ZURICH

The Value of Mental Health

Strengthening personal resilience across people, productivity, and protection systems

Country snapshot: **The UK**

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 behavioural 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, labour 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 analysed 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.

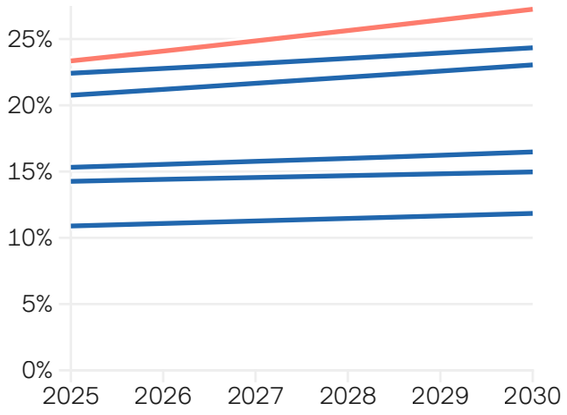
Refer to Data and methodology for a full overview of data sources, assumptions and calculations.

The UK

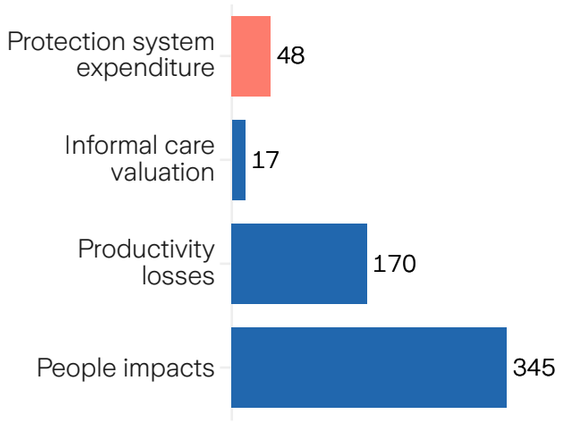
A disrupted transition from education to employment

This section brings together the latest data, modelling, and policy analysis to understand the scale, drivers, and implications of mental health conditions in the UK. 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 more than 1 in 4 people living in the UK (27%)



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



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

Lower days of healthy life lost

63 days
of healthy life lost

High average employment gap

29%
employment gap

Lower average sick days

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

Lower out-of-pocket expenditure

18%
of treatment costs covered by out-of-pocket expenditure

Lower annual hours of informal care

51 hours
of informal care received per year

UK

Prevalence: Mental illness is emerging before work begins

Mental health conditions are among the UK's most significant public health and economic pressures. By 2030, an estimated 32% of working-age adults will be living with a mental health condition – the highest prevalence of any of the six markets analyzed.

In part, this reflects earlier recognition across a broader spectrum of severity, supported by long-established primary care pathways, widespread screening, strong cultural openness, and expanding routes into support through schools, workplaces, and digital platforms.

Earlier recognition brings clear benefits for treatment. But in the UK, mental health conditions are being detected at younger ages and growing faster among adolescents than any other group. If current trends continue, by 2030, nearly two in three (64%) of 15- to 19-year-olds are projected to be living with a mental health condition, alongside three in ten (30%) of 10- to 14-year-olds.

Conditions are increasingly diagnosed before individuals even enter the labour market, and the consequences are already visible. Nearly one million young people (13% of those aged 16 to 24) are currently not in education, employment, or training (or "NEETs")[1] – the highest level in five years. Many young people now experience mental health challenges that prevent labour market entry altogether, meaning they never build skills, confidence, and work experience that support long-term participation. This dynamic is reshaping the foundations of the future workforce and amplifying long-term productivity losses.

Policy attention has shifted accordingly. The *Keep Britain Working Review* has placed economic inactivity at the center of the mental health agenda, alongside expanded access to NHS Talking Therapies and early intervention programmes.

The UK's main challenge is no longer about recognising mental illness,[2] but ensuring that early identification does not become early exclusion, by linking recognition to pathways that preserve participation before disruption hardens into long-term inactivity.

