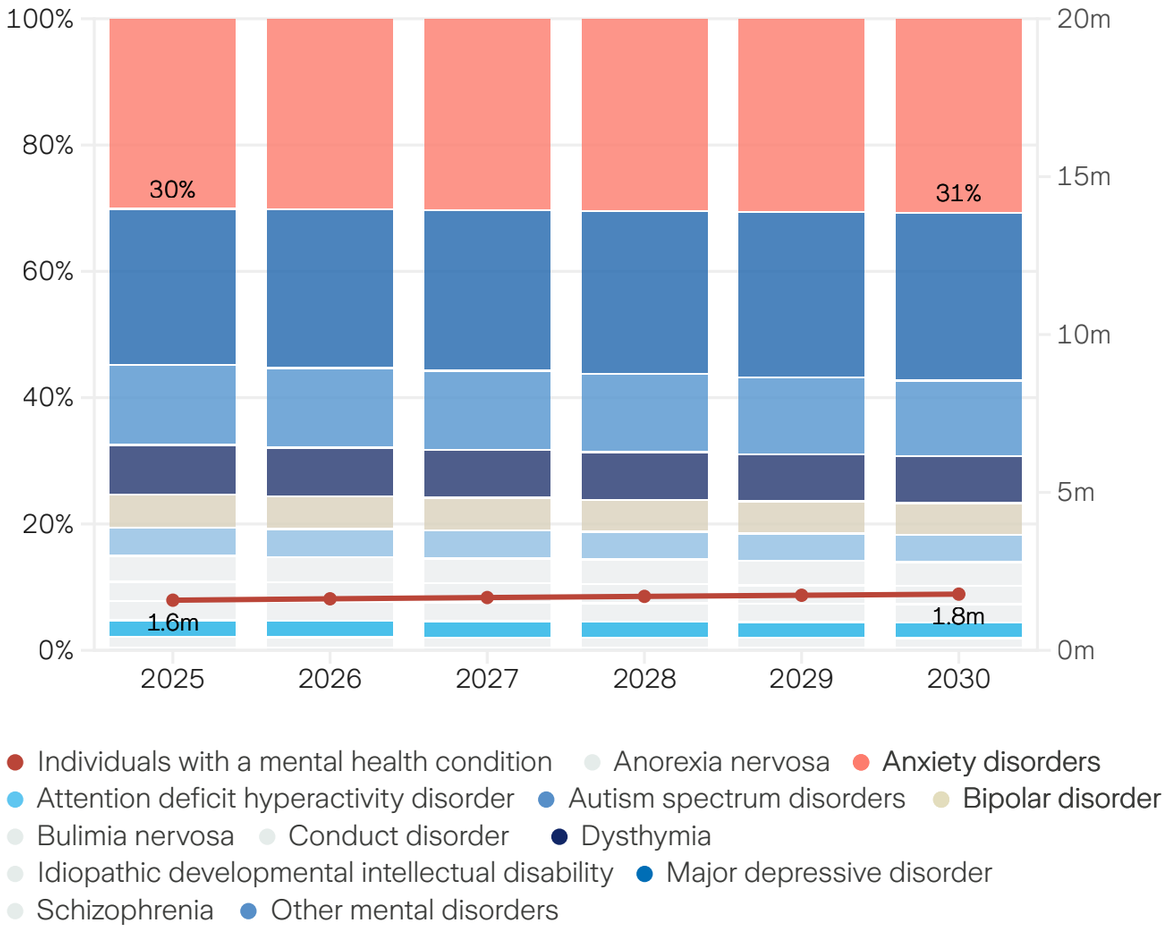
The government has expanded free mental health support, including 24/7 hotlines like HOPE, and specialist clinics such as Aspris and The Lighthouse Arabia, offering care for anxiety, depression, and trauma. New apps and digital tools also make mental health resources more accessible.

