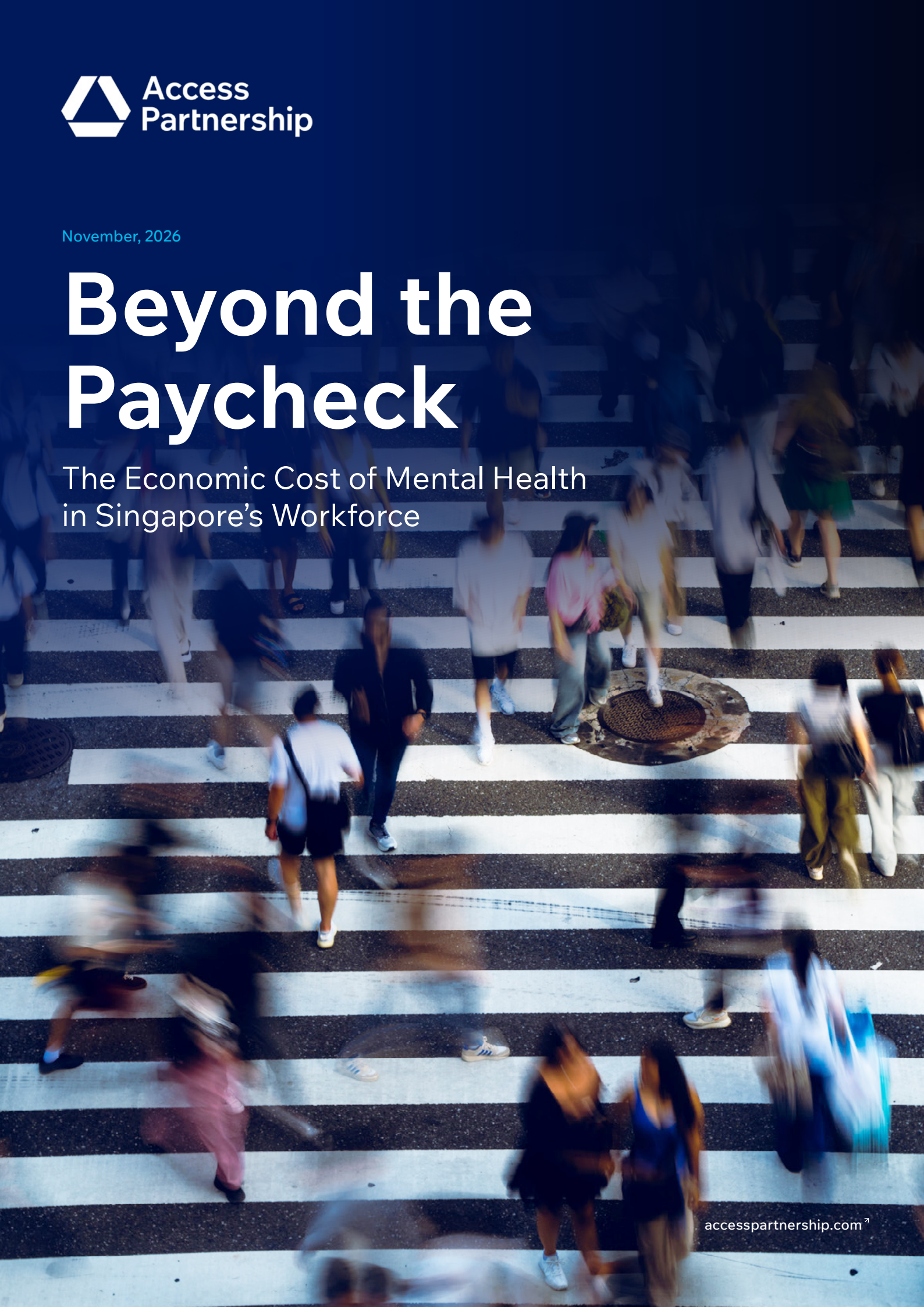
Access Partnership

November, 2026

Beyond the Paycheck

The Economic Cost of Mental Health in Singapore's Workforce



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AA Access Partnership Limited

Authors



Marcus Ng,↗
Head of APAC and Economics Strategy, Access Partnership



Megan Lim,↗
Associate Director, Economics Strategy, Access Partnership



Liting Xu,↗
Analyst, Economics Strategy, Access Partnership

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At a Glance

The Economic Burden of Mental Health

One in five adults in Singapore reports symptoms of depression or anxiety. Mental health is not only a prevalent health and social policy issue, but it is also an economic priority. Most people suffering these symptoms carry on working, but often at a reduced capacity, missing more days, and at growing risk of leaving their jobs altogether.

Mental health conditions* in the workforce are:

2025

Estimated to have cost

SGD 19.6bn

Exceeding the government's entire operating health expenditure for the year.

2030

This burden is expected to reach

SGD 21.7bn

Equivalent to 2.3% of Singapore's GDP.

* Mental health conditions assessed include depression and anxiety.

The burden in 2030 is distributed across four groups, but far from equally:



Employers

SGD 20.3bn

from presenteeism, absenteeism, and workforce turnover costs.

Government

SGD 534.4mn

from expenditure on mental health services and programmes.

Workers

SGD 566.6mn

from direct out-of-pocket healthcare expenses for treatment.

Caregivers

SGD 215.2mn

from lost productivity to support those suffering from depression and anxiety.

The Economic Returns from Intervention are Significant

Three workplace interventions can meaningfully reduce this burden:

1 > Organisation-wide mental health promotion:
Promote mental health awareness, stress management, and anti-stigma initiatives across the organisation.

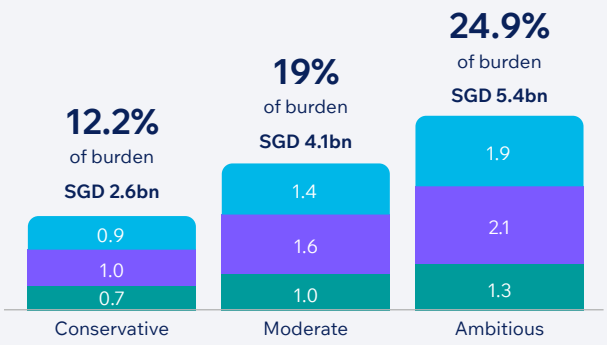
2 > Training for supervisors and managers:
Equip managers to recognise mental distress, initiate supportive conversations, and refer employees to appropriate support.

3 > Employee Assistance Programmes (EAPs):
Provide workers with confidential, short-term counselling, psychological assessment, and referral services.

Three scenarios are evaluated to estimate the potential returns from the three workplace interventions in Singapore in 2030, based on differing levels of government and employer investments.*

- Organisation-wide mental health promotion
- Training for supervisors and managers
- EAPs

Scaling up mental health investment could reduce up to a quarter of Singapore's projected 2030 economic burden.



* Scenarios are derived based on varying levels of government mental health spending and employer programme coverage rates. Figures may not sum due to rounding.

Coordinated, sustained action is now required.

Employers

- Run annual workplace stress assessments.
- Adopt accredited manager training programmes.
- Actively manage EAP utilisation through promotion and annual reviews.

Workers

- Lead peer-to-peer mental health promotion.
- Train volunteer mental health champions.
- Pool counselling access for smaller firms.

Government

- Set standards for manager mental health training.
- Strengthen promotion and EAP support through partnerships.

Community and mental health organisations

- Develop accredited manager training courses.
- Build structured referral pathways to professional support.

Source: Access Partnership analysis (2026). All figures in real 2025 Singapore dollars.

Executive Summary

One in five adults in Singapore reports symptoms of depression or anxiety.[1] Mental health is not only a prevalent health and social policy issue, but it is also an economic priority. Most people suffering these symptoms carry on working, but often at a reduced capacity, missing more days, and at growing risk of leaving their jobs altogether.

Mental health conditions have a productivity cost

Mental health conditions in the workforce, specifically depression and anxiety, are estimated to have cost Singapore's economy SGD 19.6 billion in 2025. By 2030, the burden is projected to reach SGD 21.7 billion, equivalent to 2.3% of Singapore's Gross Domestic Product (GDP).[2] The 2025 burden alone already exceeds the government's entire operating health expenditure for the year.[3] The growing cost does not depend on more workers falling ill; an expanding workforce and rising wages are enough to push costs upward, even if the share of workers affected stays where it is today.

The burden in 2030 is distributed across four groups, but far from equally:

- **Employers** are estimated to bear SGD 20.3 billion (93.9% of the total), through lost output from workers at impaired capacity, days of work missed, and resignations each year.
- **Workers** are projected to bear SGD 566.6 million (2.6%) in direct healthcare costs of seeking treatment for depression and anxiety. The bill falls hardest on those whose employers provide no insurance coverage for mental health conditions.
- **Government** is projected to bear SGD 534.4 million (2.5%) in public expenditure on mental health services, split between clinical treatment and prevention and promotion programmes.
- **Caregivers** are estimated to bear SGD 215.2 million (1%) in lost productivity as working family members reduce hours or take time off to support those suffering from depression and anxiety.