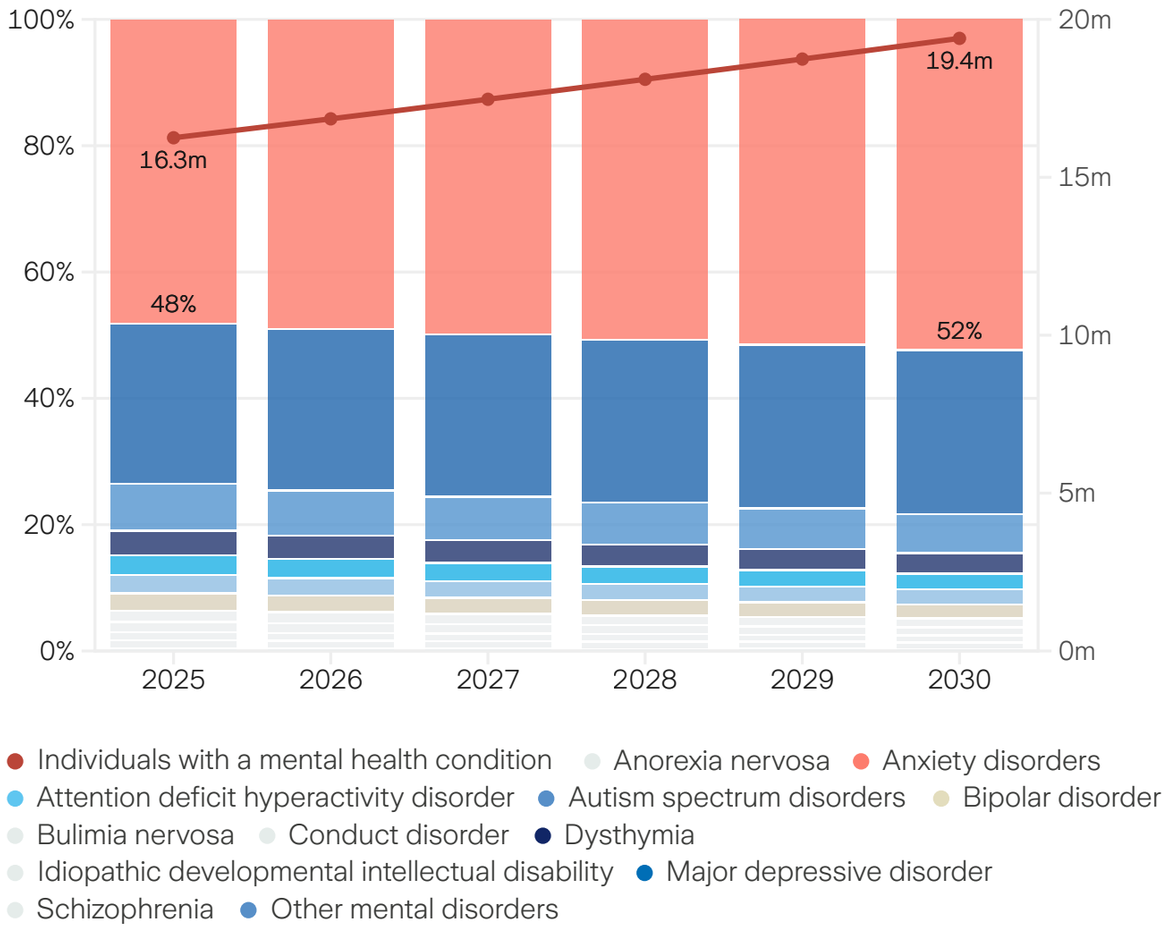
1 in 4

people in the UK (27%) are projected to be living with a mental health condition by 2030.

1. Office for National Statistics (ONS). Young people not in education, employment or training (NEET) (2026).
2. Recognising that up to a third of adults in certain segments of the population, including men, minority ethnic groups, and low-income households, remain undiagnosed: Morris, S. et al. (2025) Adult Psychiatric Morbidity Survey – Survey of Mental Health and Wellbeing, England, 2023/4.

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

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



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

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

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

Anxiety is driving functional disruption

Nearly 17 million people (24% of the total population) are estimated to currently live with a mental health condition, rising to over 19 million (27%) by 2030 – the fastest average annual growth rate among all markets analysed at 3.6%.

This acceleration likely reflects both heightened risk drivers, such as sustained socioeconomic pressure, as well as improved detection of long-standing and neurodevelopmental conditions.

Anxiety disorders (49%) and major depressive disorder (26%) account for most recorded cases in 2026. This pattern is characteristic of high-visibility systems, where early help-seeking, a strong primary care role, and cultural openness draw mild, episodic, and situational distress into formal pathways alongside more persistent conditions.

As in Australia, anxiety therefore functions as a marker of how early and broadly the system identifies need. This broad visibility is a strength in principle, enabling stabilisation before deterioration. But it also drives sharp increases in demand for psychological therapies, contributing to rising wait times and uneven access.

The UK's youth profile is the most pronounced of the countries examined

Prevalence is highest in late adolescence and early adulthood, driven by a combination of reduced stigma, social media exposure, academic pressure, economic uncertainty, and strong engagement through schools and universities. Young people are reaching services before or during key life-stage transitions: education to work, early employment, and first independent living.