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

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

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

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



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

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

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

Cases are growing following global trends, but remain comparatively contained

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

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

Generational gaps

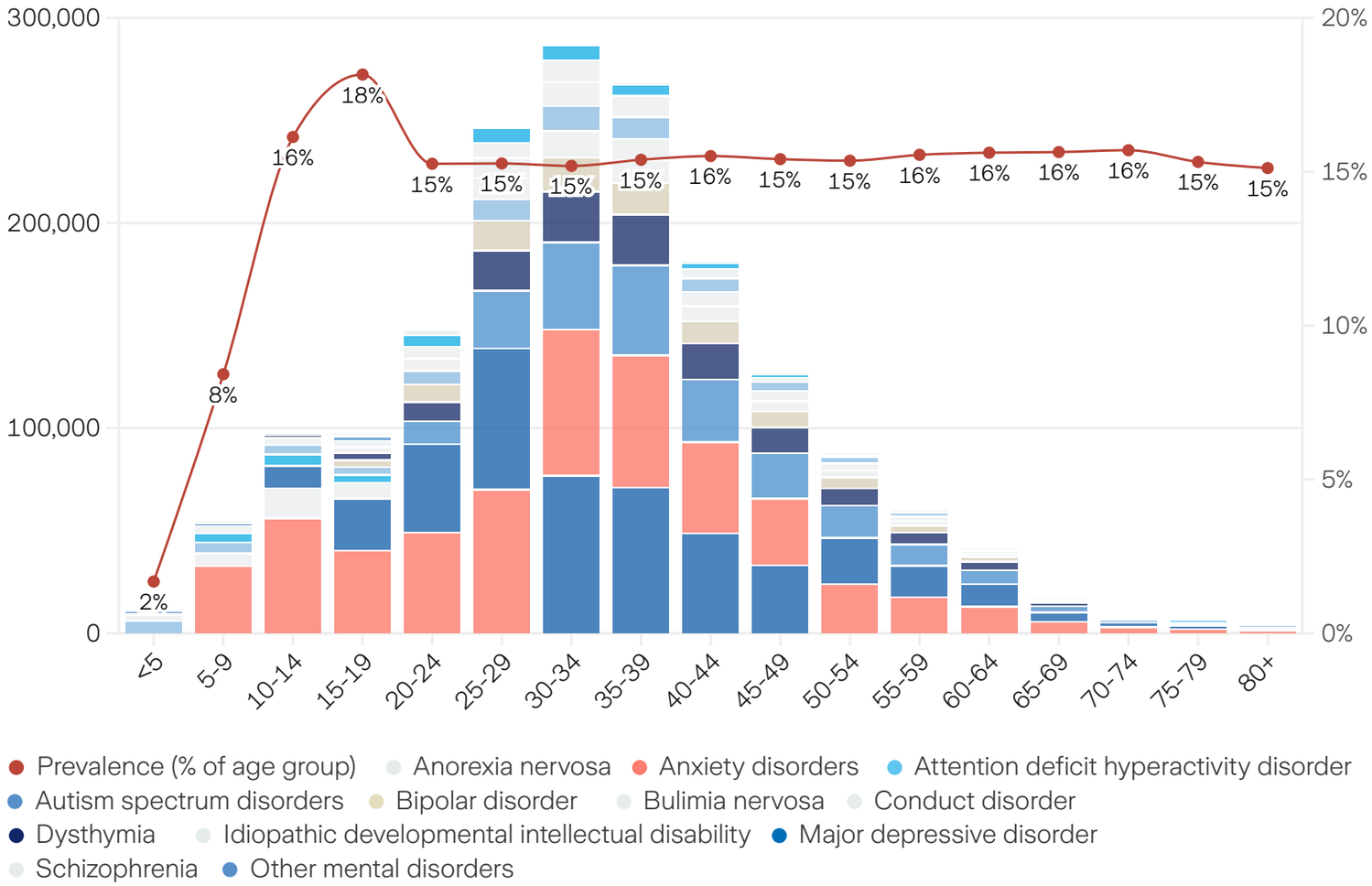
Prevalence is highest among teenagers, at 16% and 18% among 10- to 14-year-olds and 15- to 19-year-olds, respectively.

