ECONOMIST ENTERPRISE

Beyond the benefit:

Connecting workforce mental health and business performance



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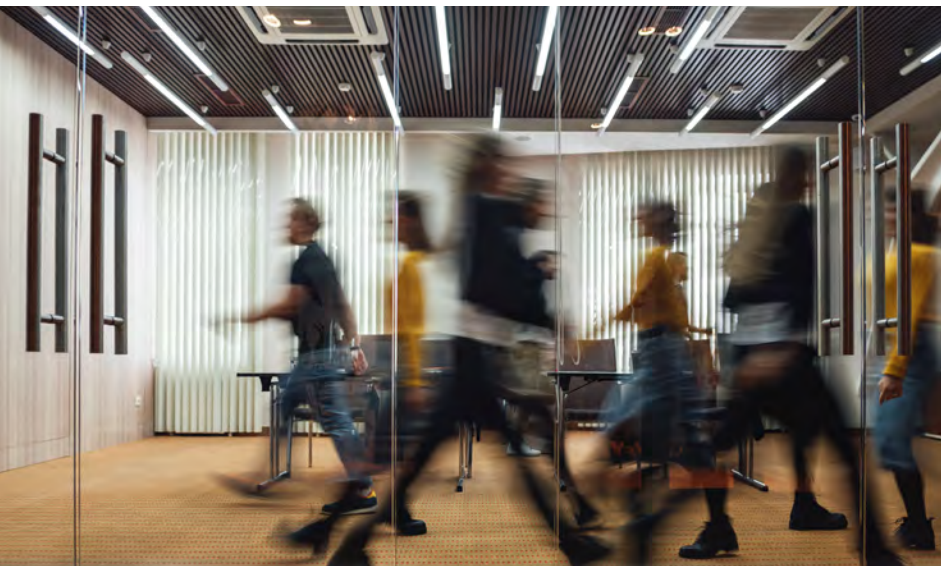
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About this report

Beyond the benefit: Connecting workforce mental health and business performance is a report produced by Economist Enterprise and supported by Lyra Health. It draws on: a targeted evidence review; a survey of 204 chief financial officers (CFOs) at American organizations with 500 or more employees; interviews with five experts in workplace well-being, organizational leadership and employee benefits; and a bespoke economic model. Our research puts a figure on the business cost of poor mental health and workplace stress in the US. It shows where those costs fall, where employers can do most to reduce them and how they can better focus, measure and adapt their response.



The editorial team at Economist Enterprise would like to thank the following individuals (listed alphabetically) for generously contributing their time and insights to this research:

- **Kristin Chenevert,** head of benefits, Citizens Financial Group
- **Jennifer Moss,** chief research and strategy officer, Global Wellbeing Group
- **Kristin Oliver,** chief human resources officer, Hyatt
- **Michelle Ricardo,** chief people officer for a leading North American provider of scientific testing, certification and consulting solutions for consumer products
- **Dave Ulrich,** Rensis Likert professor emeritus, Ross School of Business, University of Michigan; partner, The RBL Group

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This report was produced by a team of Economist Enterprise researchers:

- **Amy Roberts,** project director
- **Kati Chilikova,** research manager
- **Shivangi Jain,** quantitative lead
- **Jason Yin,** quantitative manager
- **Charlotte Bullard Davies,** survey lead

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Executive summary

American employers do not need convincing that employee mental health matters. Eight in ten CFOs we surveyed see it as a meaningful business risk, and nearly nine in ten say it has become more important to their role over the past five years.

Employers have reason to be concerned: workplace stress, anxiety and depression cost American businesses an estimated US$292bn a year. Many employers already invest in workforce mental health in some form, whether through health benefits, employee assistance programs or well-being tools. But our research reveals a gap between recognition, investment and results: mental health has moved on to the business agenda faster than employers' ability to manage it. Employers may recognize the workforce risk and provide support without knowing whether it reaches the right employees or improves an intended outcome. Bringing together evidence from our CFO survey, expert interviews, evidence review and economic analysis, we examine why that gap persists—and what employers can do differently.