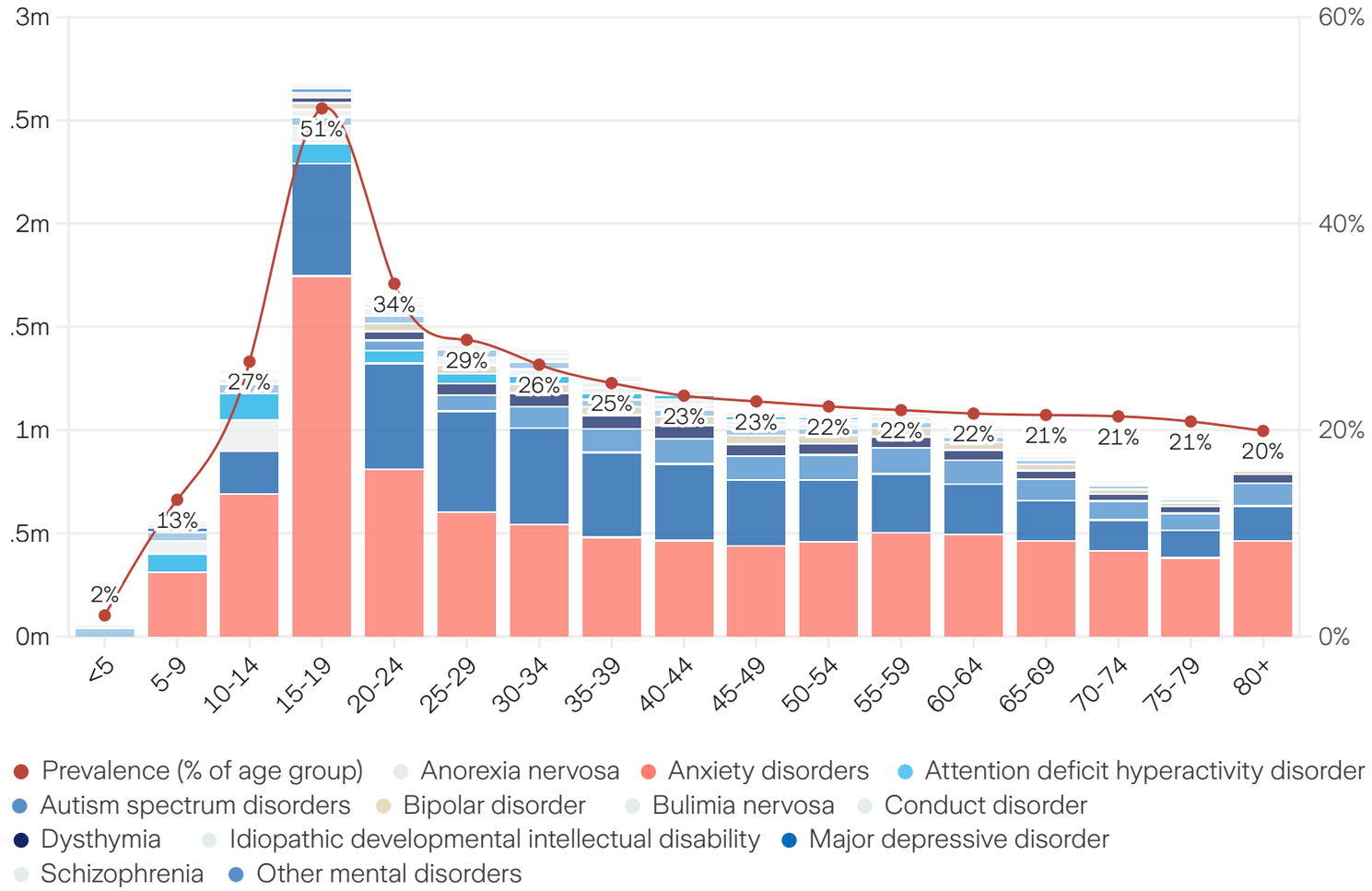
When support at these moments is delayed or fragmented, early symptoms can easily turn into disrupted participation, prolonged recovery, or repeated cycles of disengagement.

> The rise in youth mental health care needs is the start of a wave that will shape the UK's workforce for a generation. Acting early is the only way to stop today's challenges from becoming tomorrow's crisis.

Peter Hamilton, Head of Market Engagement, Zurich UK Life

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

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



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

Projected prevalence by age group (%) includes comorbidities.

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

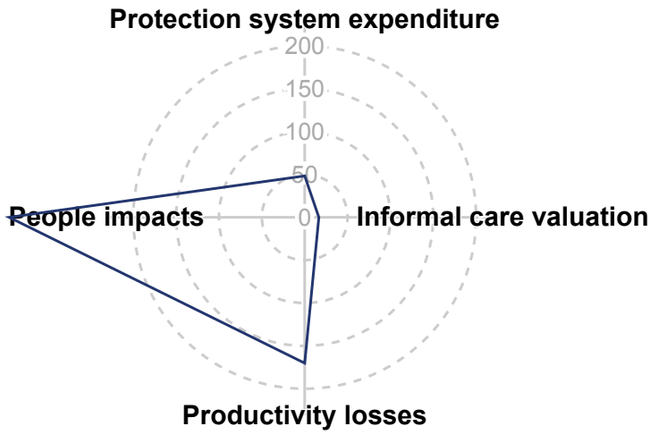
A high awareness, early identification market

These dynamics give the UK a distinct prevalence signature: high visibility, high anxiety burden, sharply rising youth demand, and clinical capacity that is struggling to expand at the same pace.

The challenge is not only recognizing need – which the UK does earlier and more comprehensively than most peers – but connecting recognition to timely, proportionate pathways that prevent early-stage distress from derailing participation.

Because prevalence alone does not capture how mental health conditions shape daily functioning and long-term system demand.

UK: Estimated impacts on people, productivity and protection systems (2030)
GBP billion



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

By 2030, despite an estimated GBP 48 billion (1.5% of GDP) in combined public and private expenditure on mental health support and protection, mental health conditions are projected to result in around:

GBP 345 billion
in wellbeing losses related to morbidity and mortality.

GBP 170 billion
in reduced workforce participation and increased absenteeism.