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

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

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

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



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

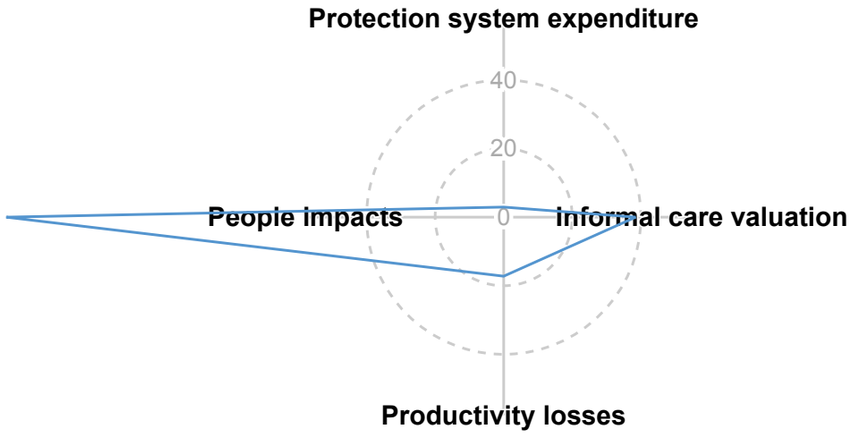
Projected prevalence by age group (%) includes comorbidities.

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

But prevalence provides only a partial view of the national picture

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

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



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

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

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

AED 17 billion
in reduced workforce participation and increased absenteeism.

AED 39 billion
in the value of informal care.

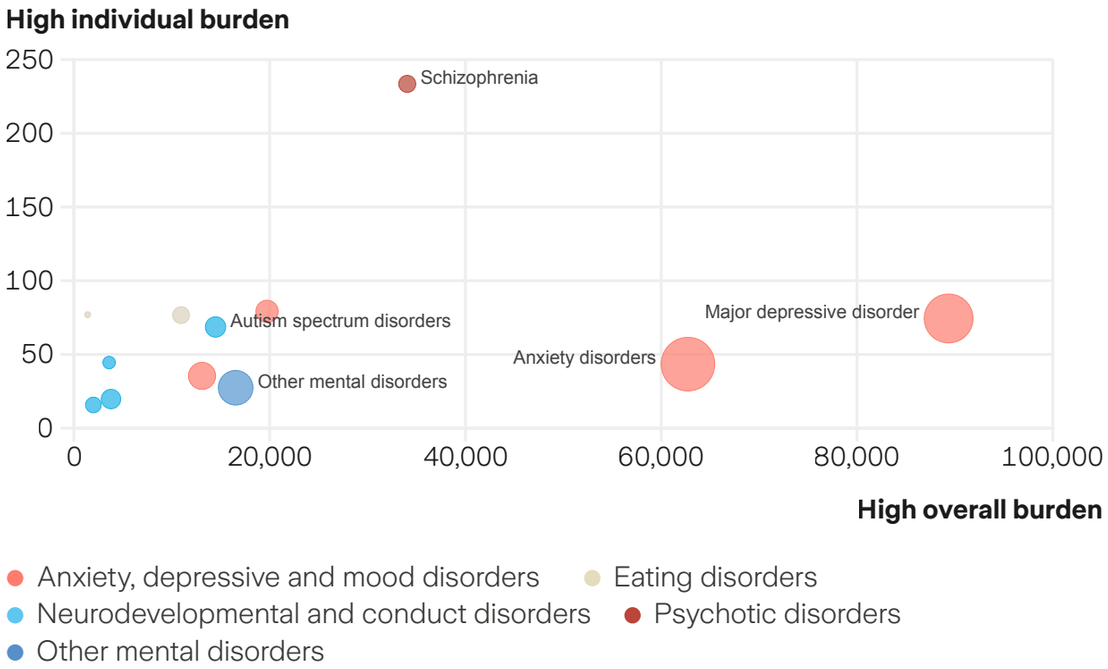
Taken together, these figures represent the annual opportunity cost of mental health conditions – or, put differently, the value that could be recaptured through more effective prevention, early intervention and sustained support.