The economic returns from intervention are significant

Workplace mental health interventions return between SGD 5.20 and SGD 7.50 for every dollar invested. This study considers three evidence-based interventions aligned with the World Health Organization (WHO)'s recommended pillars of workplace mental health action:[4]

- **Organisation-wide mental health promotion** returns SGD 6.20 per dollar invested. In Singapore, the median delay between the onset of a mood disorder and first treatment contact is five years.[5] During that period, symptoms surface at work: concentration falls, days are missed, and workers eventually resign. Awareness campaigns, stress management education, and anti-stigma programmes shorten this delay, reducing the productivity lost during the time that workers go without help.
- **Training for supervisors and managers** returns SGD 7.50 per dollar invested, the highest of the three. Over six in ten Singapore employees said they were uncomfortable raising mental health concerns with their line manager in 2022, the highest in Southeast Asia.[6] Without training, most managers will not see the problem until it surfaces as prolonged absence or resignation. With it, they can recognise early warning signs, hold a supportive conversation, and connect a colleague with help while the situation is still manageable.
- **Employee assistance programmes (EAPs)** return SGD 5.20 per dollar invested. Workers who will not seek help through visible workplace channels may often use an EAP, because it is free and confidential. This reduces symptom severity, cuts absenteeism, and lowers the likelihood of resignation that might follow.

The three interventions reinforce each other. Promotion creates the awareness that makes manager training effective; trained managers generate the referrals that give EAPs their reach. Scaled together, they could reduce the projected 2030 burden by up to SGD 5.4 billion, around one-quarter of the total.

2025

SGD 19.6bn

Economic burden

Estimated cost of depression and anxiety in Singapore's workforce, more than the government's entire operating health expenditure for the year.

2030

SGD 21.7bn

Projected burden

Equivalent to 2.3% of Singapore's GDP.

93.9%

Borne by employers

Share of the 2030 burden that falls on employers, through lost output, missed days and resignations.

SGD 5.4bn

Avoidable

Reduction in the projected 2030 burden if the three interventions are scaled together, around one-quarter of the total.

Coordinated, sustained action is now required

Singapore has moved quickly on policy. The National Mental Health and Well-being Strategy, the iWorkHealth psychosocial assessment tool, and the Tripartite Advisory on Mental Health and Well-being at Workplaces (Tripartite Advisory) are all in place. However, adoption of such initiatives remains limited, partly because promotion rarely extends to the small- and medium-sized enterprises (SMEs) where most workers are employed. Furthermore, manager training has no quality standard against which employers can measure themselves, and EAPs are available but seldom used: 93% of companies communicate their mental health programmes, yet only 5% of employees engage with them.[7]

Closing these gaps requires coordinated action across four groups:

- **Government** can act on all three pillars. The first priority is extending promotion to SMEs through trade associations, chambers of commerce, unions, and public sector agencies — the channels with strongest reach across small employers. A minimum curriculum for manager training could be established through the Tripartite Advisory, giving employers a clear standard to meet. Additionally, partnering with private service providers to extend support is critical in helping close the gap for those who currently have no employer-provided route to care.
- **Employers** have a clear opportunity to move from offering mental health programmes to managing them actively, directing effort to where stress is greatest and making sure workers use the support available. Annual workplace stress assessments through iWorkHealth identify which teams and stressors most need attention, replacing generic campaigns with targeted programmes. Additionally, extending accredited manager training to every manager, not just willing volunteers, builds a first line of detection and referral across the workforce. For EAPs, the gap between availability and actual use often comes down to visibility. A service that is clearly promoted, accessible through multiple channels, and administratively separate from human resources is far more likely to be used than one that exists only as a listing in a staff handbook.
- **Community and mental health organisations** can accelerate uptake by developing accredited, off-the-shelf manager training that any employer can adopt without building their own. Ending each course with a concrete referral step showing managers exactly how to connect a colleague with professional care turns training into a practical pathway rather than a standalone event.
- **Workers** are often the first to notice a colleague in difficulty, and peer support reaches people that formal campaigns miss. Unions and industry bodies can formalise this by training volunteer peer champions and pooling resources to fund shared counselling access for workers in smaller firms.

Singapore has the policy foundations in place. What is needed now is a shift from voluntary, ad hoc intervention to sustained, system-wide action by government, employers, community and mental health organisations, and workers together.

01

A Growing National Priority

One in five adults in Singapore reports symptoms of depression or anxiety, an experience lived personally, often silently, and at significant individual cost.[8] Depression and anxiety affect how people feel, function, and relate to those around them; that cost falls first on the people living with it. But these conditions also carry consequences that extend beyond the individual. As Singapore's labour market has tightened and work pressures have risen since the pandemic, mental health has moved to the centre of the national policy agenda. In a services-led economy that depends fundamentally on human capital, the capacity of people to show up not just physically but cognitively is a national economic concern.

Government has responded at pace. Public spending on mental health promotion, prevention and treatment grew by approximately 13% a year between FY2020 and FY2022.[9] In October 2023, the Ministry of Health (MOH) launched the National Mental Health and Well-being Strategy, the most comprehensive mental health policy statement since the 2012 Community Mental Health Masterplan.[10] It set out plans to expand inpatient psychiatric bed capacity at the Institute of Mental Health, train 10,000 more frontline personnel within two years, and extend mental health services to all new polyclinics by 2030. The National Mental Health Office, established in 2024, coordinates mental health initiatives across MOH, the Ministry of Social and Family Development, and the Ministry of Education.[11] Since June 2025, the national mindline 1771 has provided round-the-clock support, giving anyone in distress a single free number to call.[12] Public campaigns such as "It's OKAY to Reach Out" aim to reduce the stigma that deters people from seeking help.[13] Action has also reached the workplace, where the Tripartite Advisory on Mental Health and Well-being at Workplaces (Tripartite Advisory), issued jointly by the Ministry of Manpower (MOM), the Singapore National Employers Federation (SNEF), and the National Trades Union Congress (NTUC) in November 2020, sets out practical guidance for employers, including training managers to recognise distress and appointing workplace mental wellness champions.[14] In February 2024, the government named mental health and well-being a key national priority and called on the whole of society, not government alone, to take part.[15] Taken together, these measures point to a shift toward coordinated, cross-agency action that now extends beyond the health system into workplaces and communities.

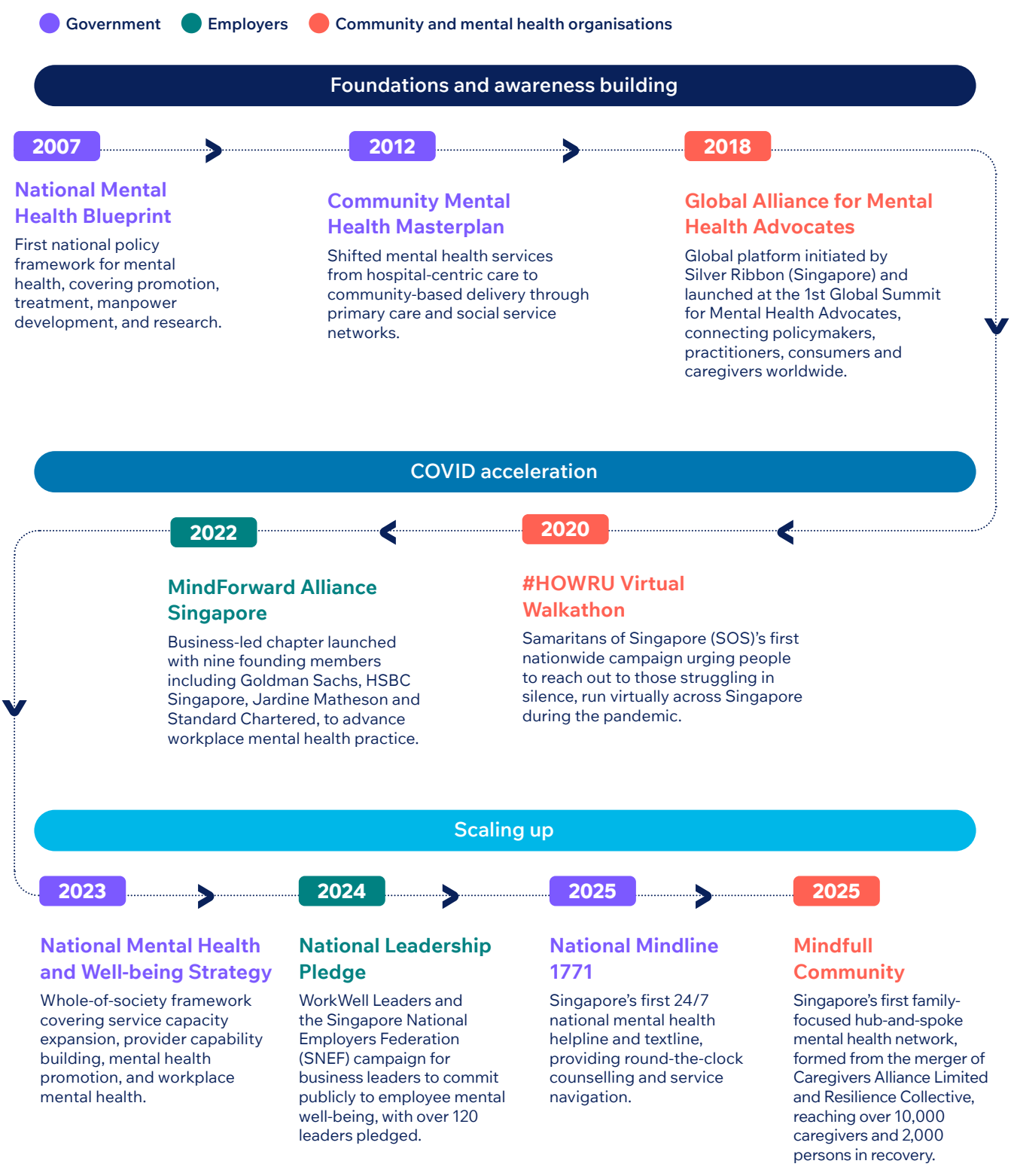
Employers and community and mental health organisations have begun to respond, though coverage and depth of engagement remain uneven. A 2026 survey found that only one in four workers in Singapore confirmed their employer provides an Employee Assistance Programme (EAP), with a further 30% unsure whether any such support exists.[16] Community and mental health organisations such as the Singapore Association for Mental Health and Silver Ribbon provide mental health outreach, counselling, and anti-stigma support.[17] These efforts sit alongside the programmes delivered by government statutory boards, forming a multi-layered but still incomplete support network.