Four findings bring the business challenge into focus:

1. **Workplace stress, anxiety and depression cost American businesses an estimated US$292bn a year—and even that does not capture the full business burden associated with employee mental health.** Across the workforce, that is equivalent to approximately US$2,120 per employee—or more than US$10m a year for a business with 5,000 employees.
2. **Nearly three-quarters of the estimated annual cost (US$214bn) shows up in healthcare, turnover and absence—areas that businesses can track—but fragmented data obscures the total impact and makes attribution difficult.** Those costs are recorded separately in claims, HR systems and leave records. The remaining US$78bn is associated with presenteeism—lost productivity that may leave no clear event or record for employers to track.
3. **Presenteeism is a blind spot—yet increased productivity is the outcome CFOs most want from employee mental health investment, and one of the hardest to measure.** Half (51%) rank increased workforce productivity and capacity among their three most important outcomes for building the business case for investment, yet one in five (18%) do not consider workforce productivity measures when evaluating workforce investments.
4. **Businesses can better assess mental health investment by tracking whether it improves intended outcomes, rather than relying on whether support is offered or used.** One in four CFOs (24%) cites a lack of measurable outcomes as a barrier to further mental health investment, while three in ten (30%) rank difficulty attributing business outcomes to specific interventions among their biggest barriers. Employers therefore need to define what an investment intends to change, how they will measure it and how that evidence will inform what happens next.

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The challenge then is turning risk recognition, and even existing investment, into better results. For employers already investing, that starts with understanding what is driving the problem and where they can act. More than 40% of the estimated cost—US$121bn—is associated with workplace stress, the drivers of which include conditions employers can shape directly, such as workload, management and work design. Businesses can also influence how employees with anxiety and depression are supported at work. Matching action to the source of the problem, measuring the intended result and using the evidence to decide what comes next puts results—not provision—at the center of investment decisions. After all, behind those decisions are nearly 63m US employees experiencing workplace stress, anxiety or depression—and the productivity, skills and workforce capacity on which businesses depend to grow and stay competitive.

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A recognized risk, an unresolved business cost

Employee mental health no longer needs an introduction to the C-suite. Eight in ten (81%) CFOs we surveyed see employee mental health as a meaningful business risk. Nearly nine in ten (88%) say it matters more to their role than it did five years ago.[1]

They have good reason to pay attention. American workers entered 2026 under exceptional strain: for the first time since Gallup began tracking their life evaluations, more American employees were struggling than thriving.[2]

Our analysis estimates that workplace stress, anxiety and depression affect nearly 63m American employees—almost one in two—with workplace stress alone affecting around one in three.*[3] The problem has intensified over time. Serious psychological distress among working-age adults rose 48% between 1999 and 2018.[4] In 2021, workers who expected to lose their jobs were more than twice as likely to experience serious psychological distress as those who believed their jobs were secure.[5] More recently, economic uncertainty has added to the pressure: in 2025, more than half of American workers said job insecurity significantly affected their stress levels at work.[6]

Working conditions regularly compound these pressures. Heavy workloads, understaffing, long hours, limited control and difficulty switching off from work can increase stress and mental-health risks.[7,8] Yet access to timely care remains uneven, as rising demand, provider shortages, costs and difficulties navigating benefits can delay treatment.[9,10]

Workplace stress, anxiety and depression affect nearly 63m American employees—almost one in two—with workplace stress alone affecting around one in three.



* The estimate combines the latest prevalence data available for workplace stress, anxiety and depression in the US. See Appendix for more details on modelling methodology and data sources.

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Behind the figures

Behind every aggregate figure are individual experiences that may resonate within any workforce. These pressures can take many forms:

- **The employee whose workload has steadily grown and whose sleep and concentration are suffering as a result;**
- **The new hire managing anxiety while trying to establish themselves in an unfamiliar role;**
- **The frontline worker dealing with unpredictable hours, limited control and sustained pressure;**
- **The manager balancing a demanding job with caring responsibilities at home;**
- **The employee living with depression who continues to work but finds that concentration, decisions and routine tasks take more effort;**
- **The experienced employee who appears to be coping but has begun to withdraw from colleagues or to consider whether to leave.**

None of these experiences will necessarily result in an absence, a healthcare claim or a request for support. They may first appear as lost capacity during the working day—or remain invisible until the employee takes leave or exits the organization.