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

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

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

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



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

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

Wellbeing impacts are driven by both scale and severity

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

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

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

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

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

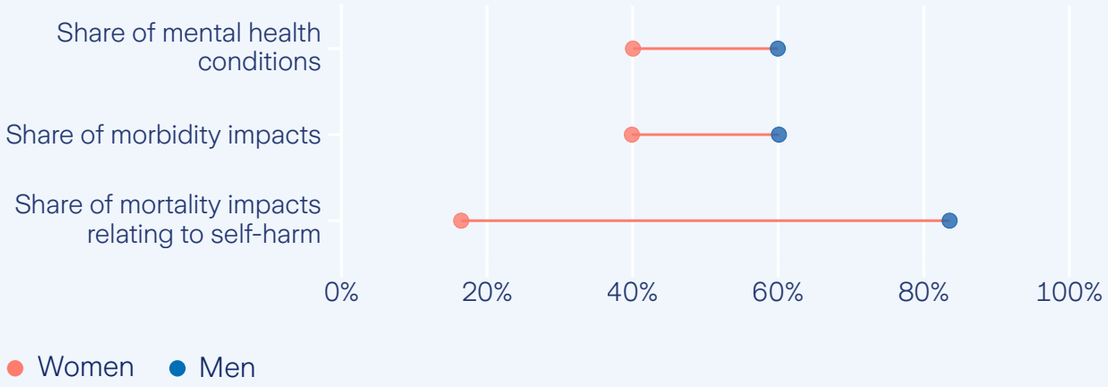
3. Includes self-harm. A value of a statistical life year of USD 127,000 has been applied.
4. UAE. Mental health (2026); ADPHC. Mental health (2023).