Government health accounts capture what the public system spends when people with depression or anxiety reach care. That spending is real, but it is only a small part of the total cost. Most of what mental health conditions cost an economy does not flow through clinics or hospitals. It surfaces in workplaces, where affected workers remain present but function below capacity, or miss days of work. It falls on employers, who absorb the lost output and bear the cost of replacing those who eventually leave. It reaches into households, where family members reduce their own working hours to provide support. Little of this appears in health expenditure accounts. This report therefore takes a wider view: it quantifies the full economic burden of depression and anxiety symptoms across employers, workers, caregivers, and government, and shows who bears how much. That disaggregation matters because the incentive to act should follow the cost, and the case for action is strongest where the burden is heaviest.

Exhibit 1

Singapore's mental health support milestones

Key measures of government, employers, and community and mental health organisations in Singapore



Source: Access Partnership analysis (2026); and literature review.

02

The Economic Cost of Mental Health Conditions in Singapore's Workforce

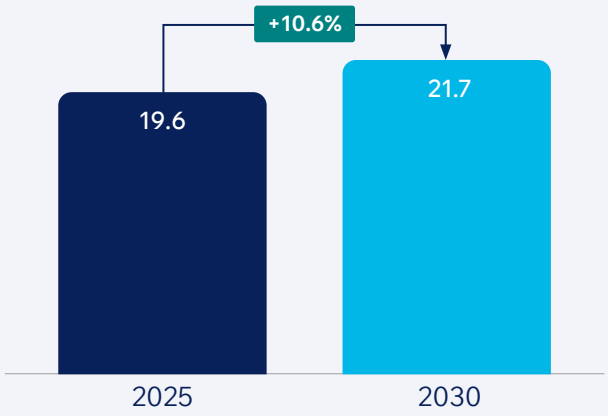
Workplace stress, rising living costs, and blurred work-life boundaries continue to put upward pressure on mental health prevalence. Persistent workplace stress remains the most commonly cited cause of poor mental health among Singapore's workforce, with one in three employees reporting work-related stress or burnout.[18] The rising cost of living compounds this pressure, with financial stress increasingly linked to anxiety and depressive symptoms among working adults.[19] Meanwhile, hybrid work has become the norm, blurring the boundaries between office and personal life, making it harder for workers to disconnect.[20]

Mental health conditions in the workforce, specifically depression and anxiety, are estimated to have cost Singapore's economy SGD 19.6 billion in 2025. The cost is expected to rise 10.6% to reach SGD 21.7 billion by 2030.[21] To put this in perspective, the 2025 burden alone already exceeds the government's entire operating health expenditure for the year. By 2030, it will reach 2.3% of Singapore's Gross Domestic Product (GDP). The estimates capture not only costs incurred by affected employees (i.e., out-of-pocket healthcare costs), but also costs borne by employers (i.e., absenteeism, presenteeism, and employee turnover costs), caregivers of affected individuals (i.e., caregiver productivity loss from working household members supporting someone with a mental health condition), and the government (i.e., expenditure on public mental health services).

Exhibit 2

Total annual economic burden of mental health in Singapore

SGD billion, 2025 and 2030



Source: Access Partnership analysis (2026). All figures are presented in real 2025 Singapore dollars. Figures may not sum due to rounding.

Note:
Prevalence of depression and anxiety symptoms is held constant at 20% (2022 baseline) throughout the projection period. The true burden may be higher if prevalence has risen since 2022, as broader trends suggest.

The significant economic burden of mental health falls on four stakeholder groups: employers, workers, caregivers, and government. The burden falls disproportionately on employers, who alone account for approximately 94% of the total burden, while workers, caregivers, and government bear the remaining 6%.

Employers bear the largest share of the burden at SGD 20.3 billion, or 93.9% of the total. Depression and anxiety directly impair how affected workers function on the job, reducing their capacity to concentrate, make decisions, and sustain effort.[22] These impairments manifest in the workplace through three channels: presenteeism, absenteeism, and turnover. For presenteeism, affected workers remain physically present but operate at significantly reduced capacity. In a 2022 survey of 304 employed adults with depression or anxiety symptoms in Singapore, respondents reported a mean productivity impairment of 41%, equivalent to losing two full working days per week.[23] Absenteeism adds a further loss, driven by 17.7 extra days of work missed per year among affected workers.[24] In addition, turnover costs are also incurred, reflecting the recruitment, vacancy, and ramp-up costs associated with an estimated 28,200 mental health-related separations.[25] Because these costs land directly on the business, employers have both the strongest financial incentive to act and the most to lose from inaction.

Workers shoulder SGD 566.6 million, or 2.6% of the total, in direct healthcare costs, covering visits to general practitioners, psychiatrists, and counsellors, as well as medication. While employer-funded insurance and government subsidies absorb part of the bill, coverage is uneven. As of 2021, only 47% of employers in Singapore included mental health benefits in their corporate health insurance packages.[26] Workers at firms without such coverage carry the full treatment cost themselves.

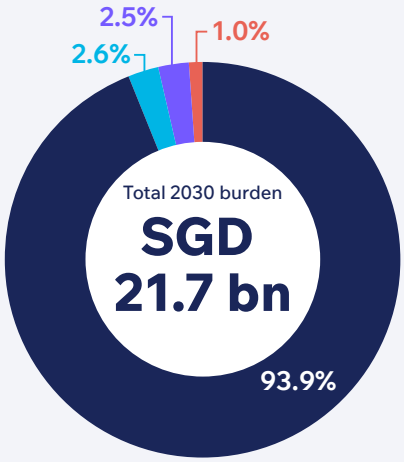
At SGD 534.4 million, the government absorbs 2.5% of the total burden, almost entirely directed at subsidised treatment through the public healthcare system. When workers with depression or anxiety symptoms seek treatment through the public healthcare system, the government absorbs a share of the cost through subsidised outpatient consultations, hospital admission, and medication. It also funds upstream prevention and promotion programmes aimed at reducing future demand on clinical services. This spending falls into two categories: care and treatment, which accounts for the vast majority, and promotion and prevention programmes. However, mental health spending by other ministries is not captured here. The Ministry of Social and Family Development, through the National Council of Social Service (NCSS), funds community-based counselling and mental health support delivered by social service agencies.[27] The government's actual exposure to the cost of mental health conditions is therefore larger than this estimate suggests. This points to a structural pattern: the balance of current government mental health expenditure is weighted toward treatment rather than prevention and promotion. A spending mix that underinvests upstream tends to defer costs rather than reduce them, and unmet early intervention needs translate, over time, into greater demand for clinical services.

A further SGD 215.2 million, or 1% of the total, falls on caregivers. When a worker develops depression or anxiety symptoms, the effects extend beyond them. Family members often step in to provide support, whether accompanying them to medical appointments, managing household responsibilities, or simply being present during difficult periods. When those family members are themselves employed, this caregiving comes at a direct economic cost. Some reduce their working hours, while others take days off. In both cases, their own productivity falls. These costs are largely invisible in workplace and policy discussions, yet they are real. This analysis captures what can be quantified. The emotional and psychological toll of caregiving, including the sustained stress, the disruption to daily life, and the longer-term effects on caregivers' own well-being, does not appear in these figures, but is no less significant. The economic impact of mental health does not stop with the affected individual.

Exhibit 3

Projected economic burden of mental health conditions by stakeholder in 2030

Share of economic burden of depression and anxiety in Singapore by stakeholder, %, 2030



Employers SGD 20.3 bn
Lost productivity from workers present but underperforming, additional days of work missed, and the cost of replacing workers who leave due to their mental health condition.

Workers SGD 566.6 mn
Out-of-pocket healthcare spending on general practitioner visits, psychiatrist consultations, counselling, and medication not covered by employer or government subsidies.

Government SGD 534.4 mn
MOH expenditure on public mental health services, including subsidised treatment and promotion and prevention programmes.

Caregivers SGD 215.2 mn
Lost productivity among working household members who take time off or leave the workforce to support someone with a mental health condition.

Source: Access Partnership analysis (2026). All figures are presented in real 2025 Singapore dollars. Figures may not sum due to rounding.