> "Organizations don't think; people do. And when mental health hinders thinking, doing and feeling, organizations falter."

Dave Ulrich, rensis likert professor emeritus, Ross School of Business, University of Michigan; partner, The RBL Group

Businesses are already seeing the effects in absence and health claims. Mental-health-related leaves of absence rose 300% between 2017 and 2023, with mental health accounting for more than one in ten leaves by early 2024.[11] Employees who rate their mental health as fair or poor also report around four times as many unplanned absence days as other workers.[12] Mental health claims among people with employer-sponsored insurance also rose from 5% of professional claims in 2018 to almost 8% in 2022.[13]

Leave and healthcare capture only part of the business impact. Poor mental health can reduce employees' capacity while they are at work and increase the risk of them leaving altogether.[14,15] 'Organizations don't think; people do,' says Dave Ulrich, professor emeritus at the University of Michigan's Ross School of Business. 'And when mental health hinders thinking, doing and feeling, organizations falter.'

Putting a figure on the business cost

To understand what this means for employers, our model translates these workforce experiences into four business cost categories: healthcare; absenteeism; presenteeism; and turnover.

Workplace stress, anxiety and depression cost American businesses an estimated US$292bn a year, more than 7% of US corporate profits in 2025, or about US$1 for every US$14 in corporate profits.*[16,17,18] Even this substantial figure captures only part of the business burden associated with employee mental health. For a single business, the bill can quickly add up: approximately US$2,120 per employee annually, equivalent to more than US$10m a year for a business with 5,000 employees.

*The analysis captures overlap between workplace stress and anxiety or depression, but treats anxiety and depression as mutually exclusive for modeling purposes. See Appendix for full methodology, limitations and data sources.

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What's included in the 292bn cost?

The US$292bn represents annual costs to American businesses associated with workplace stress, anxiety and depression among employees, across four channels:

- **Absenteeism:** lost productivity from missed working days;
- **Turnover:** the cost of replacing employees who leave, including recruitment, hiring, onboarding and lost productivity during the transition;
- **Presenteeism:** lost productivity while employees remain at work but operate below their normal capacity;
- **Healthcare:** additional employer-borne healthcare spending associated with workplace stress, anxiety and depression.

The estimate does not account for other mental health conditions, the co-occurrence of anxiety and depression, or impacts beyond these four cost channels.

The cost also varies by industry. Education and health services face the highest estimated costs per employee, followed by professional and business services and financial activities.*

These differences reflect variation across industries in the prevalence of workplace stress, anxiety and depression, as well as underlying business costs. In education and health services, for example, 36% of workers report high levels of workplace stress, compared with 30% nationally.

Table 1. Annual business cost of workplace stress, anxiety and depression in the US, by industry**

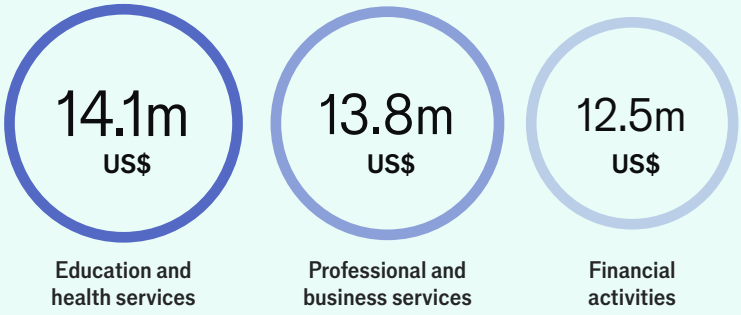
Industry	Cost per employee (US$)	Estimated business cost (US$bn)
Education and health services	2,820	79
Professional and business services	2,760	62
Financial activities	2,490	23
Information	2,080	6
Manufacturing	1,780	22
Leisure and hospitality	1,750	30
Trade, transportation and utilities	1,740	50
Other services***	1,440	9
Construction	1,200	10
Mining, quarrying and oil and gas extraction	770	0.5
Agriculture, forestry, fishing and hunting	640	1.4
US total	**2,120**	**292**