Gender divides in the UAE

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

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

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



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

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

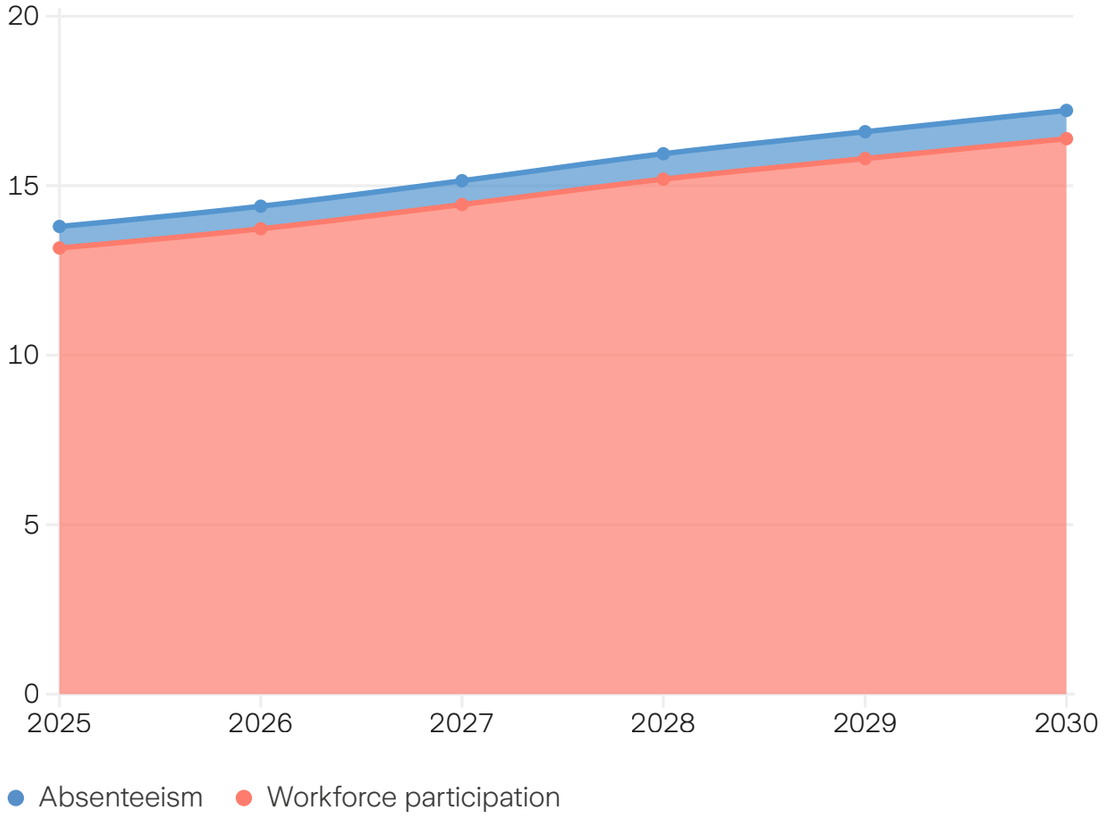
Productivity: Lost economic potential

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

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

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

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



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

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

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

Workforce participation is the larger – and less visible – challenge

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

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

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

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

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

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

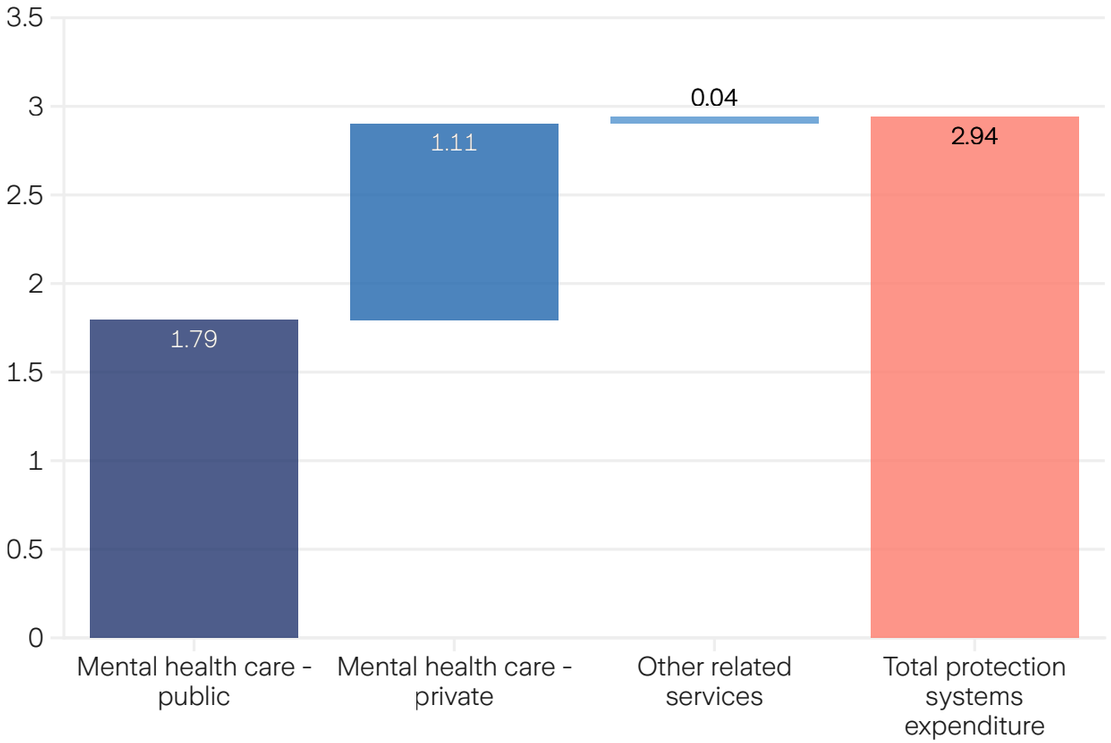
Counseling has become a cornerstone of mental health support in the UAE, with employers increasingly including it in health insurance plans. Post-COVID awareness and progressive legislation have spurred insurers to offer comprehensive coverage. This reflects a strong national commitment to holistic wellbeing.