03

Workplace Interventions with Proven Returns

Workplace mental health interventions generate returns that can far exceed their cost. The economic burden of mental health conditions on Singapore's economy continues to grow, while less than half of the workforce currently has access to an employer-provided mental health programme.[28] The gap between the scale of the problem and current investment remains significant.

International evidence consistently finds that well-designed workplace mental health interventions generate strong economic returns. A World Health Organization (WHO)-led study found that scaling up treatment for depression and anxiety yields USD 4 in better health and productivity for every dollar invested.[29] Organisation-wide mental health promotion, training for supervisors and managers, and EAPs are among the most effective interventions globally. These align with the WHO's three pillars of workplace mental health action, operating at universal, selective, and indicated levels respectively.[30]



Exhibit 4

Return on investment by intervention type

SGD per dollar invested



Source: Access Partnership analysis (2026). All figures are presented in real 2025 Singapore dollars.

Intervention 1: Organisation-wide mental health promotion

Organisation-wide mental health promotion encompasses workplace culture change, mental health awareness campaigns, stress management education, and anti-stigma initiatives. These are universal programmes that reach the entire workforce, beyond those already affected. For every dollar invested in organisation-wide mental health promotion, Access Partnership estimates a return of SGD 6.20 in reduced economic burden.[31]

Promotion generates returns largely by closing one critical gap: the time between when symptoms emerge and when workers seek help. In Singapore, the median delay between the onset of a mood disorder and first treatment contact is five years, and one year for an anxiety disorder.[32] During that gap, symptoms inevitably affect how workers perform on the job. They surface at work as reduced concentration, missed days, and potentially resignation. The longer workers go without support, the more these costs accumulate for themselves, their employers, and the wider ecosystem, and earlier intervention can prevent much of this.

Mental health promotion shortens this delay through three channels: earlier help-seeking, faster identification of distress, and stronger individual resilience. First, awareness and education reduce stigma, making workers more willing to seek help early before symptoms escalate into sustained absenteeism or presenteeism. Second, culture change normalises open conversations about mental health, enabling colleagues and managers to identify signs of distress sooner. Third, stress management and resilience tools give workers practical ways to cope with workplace pressures before they develop into clinical conditions. Together, these channels reduce both the number of workers whose symptoms reach a costly stage and the time they spend there.

In Singapore, workplace mental health promotion exists, but it rarely reaches beyond large firms or one-off events. Small- and medium-sized enterprises (SMEs), which make up 99.6% of all enterprises and account for 69.2% of total employment in Singapore, often lack the capacity to run programmes of their own.[33] The main public channel for bringing structured mental health modules into workplaces, the Health Promotion Board (HPB) Workplace Outreach Wellness (WOW) programme, concluded in February 2026.[34] HPB has since pointed employees towards self-directed digital resources rather than workplace-delivered programmes, leaving SMEs without a funded route to sustained workplace promotion. Community campaigns such as the Beyond the Label campaign, funded by the NCSS, work to reduce stigma among the general public, but do not reach individual workplaces.[35] Where workplace promotion does happen, it tends to be a one-off event rather than a sustained effort. Moving from ad hoc participation to systematic, ongoing promotion across a broader base of employers would reach the many workers who are currently left out.

SGD 6.20

Return per dollar

Estimated return for every dollar invested in organisation-wide mental health promotion.

5 years

Median delay to first treatment

Between the onset of a mood disorder and first treatment contact in Singapore, and one year for an anxiety disorder.

99.6%

of enterprises are SMEs

Accounting for 69.2% of total employment in Singapore, and often without the capacity to run programmes of their own.

SGD 7.50

Return per dollar

Estimated return for every dollar invested in manager training, the highest of the three interventions.

6 in 10

Uncomfortable telling their manager

More than six in ten Singapore employees were uncomfortable sharing mental health challenges with their managers in 2022, the highest share in Southeast Asia.

No standard

For what good training looks like

Nothing specifies what manager training should cover, how long it should last, or how its effectiveness should be evaluated.

SGD 5.20

Return per dollar

Estimated return for every dollar invested in employee assistance programmes.

SGD 1,200

Annual healthcare cost per worker

Direct healthcare expenses for depression and anxiety borne by each affected worker by 2030.

93% vs 5%

Communicated, but rarely used

93% of Singapore companies communicate their mental health programmes, but only 5% of employees actively engage with them.

10.9 weeks

Median time to present

Taken by employees facing non-acute stressors to present to one Singapore hospital's EAP.

Intervention 2: Training for supervisors and managers

Today, most workers keep their distress hidden from their managers. In 2022, more than six in ten Singapore employees said that they were uncomfortable sharing mental health challenges with their managers, the highest share in Southeast Asia.[36] When workers do not disclose and managers cannot recognise the warning signs, distress goes unnoticed until it surfaces as prolonged absence or resignation, at which point it is far more costly and far harder to address.

Manager training programmes help tackle this issue, as they equip supervisors with the knowledge, skills, and confidence to recognise signs of mental distress, initiate supportive conversations, make reasonable workplace adjustments, and refer employees to appropriate support. These are targeted capability-building programmes: rather than reaching every worker directly, they work through managers to extend mental health support across the teams they lead. For every dollar invested in manager training, Access Partnership estimates a return of SGD 7.50 in reduced economic burden.[37]

Through early identification and supportive response, training turns managers into an early point of detection and referral. Managers are the daily point of contact for most workers. Trained managers can spot early signs, such as changes in behaviour, withdrawal, or declining performance, and step in before a manageable issue becomes a costly one. Their behaviour also shapes whether workers feel safe to speak up. Employees who trust that their manager will respond constructively are more likely to disclose difficulties and accept help early, reducing the duration and severity of productivity loss across their teams.[38] When a manager also knows where to refer, that early disclosure becomes a route into professional care.

In Singapore, manager training features in workplace mental health guidance, but there is no shared standard for what good looks like. As early as 2007, HPB's Treasure Your Mind programme included a module for supervisors, and today the Tripartite Advisory explicitly recommends training supervisors and managers as one of the most effective measures at the team level.[39] However, nothing specifies what the training should cover, how long it should last, or how its effectiveness should be evaluated.

Employers who train their managers have no benchmark to measure their programme against, and for SMEs with limited human resource capacity, no clear model to follow. Setting a clear standard for the quality of training, and making it easy to adopt, would turn a general recommendation into consistent practice.



Intervention 3: EAPs

In Singapore, workers who need mental health support often face two barriers: cost and confidentiality. Professional help comes at a cost: by 2030, each worker suffering from mental health conditions will bear an estimated SGD 1,200 in direct healthcare expenses for depression and anxiety annually.[40] Accessing care through workplace channels can also require workers to disclose their conditions to employers, which many workers are unwilling to do. Without a route that is both affordable and confidential, symptomatic workers either pay out of pocket or struggle without care.

EAPs play an important role by providing confidential, short-term counselling, psychological assessment, and referral services. They have been found effective in reducing presenteeism, absenteeism, and employee turnover among workers with mental health conditions.[41] Unlike the first two interventions, which are preventive, EAPs are indicated support: they serve workers already experiencing mental health symptoms and connect them directly with professional help. For every dollar invested in EAPs, Access Partnership estimates a return of SGD 5.20 in reduced economic burden.[42]

EAPs remove both barriers of cost and confidentiality: they are free to the worker at the point of use, and they sit outside the employer's management structure. Counselling reduces symptom severity and improves day-to-day functioning, which in turn lowers absenteeism, presenteeism, and the likelihood of resignation. Because EAPs operate independently of the employer's management structure, workers who would not seek help through visible workplace channels can still access support without stigma.

EAP provision is expanding. The Tripartite Advisory includes a directory of EAP service providers, and platforms such as MindFi, a Singapore-headquartered corporate mental health platform, offer therapy, coaching, and self-care tools to employers across the Asia Pacific region.[43] Yet few workers who have access actually make use of it. Among Singapore companies, 93% communicate their mental health programmes to employees, but only 5% of employees actively engage with them.[44] Workers are also slow to come forward on their own. In one Singapore hospital's EAP, employees facing non-acute stressors took a median of 10.9 weeks to present, and fewer than one in four came through self-referral.[45] Turning EAP availability into actual use, and giving workers without an EAP a confidential route to care, is what would unlock its full potential.

Taken together, the three interventions are mutually reinforcing. Organisation-wide promotion creates the awareness that makes manager training effective, and manager training generates the referrals that EAPs convert into professional care. The challenge in Singapore is not that these interventions are unproven; it is that they are under-deployed, reaching too few workers, at insufficient scale, without consistent quality.

04

What Singapore Stands to Gain

If government and employers scale up investment in workplace mental health over the coming years, a significant share of the economic burden can be avoided. This chapter models three investment scenarios to quantify how much.