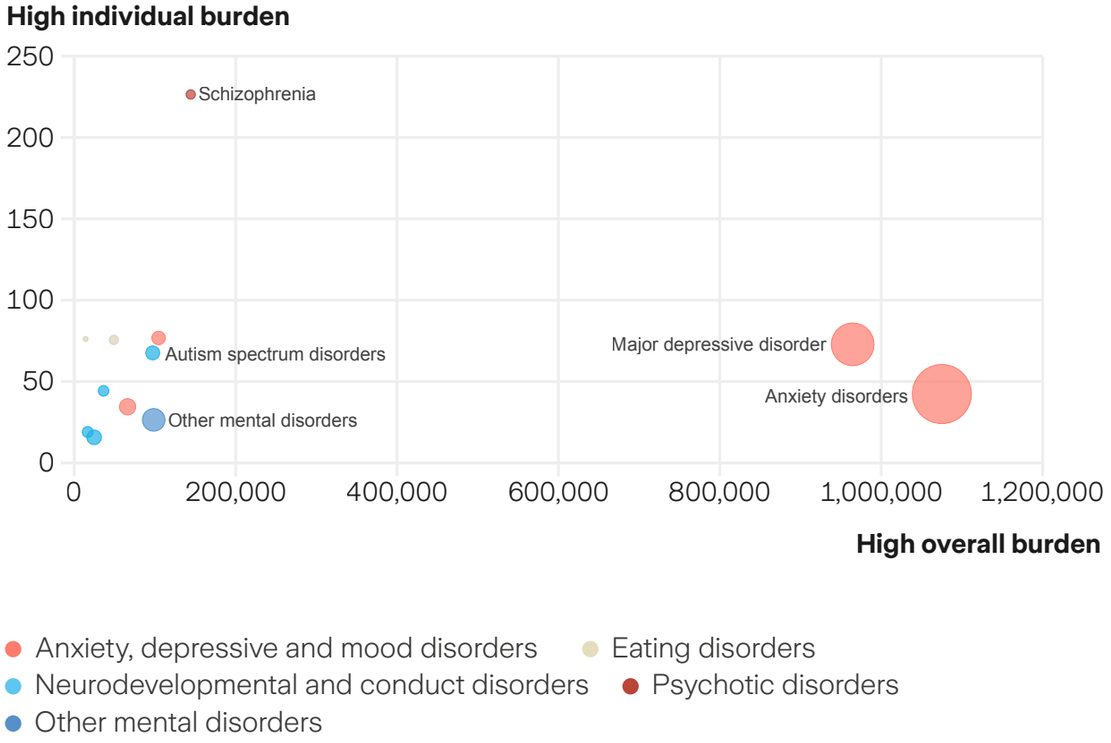
GBP 17 billion
in the value of informal care.

These projected losses illustrate the scale of value foregone each year as mental health conditions limit participation, productivity, and wellbeing – and underline the potential returns from early intervention, strong youth-focused support, and sustained return-to-work support.

People: Common conditions dominate cumulative loss

Wellbeing loss captures the personal impact of mental health: the days when a person cannot function at their usual capacity, the years spent managing persistent symptoms, and the moments when mental health challenges disrupt work, learning, relationships, and daily life.

UK: 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.

In 2026, the average person living with a mental health condition or self-harm is estimated to lose 62 days of healthy life annually, contributing to nearly 3 million years of healthy life lost nationwide, valued at GBP 298 billion.[3] The vast majority of this is driven by morbidity (92% in 2026).

Two patterns shape the UK's profile:

- **Higher prevalence conditions:** Anxiety disorders are the single largest contributor, responsible for over 1 million years lived with disability in 2026. Alongside major depressive disorder – which affects fewer people but with a higher average daily impairment – these conditions account for three-quarters (76%) of total morbidity.

- **Higher severity conditions:** Autism, bipolar disorder, eating disorders, and schizophrenia make up around 8% of cases, but contribute 15% of total morbidity, reflecting their highly impairing nature.

Mirroring prevalence patterns, wellbeing loss is highest among younger working-age adults, peaking at around 64 days lived with disability per year for females aged 25 to 29 (62 days for men). This is when skills, confidence, and labour market attachment normally consolidates – meaning early impairment can have long-lasting effects on earnings, progression, and participation.

The consequences extend beyond health. People with a mental health condition are 9.3 times more likely to find life "difficult financially" and 3.6 times more likely to fall behind on bills.[4] For those already facing housing insecurity or fragmented employment, these pressures can compound.

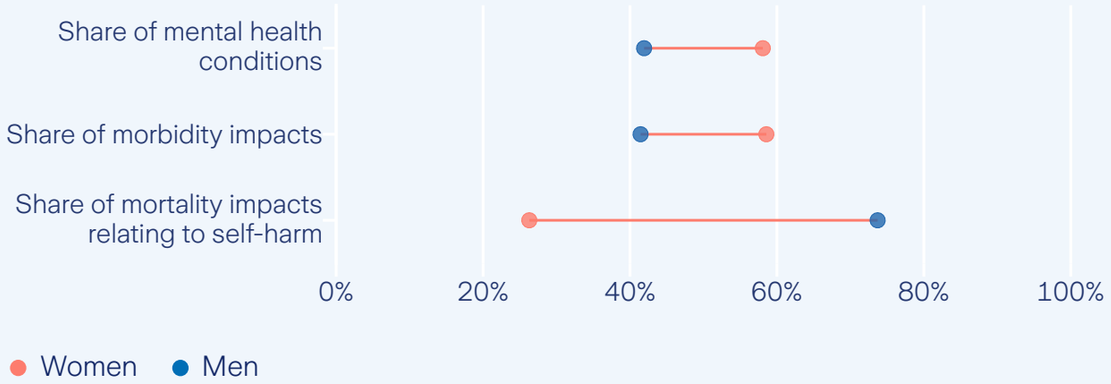
For the UK, managing scale without obscuring severity will be critical – reducing the cumulative impact of common conditions early, while ensuring specialist capacity for those with severe or complex conditions. Left unaddressed, these individual-level losses can harden into lasting disadvantage.

3. A value of a statistical life year of USD 144,000 has been applied and converted into GBP to reflect local conditions.
4. Money and Mental Health Policy Institute. Always on your mind (2024).

Gender divides in the UK

Women exhibit higher overall prevalence of mental health conditions (27% compared with 20% among men), faster average annual growth (4% versus 3%), and account for a larger share of the total disease burden and wellbeing impacts. Men, by contrast, experience more severe downstream consequences, bearing a disproportionate share of mortality impacts linked to suicide.

UK: 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: Employment impacts set to exceed 5% of UK GDP by 2030

Mental health conditions represent one of the most serious and sustained threats to UK productivity. Combined lost wages from reduced participation and higher absenteeism are estimated at GBP 141 billion in 2026 (around 4.5% of GDP), rising to GBP 170 billion by 2030.