* Industry groupings follow BLS classifications. 'Financial activities' includes finance and insurance, and real estate and rental and leasing.
** Figures may not sum to totals due to rounding. Industry estimates reflect the employer costs captured by the model, not the full burden of poor mental health among workers. Differences are driven in part by reported rates of workplace stress, anxiety and depression, alongside industry wages and patterns of healthcare use. Reported prevalence may be affected by differences in stigma, diagnosis, access to care and willingness to disclose mental-health difficulties. Modeled costs may therefore understate the underlying burden where conditions are under-reported.
*** Catch-all category for establishments not listed elsewhere in the specified industries.

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What could workplace stress, anxiety and depression cost a business each year?*

A 5,000-employee business could face annual costs of:



*Illustrative estimates based on average cost per employee per industry

Despite the scale of these costs—and the growing importance CFOs attach to employee mental health—few CFOs see greater spending as the answer. Only one in ten (11%) surveyed believes their organization invests less than needed in employee mental health. Around half (52%) think investment is about right, while three in ten (29%) think it is more than needed.

Our national estimate establishes the size of the problem, but individual employers must still understand and identify how those costs appear inside their business.



Despite the scale of these costs–and the growing importance CFOs attach to employee mental health–few CFOs see greater spending as the answer: only one in ten (11%) surveyed thinks that their organization invests less than needed in employee mental health.

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Why investment can co-exist with unmanaged workforce risk

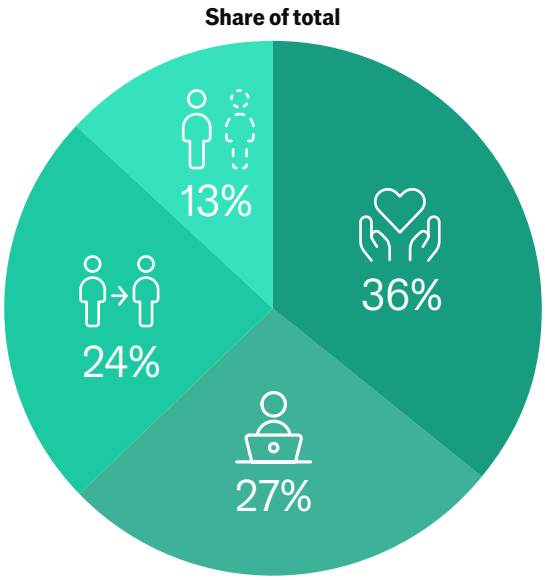
Employers can recognize the risks associated with employee stress and mental health, bear substantial costs and provide support—yet still lack the information needed to manage those risks. Our analysis highlights three reasons:

- **Costs are dispersed across the business.** Healthcare spending, absence and turnover are recorded in different systems and managed by different parts of the business.
- **Recorded costs do not reveal causation.** An employer may know how much is spent on healthcare or replacing employees without knowing how much workplace stress, anxiety or depression contributed.
- **A substantial part of the loss may not be recorded at all.** Employees may remain at work with reduced concentration, capacity or performance, without generating an absence, claim or resignation.

Businesses see fragments, not the full cost

For an individual employer, the costs represented by the US$292bn would not appear in a single cost centre. US$214bn is associated with healthcare, turnover and absence—costs that generate records businesses can, in principle, track, although usually across separate systems. The remaining US$78bn is associated with presenteeism and may leave no distinct event for an employer to record.

Where the US$292bn sits



Annual cost

Healthcare	105 US$bn
Presenteeism	78 US$bn
Turnover	71 US$bn
Absenteeism	38 US$bn
TOTAL	292 US$bn

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Of the US$292bn, healthcare is the largest single cost, at US$105bn, but nearly two-thirds of the cost sits across lost productivity, turnover and absence.*

Measuring presenteeism often relies on employees assessing changes in their own performance. Kristin Oliver, chief human resources officer at Hyatt, captures that distinction: 'The easiest ones for businesses to track are absenteeism, turnover, use of health benefits and request for leave.' Lost capacity during the working day can therefore remain hidden even as other costs come into view.