Each scenario deploys the same three interventions, but at different levels of investment intensity:[46]

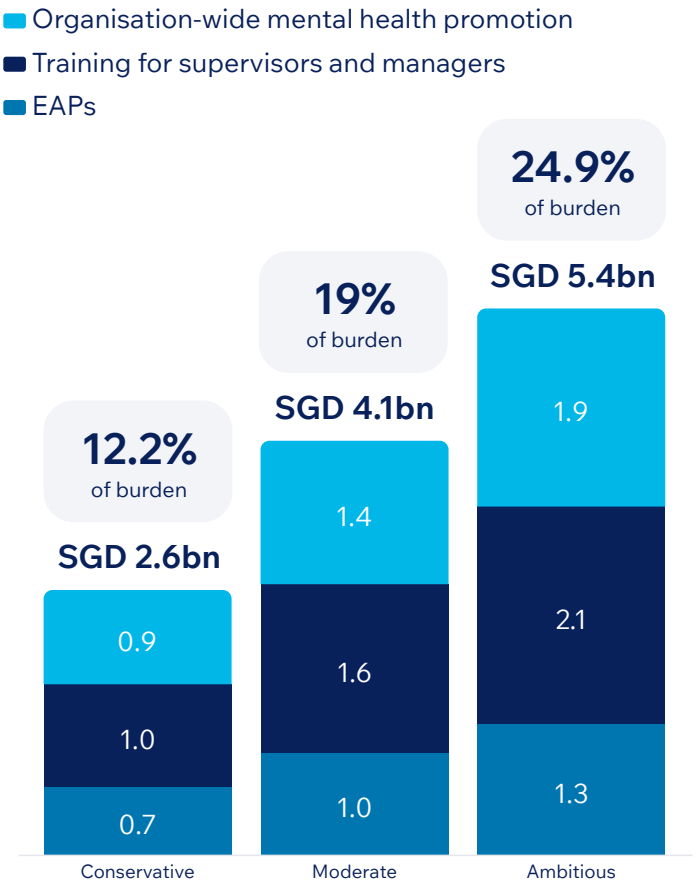
- **Conservative scenario** assumes that government mental health spending keeps pace with the wider health budget, and that the share of workers covered by employer mental health programmes stays at today's level, through to 2030;[47]
- **Moderate scenario** assumes that by 2030, government mental health spending will align with the current levels of high-income countries globally, while employer workplace mental health programme coverage will grow at an accelerated pace;[48] and
- **Ambitious scenario** assumes that by 2030, both government and employer workplace investments will match that of frontier countries today.[49]

Across the three scenarios, the projected economic burden of mental health in Singapore can be reduced by SGD 2.6 billion to SGD 5.4 billion, representing 12.2% to 24.9% of the total burden estimated in 2030. In all three scenarios, manager training contributes the largest share of returns, followed by organisation-wide mental health promotion and EAPs. Scaling these interventions effectively will require closing the gaps in current efforts that limit their reach.

Exhibit 5

Projected reduction in economic burden in Singapore if workplace interventions are scaled

SGD billion, 2030



SGD 2.6bn to 5.4bn

Reduction in the projected 2030 burden across the three scenarios

12.2% to 24.9%

Share of the total burden estimated for 2030

Source: Access Partnership analysis (2026). All figures are presented in real 2025 Singapore dollars. Figures may not sum due to rounding.

05

Turning Evidence into Action

The evidence is clear, and so is the gap between what works and what Singapore currently does. Three structural gaps limit the impact of current efforts. Promotion rarely reaches beyond large firms or one-off events. Manager training lacks a nationally recognised quality standard, and EAPs are available but seldom used. The recommendations below address each in turn, structured so that each intervention's output feeds into the next: promotion creates the conditions for manager training to take effect, and manager training generates the referrals that EAPs convert into care.

Intervention 1: Organisation-wide mental health promotion

Promotion today rarely reaches beyond large firms or one-off events. SMEs cannot easily run programmes on their own, and the main public channel for workplace delivery closed with the end of HPB's WOW programme. Extending its reach needs a delivery channel that does not depend on each firm building its own, and a way to turn one-off events into targeted, ongoing action.

Government can partner with sector intermediaries to deliver sustained promotion programmes.

Victoria, Australia, has shown what this looks like at scale. Its WorkWell programme, launched in 2017 as an AUD 50 million (SGD 44.8 million), five-year initiative, included a Mental Health Improvement Fund that financed 30 projects across 18 industries, many led by industry associations and unions, engaging more than 16,000 workplaces.[50] A similar model in Singapore, delivered through existing trade associations and unions, could extend sustained promotion to the SMEs that employ the majority of the workforce. Partnering with them to run multi-year programmes would give smaller firms access to promotion without bearing the full cost themselves. For the millions of workers employed by SMEs, it would also mean the first-time access to sustained, professionally structured workplace mental health promotion.

Employers can assess workplace stress regularly and act on the results.

Singapore already offers iWorkHealth, a free psychosocial assessment tool that gives employers an anonymised company report on key workplace stressors, together with recommended interventions.[51] Outcomes can be strengthened by making routine use of iWorkHealth an expectation, and by ensuring employers act on what it finds. Government can consider mandating annual psychosocial risk assessments for firms above a certain size, paired with a requirement to act on the findings. Employers can run it every year and use the results to decide where promotion efforts should go, allowing programmes to be directed towards the workplace's actual stressors. Japan's Stress Check Programme shows why both steps matter. Since 2015, workplaces with 50 or more workers have been required to conduct annual stress checks and report results to their local Labour Standards Inspection Office, and by 2024, 89.8% of eligible workplaces were doing so.[52] But running the check alone made little difference to workers' mental health. What proved effective was acting on the results: workers whose workplaces followed the check with concrete improvements to the work environment showed significantly lower psychological distress.[53] For Singapore, the lesson is clear: iWorkHealth gives employers the diagnosis, but only a routine expectation to act on it will turn that diagnosis into results.



Peer-led promotion reaches workers whom top-down campaigns miss, and unions can help these networks grow.
Australia's MATES in Construction, a programme designed by and for construction workers, relies on peer-to-peer support. Short on-site awareness sessions reach every worker, and volunteers train as "Connectors" who can recognise signs of distress and link colleagues to support.[54] Unions and employers back the programme, but its reach comes from workers themselves, with a network of over 32,000 Connectors. Evaluations show marked improvements in mental health literacy and a greater willingness among workers to support one another. Between 2001 and 2019, a period when MATES was the sector's primary peer-led initiative, suicide rates among construction workers dropped by roughly 3% annually, double the rate of decline seen among other employed men.[55] In Singapore, the Tripartite Advisory encourages workplace mental wellness champions, but these are typically appointed by employers.[56] A stronger model allows workers to volunteer for the role themselves, with unions providing training, support, and a network beyond any single company. Singapore's wellness champion framework serves as the foundation, and what is needed now is the institutional backing to scale it.

Intervention 2: Training for supervisors and managers

Without a shared standard, a recommendation to train managers can be met in name only, and employers have no clear model to follow. Raising quality takes two steps: define what good training looks like, then make it easy for every employer to adopt.

Government can set a minimum curriculum for manager training through the Tripartite Advisory, so that the quality of training is consistent across employers regardless of size or sector.
Canada shows how a common curriculum can lift quality at scale. The Mental Health Commission of Canada developed the Working Mind, a standardised workplace programme with a dedicated track for managers.[57] Across eight implementations involving nearly 1,300 participants, the programme reduced stigma and strengthened resilience and coping.

Three months on, participants showed greater willingness to seek help and to support colleagues.[58] The key was standardisation: a common curriculum, certified facilitators, and consistent delivery meant that every employer got the same quality of training regardless of size or sector. International guidance already sets out the essentials: the UK's National Institute for Health and Care Excellence (NICE) recommends that manager training cover how to hold supportive conversations, recognise warning signs, tackle stigma, and point employees to available support, with regular refresher training and protected time for all managers to attend.[59] A Singapore standard built on this, with minimum hours and accredited trainers added, would give employers a clear benchmark. This would ensure that manager training delivers consistent outcomes, avoiding wide variation in quality from firm to firm.

Community and mental health organisations can develop and deliver ready-made courses that meet the proposed standard, with each course ending in a structured referral step linking managers to professional support.

As suggested above, setting a national standard is a necessary first step, but it will take time. In the interim, community and mental health organisations can begin developing courses aligned with international benchmarks such as NICE guidelines, so that when a Singapore standard is set, accreditation can follow quickly rather than development starting from scratch. Most SMEs cannot design mental health training themselves, but they can adopt an accredited, off-the-shelf course. Mental health organisations are well placed to build such courses, train and accredit the instructors who deliver them, and offer them in person or online so that employers of any size can take part. Australia's Black Dog Institute provides a strong precedent. The not-for-profit institute developed RESPECT, a four-hour mental health training programme designed specifically for managers.[60] When it was tested in a randomised trial with 88 managers overseeing close to 4,000 staff at Fire and Rescue New South Wales, work-related sick leave in their teams fell by 18% over six months, while it rose by 10% in teams whose managers had not been trained.[61] For Singapore, these courses should also build on a strength that exists: managers are already the main route into professional care, with 43.6% of cases coming through department referral in one hospital setting, ahead of both self-referral and peer-supporter referral at 23.1% each.[62] Ending each accredited course with a structured referral step would extend this to managers across all workplaces, including those who have never been told that referral is part of their role, or shown how to do it. In turn, workers gain a direct route to support. As the referral comes through someone they already interact with daily, workers are far more likely to follow through and seek help.

Employers can adopt accredited training courses, extend them to every manager, and build them into the management pathway.

Once a standard and ready-made courses are available, the employer's job is to take them up in full: choosing accredited courses that match their needs, and training every manager beyond a few volunteers. Achieving full coverage is essential if training is intended to shift workplace culture. NICE's review of the evidence concluded that all line managers should receive mental health training, as good practice in every industry and organisation size, and that when managers know more, more employees use the support services on offer.[63] To make the training effective and sustainable, employers can build it into how managers are trained: as the WHO and International Labour Organization (ILO) recommend, manager training can be included in onboarding for new managers, management programmes, and leadership curricula.[64] Building it into the management pathway turns the training into a baseline expectation across the organisation.