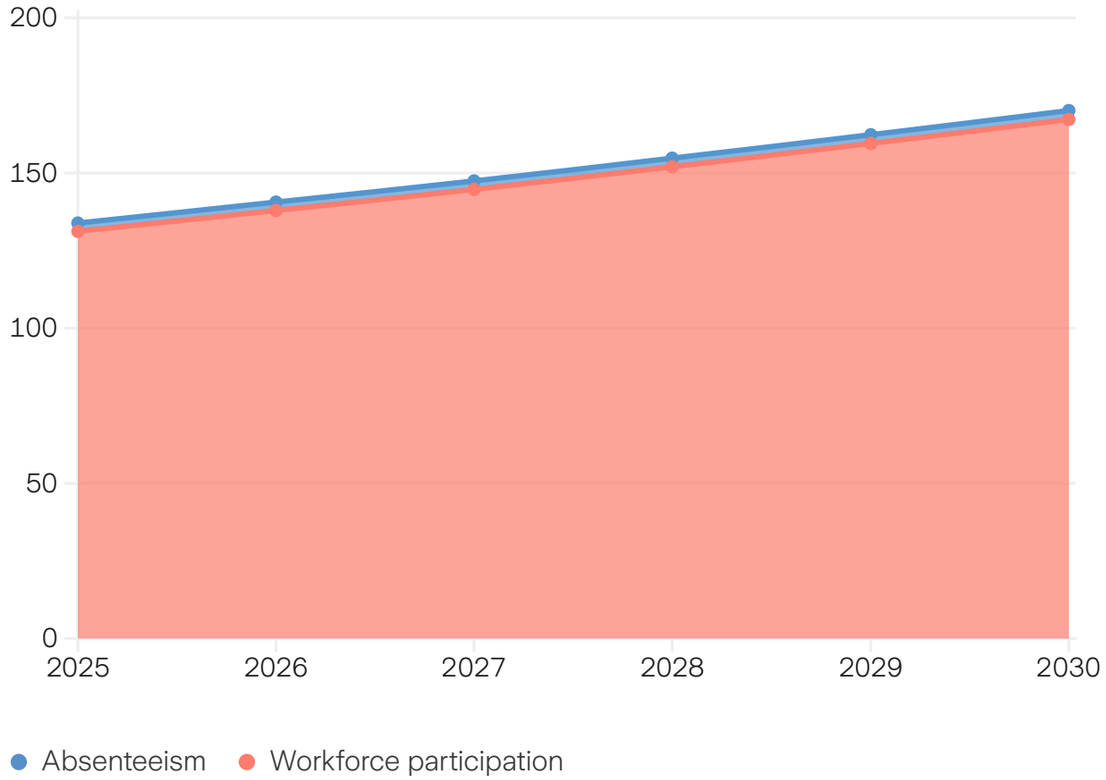
Individuals affected by mental health face a 29 percentage point employment gap

The dominant driver of these losses is long-term workforce absence, not short-term sick leave. In 2026, 98% of employment related losses (GBP 138 billion) stem from reduced workforce participation. This reflects a 29 percentage point employment gap between those with and without a mental health condition: 82% employment among those without mental health conditions, versus 53% employment for those with one.

This gap is one of the most consequential findings in the UK dataset, and materially larger than in comparator markets such as Germany and Australia, where employment gaps are closer to 17 or 18 percentage points.

The UK's gap may be driven by entry barriers, not just early exits. With mental health conditions disproportionately concentrated in younger age groups, and youth unemployment at its highest level in five years,[5] a growing share of young people are unable to secure their first foothold in work.

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



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

5. Office for National Statistics (ONS). Young people not in education, employment or training (NEET) (2026).

As entry routes become more limited – partly due to automation and AI-reducing routine roles and raising skill requirements – early distress can delay or disrupt these first steps. This makes it harder to build confidence and financial stability, which in turn can increase vulnerability. And when people never establish a stable connection to the labour market, the consequences compound across the life course.

Performance remains a secondary pressure

Absenteeism remains an operational challenge, particularly for smaller employers. In 2026, the average UK worker is estimated to take 0.6 days of mental health-related sick leave,[6] amounting to 18 million lost workdays, the equivalent of nearly GBP 3 billion in wages.

Hybrid and remote work can make early signs harder to spot, reducing day-to-day visibility and delaying intervention – increasing the risk that short-term distress becomes extended absence or exit.

Reducing absenteeism therefore matters not only for operational stability, but because time away from work quickly hardens into long-term inactivity. According to the *Keep Britain Working Review*, people who have been out of work for less than a year are nearly five times more likely to return than those absent longer.[7] This underscores the need for rapid employer-led intervention and structured return-to-work plans.

18 million days

of sick leave associated with mental health conditions are estimated to be taken by UK workers in 2026.

> Good return-to-work support restores more than income – it restores confidence, connection, and a sense of possibility. That's what early, coordinated intervention can deliver.

Nick Homer, Head of Market Management – Corporate Risk, Zurich UK

6. 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. Variances in recorded sick leave likely reflect both reporting regimes (for example, the seven day employee self-certification present in the UK), as well as labour-market incentives and constraints that shape whether distress appears as absence, long-term leave, or exit from work.
7. Department for Work and Pensions Keep Britain Working Review: Discovery (2025)

Spotlight

A New Role for UK Employers

Mental health has become a defining workforce challenge in the UK, and employers now sit at the front line of the national response. The *Keep Britain Working Review* signals a clear shift: when employers act earlier – and are supported to do so – more people stay healthy in work, recover faster and return sooner.