Measuring a cost that leaves no record[19,20,21,22]

No single measure captures presenteeism precisely.

A practical approach is to:

- **Use a validated measure,** such as the WHO Health and Work Performance Questionnaire, Stanford Presenteeism Scale or Work Limitations Questionnaire.
- **Look for where lost capacity is concentrated** by role, team or business unit, subject to appropriate privacy thresholds.
- **Compare results with other indicators,** such as workload, working hours, errors, service quality, absence and turnover, to understand what might be contributing.
- **Track change over time,** using a consistent measure and baseline rather than treating a single estimate as a precise financial cost.

What has this looked like in practice?

- In a four-year study of a large US health system, employees across six locations completed an annual health-risk assessment incorporating a productivity-loss measure. Researchers used self-reported impairment and local wage data to estimate productivity loss and associated costs across 22 health conditions. Mental illness and general anxiety were among the conditions associated with the highest estimated productivity loss.
- In a US chemicals company, researchers combined validated presenteeism measures with payroll, absence, health claims, job and biometric information to establish an organization-level estimate of presenteeism. Researchers projected the findings across the company's US workforce and estimated that work impairment associated with the chronic health conditions studied was equivalent to 6.8% of the company's total US labor costs. Depression, anxiety or emotional disorders were associated with the greatest self-reported work impairment among the conditions examined.

* Both studies rely on employees' self-reported impairment and use wage data to translate estimated productivity loss into financial terms. The health-system study annualized impairment reported over a two-week period, while the chemicals-company study annualized findings from a four-week reporting period. Their financial estimates should therefore be understood as estimates of lost capacity rather than directly observed business costs. The chemicals-company study also examined chronic health conditions broadly, rather than mental health alone.

* Healthcare here refers to additional employer-borne healthcare costs.

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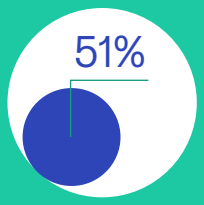
Improved productivity is the outcome CFOs most want from employee mental health investment—and one of the hardest to observe and attribute. Half (51%) rank increased workforce productivity and capacity among their three most important outcomes. By contrast, only 22% rank reduced healthcare costs among their top three, even though healthcare is the largest single component of the estimated cost.

The same cost can point to different problems

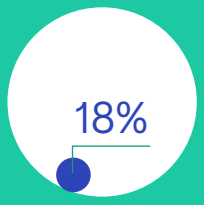
An absence, a drop in capacity or an employee departure may reflect a clinical mental health need, conditions at work or an interaction between the two. The recorded cost does not tell an employer what contributed to it, what the business can influence or which response best fits the problem.

Employers have a compelling reason to act when work itself contributes to the problem. We estimate that US$121bn a year—more than 40% of the total cost—is associated with workplace stress. This is not equivalent to US$121bn in recoverable savings: employers cannot eliminate all workplace stress

CFOs prioritize productivity but do not always measure it



of CFOs rank increased productivity and capacity among their top three outcomes for building the business case



of CFOs do not consider workforce productivity measures when evaluating workforce investments.

Different problems call for different responses[23,24,25]

What may be driving the problem?	A clinical mental health need	Workplace conditions	Both clinical need and workplace conditions
How it may affect the employee?	Anxiety, depression or other mental-health needs may affect well-being, concentration and capacity at work	High demands, long hours, low job control, job insecurity or poor work design may increase stress and reduce well-being and capacity	Workplace conditions may compound an existing mental-health need
What the employer response may include	Access to appropriate clinical care; reduce barriers to support; workplace adjustments where appropriate	Address workload, working time, management, job control and work design	Combine appropriate clinical support with action on the workplace conditions contributing to stress

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or its consequences. But it indicates the scale of the associated cost—and therefore the potential significance of acting on drivers that employers can influence, such as workload, working hours, management and job design.