Intervention 3: EAPs

EAPs in Singapore are expanding, but availability has not translated into use. Workers who have an EAP often do not trust it or do not know it is there, and many workers in smaller firms have none at all. Turning availability into use needs two things: a confidential route to care for workers without an EAP, and EAPs that workers know about and trust where they do exist.

Government can consider partnering with private service providers to extend confidential support services to workers without employer-sponsored EAP access.

For many SME workers, the main barrier to professional support is not reluctance, but the absence of accessible services, as full EAP contracts are often financially out of reach for small employers. Rather than building new infrastructure, the government can leverage existing market providers through strategic partnerships. The Korea Workers' Compensation and Welfare Service commissions a private operator to deliver free EAP services to workers in firms with fewer than 300 staff.[65] Since its launch in 2010, the programme has reached over 130,000 users, achieving an average user satisfaction score of 96.7 out of 100 from 2022 to 2024. Workers register directly to access up to seven counselling sessions annually alongside unlimited online enquiries. Crucially, statutory confidentiality guarantees ensure services reach workers completely independently of their employers.[66] A similar partnership model

in Singapore would provide workers with a reliable path to care that does not depend on employer provision, bridging the gap for the SME workforce while offering an independent alternative for those hesitant to use employer-tied services.

Employers can run their EAP as an actively managed service, not just a hotline, since low utilisation is typically driven by a lack of awareness and trust.

Many EAPs exist only as a phone number in a staff handbook, and few workers use them. Employers can change this in four practical ways. First, they can promote the EAP like a product, giving it a visible identity and keeping it in front of staff through wallet cards, posters, the intranet and short briefings at team meetings, rather than a single mention at onboarding. Second, they can make confidentiality visible, keeping the service physically and administratively separate from human resources (HR) and telling staff plainly that the employer sees only anonymised usage data. Third, they can offer several ways in, combining round-the-clock phone support with on-site or digital options, so that workers can reach help in whatever way they find least exposing. Finally, they can review the service every year with the provider, examining anonymised usage trends and adjusting where uptake is low. Evidence suggests that these steps can substantially improve uptake, and one US company has already shown their effectiveness. Together with manager training, these steps raised EAP use to 16% of its workforce and sustained it for three years, roughly four to five times the country's national average of 3% to 4%.[67] Low utilisation can be turned around if employers take ownership of EAPs instead of leaving them to run themselves.

Unions and industry bodies can pool resources to give workers in smaller firms shared access to counselling.

A service delivered through a partnership between the government and existing EAP providers, as recommended above, would provide a universal safety net, but the coverage gap is too large for any single mechanism to close. Sector-specific, industry-led services can complement it by offering workers a route to support embedded in their own professional community. A full EAP contract is often beyond the reach of a small employer, but a shared, industry-wide service can spread the cost across many firms. Australia's construction sector shows how this can work. Incolink, governed jointly by employer associations and unions, gives its members across the building and construction industry free, round-the-clock access to counselling, extended to their families. Because the service belongs to the industry rather than to any single employer, workers can use it without going through their company, and it stays with them as they move between employers on different projects. Similar shared arrangements could be developed for sectors dominated by small firms, such as food and beverage and retail, where worker unions and industry associations already have the networks to pool resources across employers, so that workers without an employer-provided EAP are not left without any route to professional support.

None of these recommendations works in isolation. Promotion creates the awareness that makes manager training effective, and manager training generates the referrals that give EAPs their reach. All three depend on coordinated action across government, employers, community and mental health organisations, and workers. The pace of action will determine how much of the burden Singapore stands to prevent.

18%



Fall in sick leave

Work-related sick leave in teams whose managers took the RESPECT training, against a 10% rise in untrained teams.

130,000+



Users since 2010

Workers reached by Korea's free EAP for firms with fewer than 300 staff, with average satisfaction of 96.7 out of 100.

16%



EAP use

Achieved and sustained for three years at one US company, four to five times the national average of 3% to 4%.

06

The Stakes of Delay

Every year Singapore delays coordinated action on workplace mental health, the burden grows, and much of it stays out of sight. It does not appear in health expenditure accounts or workplace budgets, and it grows as wages rise and the workforce expands. The more successful Singapore's economy becomes, the larger the cost of leaving this unaddressed.



What the evidence in this report makes visible is a structural misalignment. Employers bear almost the entire economic burden, 93.9% of the total, but face no common standard for what prevention looks like and no baseline expectation to invest in it. Government spending on mental health is concentrated on treatment, the downstream end of a chain that starts in workplaces and homes, months or years earlier. Community and mental health organisations deliver programmes that can be effective but cannot scale without sustained backing. The result is a burden that is large, measurable, and preventable — distributed across stakeholders who each have reason to act but no shared mechanism for doing so.

Closing that gap does not require new institutions or untested approaches. The policy architecture is in place and the interventions are proven. What is required now is alignment: government setting a common standard for manager training and closing the funding gaps that the market cannot; employers acting on what their own workplace stress data shows and actively managing the programmes they already run; community and mental health organisations building the training infrastructure that smaller employers cannot build alone; and workers extending support to those whom formal channels miss.

The cost of delay is measurable. So is the return from action. What remains is the decision to move.

Appendix: Approach and Methodology

This section describes the approach undertaken by Access Partnership to estimate the economic burden of mental health conditions in Singapore and the return on investment from three workplace interventions. All figures are presented in 2025 Singapore dollars (SGD). Values for other years have been adjusted for inflation.

Appendix A1: Economic burden of mental health conditions in Singapore in 2025 and 2030

Content	Description
Goal	Estimate the total annual economic burden of depression and anxiety symptoms across Singapore's workforce in 2025 and 2030, disaggregated by four stakeholder groups
Total estimated burden	SGD 19.6 billion in 2025, rising to SGD 21.7 billion in 2030, distributed across employers, workers, caregivers, and government
Methodology	**Prevalence base:** The 2022 web panel survey by Chodavadia et al., using the PHQ-4 screening instrument, found that 20% of residents screened positive for depression or anxiety symptoms, applied to the employed resident population. This prevalence rate in 2022 is held constant from 2022 through 2030, and serves as a conservative assumption in the economic analysis. Mental health prevalence in Singapore has been rising across successive national surveys. The Singapore Mental Health Study found that lifetime prevalence of any mental disorder rose from 12.0% in 2010 to 13.9% in 2016. More recently, the MOH's 2025 National Population Health Survey reported overall poor mental health prevalence of 15.9% among residents aged 18 to 74, rising to 25.8% among young adults aged 18 to 29. This upward trajectory is consistent with regional evidence. A Global Burden of Disease (GBD)-based analysis of mental disorders across ASEAN found approximately 80.4 million cases in 2021, an increase of roughly 70% since 1990. After adjusting for population growth and age structure, the age-standardised prevalence still rose by 6.5%, with anxiety and depressive disorders the most common across all member states. Globally, the burden of mental disorders has been on a sustained upward trajectory over the past three decades. A 2025 analysis of GBD 2021 data across 204 countries found that the age-standardised incidence rate of mental disorders rose by 15.2% between 1990 and 2021, meaning more people are developing mental disorders each year even after adjusting for population growth. Sources: Chodavadia, P., Teo, I., Poremski, D., Fung, D.S.S., & Finkelstein, E.A. (2023), "Prevalence and economic burden of depression and anxiety symptoms among Singaporean adults: results from a 2022 web panel." BMC Psychiatry, 23, 104. Available at: https://doi.org/10.1186/s12888-023-04581-7; Subramaniam, M., et al. (2020), "Tracking the mental health of a nation: prevalence and correlates of mental disorders in the second Singapore Mental Health Study." Epidemiology and Psychiatric Sciences, 29, e29. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC8061188/; Ministry of Health, Singapore (2026), "National Population Health Survey (NPHS) 2025 Report." Available at: https://www.moh.gov.sg/others/resources-and-statistics/national-population-health-survey--nphs--2025-report/; Tan, S.H.S., et al. (2025), "The epidemiology and burden of ten mental disorders in countries of the Association of Southeast Asian Nations (ASEAN), 1990–2021: findings from the Global Burden of Disease Study 2021." The Lancet Public Health. Available at: https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(25)00098-2/fulltext; and Li, X., et al. (2025), "Global burden of mental disorders in 204 countries and territories, 1990–2021: results from the Global Burden of Disease Study 2021." BMC Psychiatry, 25, 321. Available at: https://link.springer.com/article/10.1186/s12888-025-06932-y **2025 estimates:** **Employer costs — Presenteeism:** A. Number of workers screening positive for depression or anxiety symptoms B. Hourly wage C. Annual working hours D. Productivity impairment rate (i.e., the share of working hours during which affected workers report reduced functioning due to mental health symptoms, measured using the Work Productivity and Activity Impairment scale) Methodology: (A)*(B)*(C) *(D) Sources: Ministry of Manpower, Singapore (2025), "Labour Force in Singapore, 2025." Available at: https://stats.mom.gov.sg/Pages/Labour-Force-Summary-Table.aspx; Chodavadia, P., et al. (2023), "Prevalence and economic burden of depression and anxiety symptoms among Singaporean adults." BMC Psychiatry, 23, 104. Available at: https://doi.org/10.1186/s12888-023-04581-7; and Ministry of Manpower, Singapore (2025), "Summary Table: Income." Available at: https://stats.mom.gov.sg/Pages/Income-Summary-Table.aspx