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

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

Protection systems: Family as frontline support

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



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

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

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

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

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

Informal care carries the load

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

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

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

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

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

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

Reliance on informal networks carries several implications:

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

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

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

1.7 billion hours

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

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

Dr Khatchik Kinoyan, Chief Underwriter, Zurich Middle East

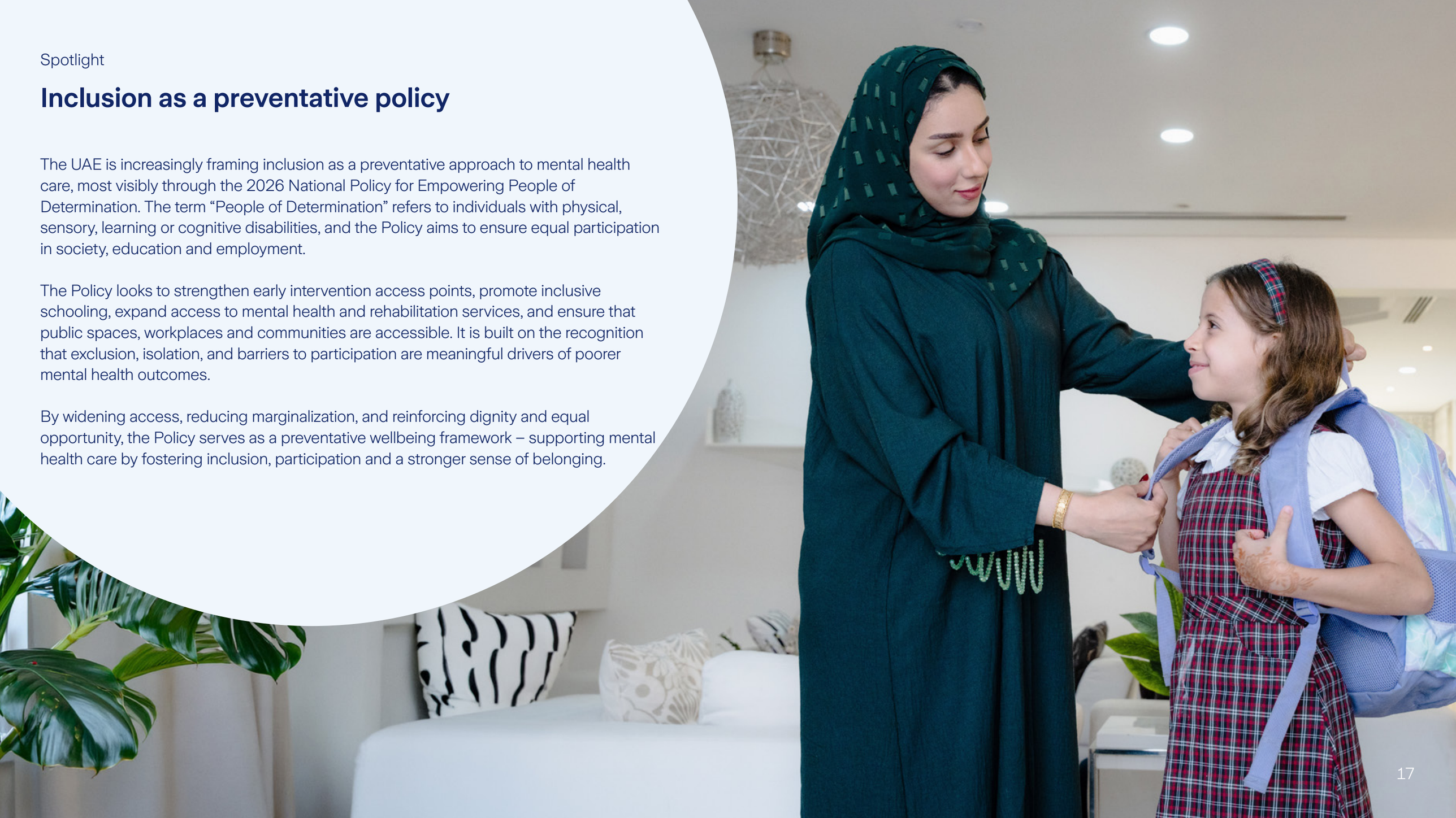
Spotlight

Inclusion as a preventative policy

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

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

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



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

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

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

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

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

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

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

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).