Employer influence also extends beyond conditions caused primarily by work. Anxiety and depression may reflect a combination of work-related and non-work-related factors, but employers can still shape access to care, workplace support and whether or not affected employees can participate effectively at work.

Providing support does not guarantee reach or improved outcomes

Even across a broad range of support, from preventive resources to clinical care, nearly 40% of employees report not using mental health benefits in the previous six months, while 20% report little or no awareness of available resources.[26] Cost, provider access, stigma, confidentiality concerns and benefit complexity can all stand between availability and use.[27]

Employers may not even know whether that gap exists: only 22% of large employers track mental health service utilization.[28] Without that visibility, low use is hard to interpret: it may reflect lower need or barriers that prevent employees from accessing support.

A third (33%) also cite a lack of evidence demonstrating return on investment among their top three barriers.

US$121bn a year—more than 40% of the total cost—is associated with workplace stress

Even visibility into uptake only tells employers so much. An employer may know that a service was used without knowing whether productivity improved, absence fell or another intended outcome was met. That gap between uptake and outcomes matters not only for evaluating existing support, but for deciding whether further investment can be justified. One in four CFOs surveyed (24%) cited a lack of measurable outcomes as a barrier to further investment.

Attribution adds another challenge. Three in ten CFOs (30%) rank difficulty attributing business outcomes to specific interventions among their three biggest barriers to further investment. A third (33%) also cite a lack of evidence demonstrating return on investment among their top three barriers. Our findings demonstrate why measures of availability and utilization do not complete the forward-looking investment case. CFOs also want to see evidence of what changed, whether the intervention contributed and whether the result justified the committed resources. Effective action therefore requires employers to connect the problem they are trying to solve with the employees they need to reach, the intervention and the intended outcome.

Managing mental health as a workforce risk

Mental health investment is often assessed through what an employer spends, offers or sees employees use. Workforce-risk management starts somewhere else: with the business problem the employer is trying to address.

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"When you burn people out, your top performers are the first to go."

Jennifer Moss, chief research and strategy officer, Global Wellbeing Group

This requires employers to connect mental health investment to their wider workforce strategy. 'When you're going to a CFO or you're asking for an investment, it needs to be tied to the broader strategy,' says Michelle Ricardo, chief people officer for a leading North American provider of scientific testing. 'Tie it to turnover, talent, attraction and retention, and make it part of a multi-faceted strategy.'

Employers then need to locate where the risk is concentrated, understand what is contributing to it and use that diagnosis to guide what happens next.

Decide where to focus. ***Get really curious about the problem you need to solve.*** Employers do not need a perfect estimate of their total mental-health-related cost before they can act. They do need to know where the warning signs are concentrated.

Company-wide averages can hide that risk: turnover may look stable across the business while rising in a particular team; absence may climb in a business unit where workloads or working hours have increased. Workplace conditions can also deteriorate before those losses appear in company-wide figures. Ricardo describes leave and injury as 'lagging indicators' and insists 'there's probably already a problem' by the time they appear. 'Anything that happens upstream from this is very difficult to capture data on. But it can be done.' Employers therefore need to look beyond lagging indicators for earlier signs of the areas in which pressure is building.

'When you burn people out, your top performers are the first to go,' says Jennifer Moss, chief research and strategy officer at Global Wellbeing Group. The business risk lies not only in how many employees leave, but in who leaves and what skills, knowledge and capacity go with them.

Cost alone should not determine where employers focus. The scale of the loss matters, but so does whether employers have a clear route to reducing its workplace impact.

Define the problem before choosing the response

- **Size it:** establish the scale of the problem using relevant measures such as absence, turnover, healthcare use or lost capacity.
- **Locate it:** break company-wide figures down by team, role or business unit to see where the problem is concentrated.
- **Look upstream:** examine whether workload, working hours, job control, management or other working conditions coincide with higher or rising mental-health-related costs.
- **Understand what is contributing:** assess how work-related and non-work-related factors may be contributing, including where they interact.
- **Define the outcome:** specify what needs to change before deciding which response is most appropriate.