Content	Description
Methodology	**Employer costs — Absenteeism:** A. Number of workers screening positive for depression or anxiety symptoms B. Average daily wage C. Excess days absent per year (i.e., the number of additional working days missed by employed adults with depression or anxiety symptoms compared to those without) Methodology: (A)*(B)*(C) Sources: Ministry of Manpower, Singapore (2025), "Labour Force in Singapore, 2025." Available at: https://stats.mom.gov.sg/Pages/Labour-Force-Summary-Table.aspx; Chodavadia, P., et al. (2023), "Prevalence and economic burden of depression and anxiety symptoms among Singaporean adults." BMC Psychiatry, 23, 104. Available at: https://doi.org/10.1186/s12888-023-04581-7; and Ministry of Manpower, Singapore (2025), "Summary Table: Income." Available at: https://stats.mom.gov.sg/Pages/Income-Summary-Table.aspx **Employer costs — Turnover:** A. Number of workers screening positive for depression or anxiety symptoms B. Mental health-attributable turnover rate (i.e., the share of employed adults with depression or anxiety symptoms who voluntarily left their role due to their mental health conditions) C. Average replacement cost per worker who leaves the workplace Methodology: (A)*(B)*(C) Sources: Deloitte UK (2024), "Mental health and employers: the case for investment — pandemic and beyond." Available at: https://www.deloitte.com/uk/en/about/press-room/poor-mental-health-costs-uk-employers-51-billion-a-year-for-employees.html; Fujimoto, A., et al. (2024), "The association between employee lifestyles and the rates of mental health-related absenteeism and turnover in Japanese companies." Epidemiology and Health, 46, e2024068. Available at: https://doi.org/10.4178/epih.e2024068; Society for Human Resource Management (SHRM) (2025), "SHRM Releases 2025 Benchmarking Reports: How Does Your Organization Compare?" 15 October 2025. Available at: https://www.shrm.org/about/press-room/shrm-releases-2025-benchmarking-reports--how-does-your-organizat; Mavenside Consulting (2025), "How Much Does It Really Cost to Hire an Employee in Singapore?" Available at: https://www.mavenside.com/; Wonderlic (2026), "The True Cost of Hiring." Available at: https://wonderlic.com/resources/; National Alliance on Mental Illness (NAMI) (2026), "2026 NAMI-Ipsos Workplace Mental Health Poll." Available at: https://www.nami.org/research/publications-reports/survey-reports/2026-nami-ipsos-workplace-mental-health-poll/ Pike, J. and Grosse, S.D. (2018), "Friction cost estimates of productivity costs in cost-of-illness studies in comparison with human capital estimates: a review." Applied Health Economics and Health Policy, 16(6), 765–778. Available at: https://doi.org/10.1007/s40258-018-0416-4; Society for Human Resource Management (SHRM) (2026), "2026 Recruiting Executives Benchmarking: Attracting Critical Talent." Available at: https://www.shrm.org/topics-tools/research/recruiting-benchmarking; Exec (2025), "15 Essential Onboarding Metrics for Faster Productivity." Available at: https://www.exec.com/learn/onboarding-metrics; and Department of Statistics Singapore (SingStat), "Exchange Rates." Available at: https://www.singstat.gov.sg/find-data/search-by theme/trade-and-investment/exchange-rates/latest-data **Worker costs — Healthcare:** A. Number of workers screening positive for depression or anxiety symptoms B. Per capita healthcare cost Methodology: (A)*(B) Sources: Ministry of Manpower, Singapore (2025), "Labour Force in Singapore, 2025." Available at: https://stats.mom.gov.sg/Pages/Labour-Force-Summary-Table.aspx; Chodavadia, P., et al. (2023), "Prevalence and economic burden of depression and anxiety symptoms among Singaporean adults." BMC Psychiatry, 23, 104. Available at: https://doi.org/10.1186/s12888-023-04581-7; and Department of Statistics Singapore (SingStat) (n.d.), "Consumer Price Index Dashboard." Available at: https://www.singstat.gov.sg/publication-resources/consumer-price-index-dashboard **Caregiver costs — Productivity loss:** Average of two proxy estimates: Proxy 1: Days off taken by working caregivers A. Employed residents B. Share of working adults concerned about a household member's mental health C. Share of those concerned who took days off work D. Days off taken per year E. Average daily wage Methodology: (A)*(B)*(C)*(D)*(E) Sources include: Ministry of Manpower, Singapore (2025), "Labour Force in Singapore, 2025." Available at: https://stats.mom.gov.sg/Pages/Labour-Force-Summary-Table.aspx; Ministry of Manpower, Singapore (2025), "Summary Table: Income." Available at: https://stats.mom.gov.sg/Pages/Income-Summary-Table.aspx; and Deloitte UK (2024), "Mental health and employers: the case for investment — pandemic and beyond." Available at: https://www.deloitte.com/uk/en/about/press-room/poor-mental-health-costs-uk-employers-51-billion-a-year-for-employees.html

Content	Description
Methodology	Proxy 2: Income lost by caregivers who leave the workforce A. Registered mental health caregivers in Singapore B. Share of primary mental health caregivers who leave the labour force C. Annual income lost per caregiver who leaves the labour force Methodology: (A)*(B)*(C) Sources: Schofield, D., et al. (2022), "The costs of mental ill-health: the economic costs in lost productivity of mental disorders in Australia, and its states and territories." BJPsych Open, 8(6), e189. Available at: https://doi.org/10.1192/bjo.2022.592; Caregivers Alliance Limited (2020), "Annual Report 2020." Available at: https://www.cal.org.sg/; International Monetary Fund (n.d.), "World Economic Outlook Database." Available at: https://www.imf.org/en/Publications/WEO; and Department of Statistics Singapore (SingStat), "Exchange Rates." Available at: https://www.singstat.gov.sg/find-data/search-by-theme/trade-and-investment/exchange-rates/latest-data **Government costs — Mental health expenditure:** A. Projected MOH operating health expenditure in target year B. Average share allocated to mental health Methodology: (A)*(B) Sources include: Ministry of Health, Singapore, Parliamentary Questions and Answers on mental health expenditure (FY2020–FY2022). Available at: https://www.moh.gov.sg/newsroom/expenditure-on-mental-health-promotion-prevention-and-treatment/; and Department of Statistics Singapore (SingStat), "Government Operating Health Expenditure." Available at: https://www.singstat.gov.sg/ **2030 projection:** The productivity components are presenteeism, absenteeism, and turnover costs. Each is projected by multiplying 2025 values by growth in two drivers: the wage base and the size of the workforce. • *Wage base.* The 2030 wage base is the 2025 mean gross monthly income of employed residents compounded forward at the mean wage compound annual growth rate (CAGR) derived from the MOM quarterly income data for 2022 to 2025. • *Workforce.* The 2030 workforce is the 2025 employed resident population compounded forward at a workforce CAGR derived from MOM and Singapore Department of Statistics (SingStat) employed resident figures for 2022 to 2025. Healthcare costs are held constant in real terms at their 2025 level through 2030. Government mental health expenditure is projected using the CAGR of MOH operating health expenditure from FY2022 to FY2025. All 2030 values are converted to constant 2025 Singapore dollars using the IMF World Economic Outlook CPI forecasts for Singapore. Sources: Ministry of Manpower, Singapore (2025), "Summary Table: Income." Available at: https://stats.mom.gov.sg/Pages/Income-Summary-Table.aspx; Ministry of Manpower, Singapore (2025), "Labour Force in Singapore, 2025." Available at: https://stats.mom.gov.sg/Pages/Labour-Force-Summary-Table.aspx; Department of Statistics Singapore (SingStat), "Government Operating Health Expenditure." Available at: https://www.singstat.gov.sg/; and International Monetary Fund (n.d.), "World Economic Outlook Database." Available at: https://www.imf.org/en/Publications/WEO

Appendix A2: Intervention 1 — Organisation-wide mental health promotion

Content	Description
Goal	Estimate the return on investment from organisation-wide mental health promotion covering awareness, education, culture change, and anti-stigma initiatives
Estimated ROI	SGD 6.20 returned for every dollar invested
Key Assumptions	The total investment base is split equally (one-third) across the three interventions. This intervention is applied first in the multiplicative sequence. Returns are calculated against the full recoverable burden pool (total economic burden). ROI ratios are drawn from international studies reported in GBP (Deloitte UK, Milligan-Saville et al.) and USD (CuraLinc, Attridge/WOS). They are applied as unitless returns per unit invested to a Singapore investment base and burden pool in real 2025 Singapore dollars, with no currency conversion, assuming relative intervention efficiency is broadly transferable across labour markets.
Methodology	A. ROI estimate 1: Deloitte UK (2020) — GBP 6.00 returned for every GBP 1 invested in organisation-wide culture and awareness programmes B. ROI estimate 2: Deloitte UK (2024) — GBP 6.30 returned for every GBP 1 invested in universal/culture-change programmes C. Average ROI: simple average of (A) and (B) — SGD 6.20 returned for every SGD 1 invested in organisation-wide mental health promotion D. Investment allocated to this intervention is assumed to be one-third of the total investment base under each scenario Estimated return: (D)*(C) Sources: Deloitte UK (2020), "Mental health and employers: refreshing the case for investment." Available at: https://www2.deloitte.com/uk/en/pages/consulting/articles/mental-health-and-employers-refreshing-the-case-for-investment.html; and Deloitte UK (2024), "Mental health and employers: the case for investment — pandemic and beyond." Available at: https://www.deloitte.com/uk/en/about/press-room/poor-mental-health-costs-uk-employers-51-billion-a-year-for-employees.html