Employers see issues first, can adjust job design, and can integrate treatment with phased, supported returns. They are also closest to life stage events that often trigger mental health challenges – whether returning from maternity leave or coping with bereavement. This places employers at the earliest point of detection and in the strongest position to intervene before problems escalate.

A three-year "Vanguard" phase (2026–2029) brings over 150 employers together to create a workplace health standard focused on recruitment and onboarding, prevention, staying in work, return-to-work and redeployment. Zurich UK already applies a prevention-first approach with a network of 130 Mental Health First Aiders, regular "Time to Talk" sessions, workforce tools that track wellbeing, and expanded support for neurodiverse employees – including assessments, sensory-aware workplace design, flexible hiring practices, and reverse mentoring. Outside the workplace, Zurich UK and the Z Zurich Foundation work with the charity Ambitious About Autism on the *'Autistic and OK'* programme – an initiative supporting autistic young people's mental health in high schools, including a downloadable toolkit for educators and students.

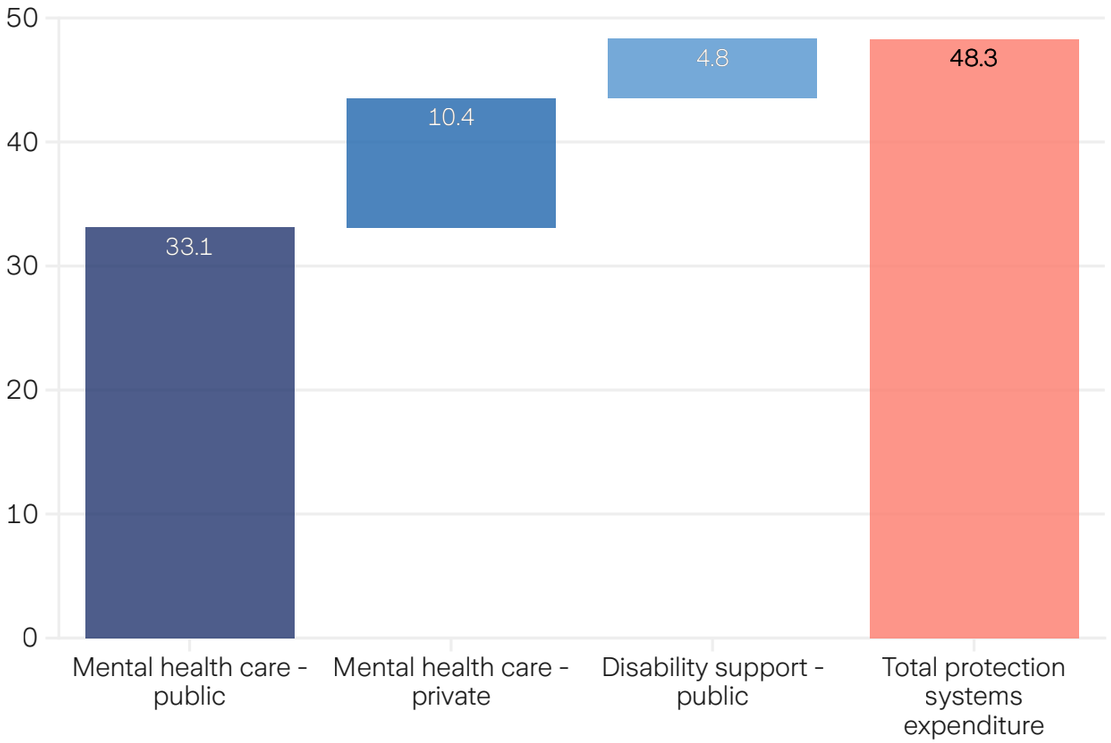
The Keep Britain Working Review is also considering what support could be provided to employers and employees. One element already making a difference is individual and group protection schemes, which can cover life insurance, critical illness, and income protection, and increasingly act as enablers of prevention and recovery, supporting:

- **Wellbeing and prevention:** such as mental health helplines, suicide prevention support, early psychological support, online wellbeing workshops, and Employee Assistance Programs (EAPs), providing confidential counselling and crisis support services.
- **Earlier identification and intervention:** Claims data and early notifications can reveal patterns before long-term absence develops, while fast-tracked assessments, virtual GP access, trauma, bereavement and crisis counselling, vocational rehabilitation support, and psychological therapy may be provided when symptoms first emerge.
- **Structured pathways back to work:** including case management, workplace adjustments, coaching, and phased returns.

These mechanisms help individuals to access support early, preventing short-term disruption from becoming long-term disengagement. Together, policy direction, employer practice and enabling structures can shift workplaces from "endpoints of sickness" to active sites of prevention and recovery – where return-to-work functions as a core tool for sustaining participation.

Protection systems:
Universal access under growing strain

UK: Mental health care protection systems (2030)
Projected expenditure, GBP billion



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

Mental health support in the UK is delivered through a mixed protection system, spanning publicly-funded health care, private health care expenditure, insurance-enabled provision and unpaid informal care. In 2026, total mental health spending is estimated at GBP 42 billion (around 1.4% of GDP), rising to GBP 48 billion by 2030. Most formal spend remains publicly-funded (78%).

Spending levels alone, however, are not a proxy for system effectiveness. How these components interact matters as much as how much is spent – particularly in a system where rising demand is placing growing pressure on primary care, specialist services, and families.

For most people, general practice is the main entry point into the mental health system. GPs assess symptoms, provide initial support, prescribe medication where appropriate, and refer patients to community or specialist services. They are also the clinicians who most frequently issue Statements of Fitness for Work for mental health-related sickness absence, placing them at the intersection of health and work. Whether they are best placed to perform this role is one of the questions considered by the *Keep Britain Working Review*.