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Table 2. From workforce risk to deciding where to focus[29,30,31]

The examples below are illustrative but demonstrate common situations employers may encounter. Where employers choose to focus will depend on how widespread and severe an issue is, its impact on the business and the scope to reduce its workplace impact.

Cause or cost area	What to look for	Scope to reduce workplace impact	Potential response
Excessive workload and understaffing	Assess whether pressure is temporary or persistent, localized or widespread, and linked to absence, errors, turnover or safety risks.	**High:** employers can reduce the impact through staffing, workload, deadlines and job design, although external constraints may limit action.	If widespread and damaging, review staffing, demand, deadlines and job design. If localized, target the affected teams.
Bullying or harmful management behaviour	Consider the number and seriousness of complaints, patterns in employee feedback, turnover or absence, and whether employees feel safe reporting concerns.	**High:** employers can reduce the impact through clear standards, investigation, management accountability and support for affected employees.	Serious cases require immediate action even if few people are affected. Wider patterns call for organizational action, not training alone.
Poorly managed organizational change	Assess how many employees are affected, how long uncertainty persists and any associated decline in well-being, trust, retention or performance.	**Moderate to high:** employers can reduce the impact through consultation, communication, timing and implementation, although they may have less control over the need for change itself.	Prioritize where change is extensive, repeated or causing significant disruption. Improve participation, communication and change planning.
Financial stress linked partly to low or unpredictable pay	Assess how many employees face pay insecurity, which groups are most affected and links with hardship, absence, turnover or recruitment.	**Moderate to high:** employers can reduce the impact through pay, scheduling, benefits and other support, although their scope will depend on the source of the financial pressure.	Where the problem is widespread, review pay, scheduling and employment practices. Benefits and financial support can help but should not substitute for addressing employment-related causes.
Bereavement or family crisis	Consider whether cases are isolated or more widespread, alongside the severity and duration of their effects on employees and work.	**Moderate:** employers cannot influence the cause, but can reduce its workplace impact through flexibility, leave, adjustments and management support.	Provide proportionate flexibility, leave, adjustments and compassionate management. A shared or widespread event may call for a coordinated response.
Mental illness primarily unrelated to work	Assess prevalence and severity, where the impact is concentrated and effects on absence, performance and retention, without assuming that work caused the condition.	**Moderate:** employers may not control the cause, but can reduce the workplace impact through access to care, adjustments, support and inclusive working practices.	Where the impact is substantial, prioritize adjustments, occupational health and access to support, without making inappropriate claims about causation.

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A clear diagnosis turns a general concern about mental health into a practical question of ownership: who has the authority, information and operational responsibility to change whatever is driving the problem? The answer will rarely sit with one function. Depending on the issue, industry and operational context, relevant functions may include:

- **Benefits and occupational health** may lead where the priority is access to clinical care, workplace adjustments or return-to-work support.
- **Business leaders and managers** need to act where workload, staffing, working hours, management behaviour or job design are contributing to the problem.
- **HR and people teams** may connect patterns in absence, turnover, employee feedback and workforce demographics, while setting policies and standards across the organization.
- **Finance** can help connect costs held in different systems, agree the outcomes against which investment will be assessed and determine whether results justify further resources.
- **Employees and their representatives** can provide insight into how work is experienced and whether a proposed response is practical, accessible and reaching the people it is intended to support.

Ownership may also shift as the organization learns more. What initially appears to be a benefits issue may reveal a problem with management or work design; a company-wide concern may prove concentrated in one business unit. Shared ownership should therefore not mean diffuse accountability. Nearly half of CFOs say decisions are made jointly with HR or that finance approves HR-led recommendations. As Chenevert puts it: 'Well-being is the foundation of a culture where all colleagues can thrive; everybody owns a piece of it.' The task is to make those pieces explicit, assign accountability for action and agree what each part of the business is responsible for and how progress will be measured.

Build the response to the problem: *individual support, organizational action, or both.* Individual support can address an employee's clinical needs, while organizational interventions can address workplace conditions that contribute to stress. The two are not mutually exclusive: where these overlap, employers may need to support the employee and address the conditions at work.[32]

The appropriate response depends on fit, evidence, feasibility and cost. 'The individual interventions are always faster,' says Oliver. 'But when the same problem appears across a team or business unit, the question becomes: "Is there a systemic issue here?"'