Appendix A3: Intervention 2 — Training for supervisors and managers

Content	Description
Goal	Estimate the return on investment from structured manager mental health training programmes targeting supervisors and line managers
Estimated ROI	SGD 7.50 returned for every dollar invested
Key Assumptions	The total investment base is split equally (one-third) across the three interventions. Returns are calculated against the residual recoverable burden pool after Intervention 1 has been applied. ROI ratios are drawn from international studies reported in GBP (Deloitte UK, Milligan-Saville et al.) and USD (CuraLinc, Attridge/WOS). They are applied as unitless returns per unit invested to a Singapore investment base and burden pool in real 2025 Singapore dollars, with no currency conversion, assuming relative intervention efficiency is broadly transferable across labour markets.
Methodology	A. ROI estimate 1: Deloitte UK (2024) — GBP 5.00 returned for every GBP 1 invested in training and education programmes targeting leaders and managers B. ROI estimate 2: Milligan-Saville et al. (2017) — GBP 9.98 returned for every GBP 1 invested from a cluster randomised controlled trial in the Australian fire and rescue service C. Average ROI: simple average of (A) and (B) — SGD 7.50 returned for every SGD 1 invested in training for supervisors and managers D. Investment allocated to this intervention is assumed to be one-third of the total investment base under each scenario Estimated return: (D)*(C) Sources include: Deloitte UK (2024), "Mental health and employers: the case for investment — pandemic and beyond." Available at: https://www.deloitte.com/uk/en/about/press-room/poor-mental-health-costs-uk-employers-51-billion-a-year-for-employees.html; and Milligan-Saville, J.S., et al. (2017), "Workplace mental health training for managers and its effect on sick leave in employees: a cluster randomised controlled trial." The Lancet Psychiatry, 4(11), 850–858. Available at: https://doi.org/10.1016/S2215-0366(17)30372-3

Appendix A4: Intervention 3 — EAPs

Content	Description
Goal	Estimate the return on investment from EAPs including confidential counselling, psychological assessment, and referral services for workers experiencing mental health symptoms
Estimated ROI	SGD 5.20 returned for every dollar invested
Key Assumptions	The total investment base is split equally (one-third) across the three interventions. Returns are calculated against the residual recoverable burden pool after Interventions 1 and 2 have been applied. ROI ratios are drawn from international studies reported in GBP (Deloitte UK, Milligan-Saville et al.) and USD (CuraLink Healthcare, Attridge/WOS). They are applied as unitless returns per unit invested to a Singapore investment base and burden pool in real 2025 Singapore dollars, with no currency conversion, assuming relative intervention efficiency is broadly transferable across labour markets.
Methodology	A. ROI estimate 1: CuraLinc Healthcare (2025) — USD 5.26 returned for every USD 1 invested, based on 166,000+ EAP cases across US employers B. ROI estimate 2: Attridge/Workplace Outcome Suite (2024) — USD 5.11 returned for every USD 1 invested, based on empirical pre-post outcome data across multiple employers C. Average ROI: simple average of (A) and (B) — SGD 5.20 returned for every SGD 1 invested in EAPs D. Investment allocated to this intervention is assumed to be one-third of the total investment base under each scenario Estimated return: (D)*(C) Sources: Attridge, M., et al. (2025), "CuraLinc Healthcare peer-reviewed study reveals $5.39:1 ROI for employee assistance and mental health programs." International Journal of Scientific and Research Publications. Available at: https://curalinc.com/blog/curalinc-healthcare-peer-reviewed-study-reveals-5391-roi; and Attridge, M. (2024), "Workplace Outcome Suite (WOS) annual report 2024: EAP counselling global usage, costs, and ROI." TELUS Health and Employee Assistance Professionals Association. Available at: https://cdn.ymaws.com/eapassn.org/resource/resmgr/research/wos_annual_report_no6_attrid.pdf

Appendix A5: Reduction in economic burden under three modelled scenarios

Content	Description
Goal	Estimate the total economic burden reduced when all three interventions are deployed together under three modelled scenarios
Estimated burden reduced (2030)	Conservative: SGD 2.6 billion (12.2% of the total projected 2030 economic burden) Moderate: SGD 4.1 billion (19% of the total projected 2030 economic burden) Ambitious: SGD 5.4 billion (24.9% of the total projected 2030 economic burden)
Key Assumptions	Mental health investment includes both government and employer spending on mental health initiatives. **Government mental health investment:** Conservative scenario maintains current government spending at 3.1% of total healthcare expenditure; moderate scenario increases spending to 4.3% by 2030, aligning with the current median share of government health expenditure allocated to mental health in high-income countries; and ambitious scenario increases spending to 13.7% by 2030, matching the average share seen in frontier countries (i.e., Norway, France, and Germany). **Employer mental health programme coverage:** Conservative scenario holds coverage at the current level of 48% of employed residents; moderate scenario expands coverage to 78% by 2030, matching current levels in the United States; and ambitious scenario expands coverage to 91% by 2030, matching current levels in the United Kingdom. Per-employee spend on these mental health programmes is assumed to be constant across all scenarios. **Investment allocation:** The investment base is split equally (one-third) across the three interventions.

Content	Description
Methodology	The three interventions are applied using a multiplicative sequential model, preventing double-counting of benefits across overlapping populations. The recoverable pool is defined as the total economic burden. The sequence is as follows: • Intervention 1 (organisation-wide mental health promotion) is applied to the full recoverable pool; • Intervention 2 (training for supervisors and managers) is applied to the residual pool after Intervention 1's returns are deducted; and • Intervention 3 (EAPs) is applied to the residual pool after the returns of Interventions 1 and 2 are deducted. The total burden reduced per scenario is the sum of returns from all three interventions after the sequential adjustment. The total government and employer investment in mental health for 2030 is estimated in real 2025 Singapore dollars, comprising: • Conservative scenario: Public sector expenditure (comprising MOH mental health promotion and prevention expenditure alongside NCSS mental health funding) is projected using programme-level scaling based on total programme count and average expenditure per programme from 2022 to 2025. Employer mental health investment is projected using a corporate wellness market CAGR of 5.06% from 2025 to 2030, calculated as the average across five estimates covering the Singapore, Australia, and broader Asia-Pacific markets. • Moderate and ambitious scenarios: Public sector investment is derived from target government spending as a share of total health expenditure (4.3% and 13.7% respectively). Employer workplace mental health investment is derived by applying the target employer mental health programme coverage rate to the employed population (i.e., 78% and 91% respectively) and the average per-employee spend. Sources: Mold, J.W., Hamm, R.M. and McCarthy, L.H. (2010), "The law of diminishing returns in clinical medicine: how much risk reduction is enough?" Journal of the American Board of Family Medicine, 23(3), 371–375. Available at: https://doi.org/10.3122/jabfm.2010.03.090178; Ministry of Health, Singapore, Parliamentary Questions and Answers on mental health promotion and prevention expenditure (FY2020–FY2022). Available at: https://www.moh.gov.sg/newsroom/expenditure-on-mental-health-promotion-prevention-and-treatment/; National Council of Social Service (NCSS), annual reports and programme data (FY2022–FY2024). 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Brussels

8th Floor, Silversquare Europe
Square de Meeûs 35
B-1000 BrusselsBelgium

brussels@accesspartnership.com

North America

Washington DC

1300 Connecticut Avenue NW,
Suite 250
Washington, DC 20036
USA

+1 202 503 1570
washingtondc@accesspartnership.com

Asia

Bangkok

188 Spring Tower
11th Floor, Unit 106, Phayathai RoadThung
Phayathai, Ratchathewi, 10400
Thailand

+ 66 (2)-8216148

Hanoi

19th floor, Tower 1
Capital Place Building
No 29 Lieu Giai Street
Ngoc Khanh Ward, Ba Dinh District
Vietnam

Jakarta

Revenue Tower 21st Floor
Unit 104 SCBD Lot 13, Jl. Jend. Sudirman Kav.
52-53
Provinsi DKI Jakarta, 12190
Indonesia

+62 21 5020 0949

Manila

CG8ROCKWELL Level 21, 8 Rockwell,
Hidalgo Dr., Rockwell Center, Bgy.
Poblacion, 1210
Makati City, Metro Manila
Philippines

Kuala Lumpur

Common Ground Q Sentral
Level 39, Unit 39-02 (East Wing), 2A,
Jalan Stesen Sentral 2, Kuala Lumpur
Sentral, 50470
Malaysia

Singapore

12 Marina View
#11-20, Asia Square Tower 2
Singapore 018961

+65 8323 7855
singapore@accesspartnership.com

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