While GPs can connect patients with non-clinical support – such as peer groups, financial wellbeing services, and community resources – rising demand, limited consultation time, and waiting lists for specialist treatment mean GPs often operate as the gatekeepers of a system under pressure. Specialist capacity constraints deepen these pressures. In 2023, the UK had 10.1 psychiatrists per 100,000 people, far below Australia (16) and Germany (28.9).[8] These gaps underscore the need for early support beyond primary care, including employer- and insurer-led pathways.

8. Royal College of Psychiatrists. Workforce figures (2023); AIHW. Mental health workforce (2023); Eurostat. Physicians by category (2025).

Private burden remains high

Despite the UK's universal health care model, nearly one-quarter (22%) of mental health care spending is private, with about 85% coming from out-of-pocket payments for counselling, therapy and other support accessed outside the NHS. Private insurance covers the remaining share and helps people access faster treatment, structured pathways, and work-focused rehabilitation. This split highlights an important tension within the system: private provision often improves speed and choice, but access remains uneven, reinforcing differences by income, employment status, and employer support.

A further layer of support sits largely outside formal markets altogether. In 2026, an estimated 470,500 informal mental health caregivers will provide over 13 million hours of unpaid care each week – equivalent to 683 million hours a year – valued at GBP 15 billion. This reflects the scale of support carried by families and communities even within a universal system, and while the proportionate share of informal care in the UK is lower than other in-scope markets, it remains a crucial, and often overlooked, component of the protection system.

Spotlight

Supporting caregivers

Caring for a child or relative with a mental health condition can be emotionally demanding, unpredictable, and difficult to balance alongside full-time work. Without flexibility, many mental health caregivers face rising stress, burnout, and, ultimately, the risk of leaving the workforce altogether. Employers can play a vital role by offering flexible, stigma-free working practices that allow caregivers to stay in work while managing complex and often fluctuating caregiving responsibilities.

For example, all new vacancies at Zurich UK have been advertised as open to part-time, job-share or full-time applicants since 2019. This gives mental health caregivers genuine choice in structuring work without penalty or the need for special exemptions. Zurich also embeds flexible working policies across all roles, enabling caregivers to accommodate crises, appointments, and unpredictable support needs while maintaining career progression. Caregivers are also offered the option of taking up to one week of unpaid leave in any 12-month period, structured in a way to meet their needs.

Managers are trained to hold early, supportive conversations, and teams plan workloads collaboratively so flexibility is shared fairly. These measures help protect caregivers' mental health, reduce stress, and prevent avoidable exits from work – strengthening participation while supporting those who shoulder some of the most demanding caring roles in society.

From early warning to early action:
Where the UK's next opportunity lies

The UK is confronting a landscape of mental health conditions that are defined by early-life disruption, widening gaps, and mounting pressure on primary care and workplaces. Rising prevalence – especially among young people – is reshaping transitions into training and employment and placing employers at the front line of detection and support.

The UK has clear strengths to build on: universal access to mental health care; expanding early intervention models; and sustained policy focus on prevention, workplace-based support, and better coordination across health, employment and rehabilitation systems.

It does not need to build a new system from scratch; it needs to connect what already exists – earlier, faster, and more consistently. This means:

1. **Strengthen early support in the transition from education to employment:** With mental illness emerging before work begins, rapid access support across schools, colleges, apprenticeships, and youth employment programs is essential. In practice, this can mean offering flexible or phased start arrangements for new hires, supported transitions from education or training into work, and early access to workplace adjustments, such as reduced initial hours, or additional supervision during periods of vulnerability. These measures help prevent early-life distress from becoming a barrier to labour market entry.

2. **Expand the availability and reach of effective psychological support:** A large share of the UK's wellbeing loss comes from anxiety and depressive disorders, which cause long-duration impairment when left untreated. Pressure on GPs requires alternative routes to help. Employer services, insurer-enabled rehabilitation, community mental health hubs, and digital triage pathways can shorten the time to first support and ease the load on primary care.

3. **Equip employers to act earlier and more effectively:** Employers are now the earliest and most reliable point of detection. Clear guidance, evidence-based early intervention models, and rapid access psychological support can prevent short-term challenges from escalating into long-term inactivity. Government can accelerate progress by aligning standards, incentives, and data.

The task now is to connect early identification, timely support, and inclusive work design so mental health challenges do not lead to permanent detachment from the labour market. In doing so, the UK can move from identification to integration and strengthen participation across the working-age population.

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 monetised, 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 standardised 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 year;
- Valued absenteeism impact: calculated using the employed working-age population, the annual mental health sick days per worker, and average wages per day.

Inputs	Definition	Methodology notes	Primary source(s)
Employment rate gap	The gap between the employment rate of individuals with a mental health condition (MHC) and the employment rate of individuals without a MHC.	• The employment rate across the working age population was modelled 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. • A simple 50:50 ratio of moderate and severe mental distress was assumed to approximate diagnosed MHC. We assumed the weighted employment gap estimated using data aggregated by the OECD for severe / moderate mental distress is broadly representative of 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 labour 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 labour force statistics and serves as the baseline for projections. ILO-modelled 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).
Number of working days lost from sickness	Total number of working days lost from sickness in the UK labour market due to mental health.	• Forecasts are based on the estimated 10-year arithmetic mean of total sick leave days per worker.	Office for National Statistics. Labour force survey - Sickness absence in the UK labour market: 2023 and 2024 (2025).