Productivity

Projections of employment-related impacts are based on:

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

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

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

Average annual mental health sick days per worker	The difference in the proportion of sick leave days taken by workers with MHC compared to those without MHC.	• Baseline sick leave from proxy countries (Saudi Arabia / Qatar) focuses on limited professions and may not reflect the UAE's labor market. • The OECD reports average annual sick days among workers, by mental distress rate. Calculations assume the proportional sick day gap estimated using data aggregated by the OECD for mental distress is broadly representative of diagnosed mental illnesses. • The OECD sick-day data measures days absent conditional on taking any sick leave. This is calibrated to an unconditional per-worker measure (i.e. averaged across all employed workers, including those with zero sick days) and the calibration is assumed to be appropriate. • Proportional sick-leave differentials are based on OECD definitions of mental distress and may not reflect gaps for diagnosed disorders. • The estimated differences reflect excess absenteeism associated with mental health status rather than causal effects.	Elabd et al. Sick Leaves Pattern in a Tertiary Healthcare Facility in Saudi Arabia (2020). Nuaimi et al. Sickness absenteeism among primary health care workers in Qatar before and during the COVID-19 pandemic (2023).

Protection systems

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

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

- Other social services expenditure.

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

Inputs	Definition	Methodology notes	Primary source(s)
Period adjustment (for projections to 2030)	Period adjustment (%) to extrapolate most recent data to 2030.	• Calculated based on projected prevalence and inflation. Inflation rate is calculated using historical CPI and inflation projections. • Expenditure projections assume a constant growth trajectory; estimates assume no change in the business cycle.	IHME (2025). World Bank (2025). IMF (2025).
General health expenditure	Total government expenditure and compulsory contributory health care financing expenditure, apportioned to MHC.	• Proportion of spending related to mental health care/treatment was estimated using the Dubai Health Authority's reported spending for Major Diagnostic Categories (MDCs).	Federal Competitiveness and Statistics Centre. Health Services 2023 (2023). Dubai Health Authority, Health accounts system of Dubai (2022).

Pharmaceutical services	Total drugs and supplies cost for MHC-related clinical services.	• Includes anxiety disorders, depression, psychosis and attention disorders reported by UNDP, but epilepsy, developmental disorders, conduct disorders, and alcohol use have a reported zero value.	World Health Organization. The cost of health services delivered at primary care facilities in the United Arab Emirates (2023).
Private health insurer spending	Total expenditure from voluntary health insurance and compulsory private insurance related to health, apportioned to MHC.	• The apportionment method used for health services expenditure was applied.	Federal Competitiveness and Statistics Centre (2023).
Out-of-pocket expenses	Total household out-of-pocket expenses for health services and domestic private health expenditure, apportioned to MHC.		
Other social services expenditure	Total budget allocation for social protection, apportioned to MHC.	• The apportionment method used for health services expenditure was applied.	UAE Government – Ministry of Community Empowerment, Social Protection Budget (2024).
Hours of informal care for MHC	Total hours of informal care provided to people with MHC	• Total hours of informal care is estimated using the total population aged 15 and above, multiplied by the average weekly caregiving hours per person estimated by ILO (2019). • Total hours per week of informal care delivered by the average person in the UAE was estimated using the average hours of informal care provided (including community, caregiving, and domestic services) multiplied by the proportion of informal care apportioned to caregiving services only. • Total population in UAE aged 15 and above is based on historical and forecasted values from World Bank. Total number of MH carers is not estimated as the ILO reports caregiving hours as an average across the entire population.	World Bank (2025). ILO. The Unpaid Care Work and the Labour Market. An analysis of time use data based on the latest World Compilation of Time-use Surveys (2019).

Replacement cost per hour	The value of unpaid care using the replacement cost approach. Valued at the cost of employing a formal carer to replace an informal carer.	• Replacement carer cost was estimated using the average salary for caregivers from Indeed (2026), and the Domestic Worker Wage Schedule from MoHRE Tadbeer (2025). • Estimated as the average of pay rates plus additional salary on-costs (23%) and organisational overheads (20%). Pay rates were forecasted using real wage growth, estimated from IMF WEO and ILO ILOEST.	Diminic et al. (2017). Indeed. Caregiver salary in UAE (2026). MoHRE Tadbeer (accessed 2025) IMF (2025). ILO (2025).

Additional assumptions and limitations

- An exchange rate of USD-AED of 3.67 was applied (January 2-30 2026 period average).[1]
- A VLY of USD 127,000 was applied.

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

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