Protection systems

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

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

- 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).

Mental health care services	Total expenditure on mental health care services in NHS budgets from NHS England, Scotland, Wales and Northern Ireland public accounts		NHS England, NHS mental health dashboard (accessed 2025). NHS Scotland. Mental Health expenditure - financial years 2012/13 to 2023/24 (2025). StatsWales. NHS expenditure by programme budget category, organisation and commissioner (2024). Northern Ireland Assembly. Report on Mental Health Services in Northern Ireland (2024).
Primary care relating to MHC	Total spending on primary care services, for general health, apportioned to MHC.	• England: Estimated MH related GP expenditure obtained from the Centre for Mental Health, extrapolated to 2030 using the period adjustment. • Scotland: Total budget spending (Level 3) on General Medical Services. The proportion of primary care spending related to MHC was based on the MH expenditure as a share of total net NHS expenditure from NHS Scotland (2025). • Wales: Total expenditure on general practice, net of dispensing. The proportion of general practice spending related to MHC was based on the NHS expenditure on 'Mental health problems' and 'Learning disability problems' as a % of total LHB and PHW expenditure from Welsh Government (2025). • Northern Ireland: Total payments towards overall cost of GP services. The proportion of GP services costs related to MHC was based on total investments in MH services as a % of overall health budget from NISRA (2024).	Centre for Mental Health. The economic and social costs of mental ill health (2024). NHS England (2025). NHS Scotland (2025). Scotland Government. Scottish Budget 2025 to 2026 (2024). Welsh Government (2025). StatsWales. Investment in general practice for the 2019 to 2020 financial year to the 2023 to 2024 financial year (2024). Northern Ireland Statistics and Research Agency (2024).

Pharmaceutical services	Total spending on MHC related medications and pharmaceuticals.	• England & Scotland: Net ingredient costs for antidepressants, CNS stimulants, and drugs used in psychosis and hypnotics. • Wales & Northern Ireland: Total pharmaceutical costs (including non-mental health medications). The apportionment method used for primaru care was applied.	NHSBSA – Statistics, Prescription Cost Analytics (2025). Public Health Scotland. Dispenser payments and prescription cost analysis. (2025). StatsWales. Health and social care (2024). Business Services Organization. Pharmaceutical statistics (2025).
Private health insurer spending	Total voluntary health insurance expenditure reported for the UK, for general health, apportioned to MHC.	• The apportionment method used for primary care was applied.	Office for National Statistics, Healthcare expenditure, UK Health Accounts: 2023 and 2024 (2024).
Out-of-pocket expenses	Total consumer out-of-pocket expenses for health services reported for the UK, for general health, apportioned to MHC.		

Other social services expenditure	Total spending on disability support payments and other local social services that are MHC specific.	• England: Expenditure by local authority social services on MHC. • Scotland: Adult, child and pension age payments with “Mental and Behavioural Disorders” listed as a primary disability. • Wales: Direct payments for social services to adults with “mental health needs” and “learning disabilities,” under 65 years old. • Northern Ireland: Total social service payments for “Mental Health” and “Learning Disability”.	Centre for Mental Health (2024) Social Security Scotland (2025). StatsWales (2024). Northern Ireland Assembly (2024).
Number of informal caregivers	Total number of informal caregivers caring for people with MHC.	• Proportion of informal caregivers that care for a recipient with a MH condition, estimated using the share of people who receive care for mental health support in England reported in the Personal Social Services Survey of Adult Carers in England (2024).	NHS England. Personal Social Services Survey of Adult Carers in England (2024). ONS. Unpaid care, England and Wales: Census 2021 (2021).
Total cost per informal MH carer	The value of unpaid care using the replacement cost approach. Valued at the cost of employing a formal carer to replace an informal carer.	• Replacement carer cost was estimated using the rate of pay for care workers and home carers (SOC 6135) and senior care workers (SOC 6136). Estimated as the simple 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. • Total hours per week of informal care delivered by an informal carer to a person with a MHC was estimated using the average hours spent providing care per week reported in the Personal Social Services Survey of Adult Carers (PSSAC). Treated categorical survey responses (0-4, 5-19, 20-34, 35-49 hours) by taking the midpoint. Midpoint of unbounded categories (50 or more hours, varies but less than 35 hours, varies but 35 or more hours) assumed to be 50% higher.	Diminic et al. (2017). ONS. Earnings and hours worked, occupation by four-digit SOC: ASHE Table 14 (2025). IMF (2025). ILO (2025).

Additional assumptions and limitations

- An exchange rate of USD-GBP of 0.74 was applied (January 2-30, 2026 period average).[1]
- A VLY of USD 144,000 was applied.

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

Acknowledgments

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

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

This report was originally published in English. In the event of any inconsistency or discrepancy between the English version and any translated version, the English version shall prevail.

About us

Zurich Insurance Group (Zurich) is a leading global multi-line insurer founded more than 150 years ago, which has grown into a business serving more than 82 million customers in more than 200 countries and territories, while delivering industry-leading total shareholder returns. Reflecting its purpose to 'create a brighter future together,' Zurich offers protection services that go beyond traditional insurance, to support its customers in building resilience. Since 2020, the Zurich Forest project has supported reforestation and biodiversity restoration in Brazil's Atlantic Forest. The Group has more than 65,000 employees and is headquartered in Zurich, Switzerland. Zurich Insurance Group Ltd (ZURN), is listed on the SIX Swiss Exchange and has a level I American Depositary Receipt (ZURVY) program, which is traded over-the-counter on OTCQX. Further information is available at www.zurich.com.