Organizational changes can be harder to implement because they require leadership backing, operational choices and time. But faster does not necessarily mean more effective. Evidence on individually focused interventions is mixed; interventions that address working time, work design and psychosocial conditions show more consistent effects.[33,34,35]

> "The individual interventions are always faster, but when the same problem appears across a team or business unit, the question becomes: "Is there a systemic issue here?"
>
> **Kristin Oliver,** chief human resource officer, Hyatt

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The appropriate investment may therefore extend beyond a benefits contract. It may include management time, changes to working practices or different operational choices. 'The investment isn't always in hard dollars to a program,' says Chenevert. 'The investment can be the commitment to open dialogue around well-being.'

What does this look like in practice?

Before committing resources to an intervention or support, consider:

- **Problem definition | what does the data show about the problem, who is affected and what business outcome needs to change?**
- **Fit | Does the response address whatever is contributing to the problem?**
- **Evidence | What evidence suggests it can change the intended outcome?**
- **Feasibility | Can the business implement and sustain it?**
- **Cost | What money, management time and operational change will it require?**

Decide what success looks like. *Measurement should determine what happens next.* The intended result should be defined before resources are committed. If the business case rests on absence, employers need to understand current absence levels and what is contributing to them. If it rests on workforce capacity or turnover, those outcomes and their drivers also need to be measured.

Success needs a timeframe, too. CFOs are most likely to expect measurable improvements from investments in employee mental health within one to two years in order to justify financial investments, according to our survey.* Employers therefore need to define not only what should change, but by when.

Those expectations should be agreed across the business, not assumed. HR, finance and relevant business leaders may bring different priorities or expectations about when returns should emerge. Aligning on the outcome, timeframe and evidence of progress upfront creates a common baseline for deciding whether an investment is working and whether to continue, adapt or expand it.

When piloting an intervention, employers should define how they will measure both reach and results. This includes whether the intended employees used or experienced the intervention, and whether the intended business outcome changed.

What does this look like in practice?

Define the outcome, record the baseline and set a review point. Then follow the response through four stages:

Stage 1 · Fit

Did the response address the identified need?

Stage 2 · Implementation

Was the response delivered as intended?

Stage 3 · Reach

Did it reach the intended employees?

Stage 4 · Outcome

Did the intended outcome occur?

* Timing expectations vary by outcome measured.

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Decide what the evidence changes. ***The goal of measurement is not to prove success but to decide what to do next.*** Oliver describes the approach as 'constantly adjusting and evaluating', including reinvesting resources in areas that may 'make a bigger difference for wellbeing.'

What does this look like in practice?

If the evidence shows…

Implementation or reach is weak

→ **Address delivery or access before judging the response or committing further resources**

Implementation and reach are strong, but the intended outcome does not improve

→ **Revisit the diagnosis. If the response does not fit the problem, redirect resources. If it does, identify what is limiting results and adapt or stop the intervention.**

The intended outcome improves

→ **Consider continuing or expanding the response, while monitoring whether results are sustained**

Putting it all together: how the steps work in practice

Organizations routinely apply these steps when managing workforce risks.[36] The examples below show how different employers have diagnosed a problem, matched the response to its drivers, defined success and used evidence to refine their approach. The specific actions and results reflect each organization's workforce and operating context.

Managing mental health as a workforce risk is an ongoing business discipline, not a one-off spending decision. The results of organizational interventions depend not only on what employers do, but on how changes are implemented and adapted over time.[41] What matters is how deliberately businesses direct, measure and adjust their investment.



Managing mental health as a workforce risk is an ongoing business discipline, not a one-off spending decision.

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Table 3. How organizations apply the four steps[37,38,39,40]

Step	Example in practice	What it illustrates
Decide where to focus	A US energy company used an organization-wide assessment and individual worksite reviews to identify strengths and gaps in employee health and wellbeing. The process identified 11 priorities, including behavioural health, data and analytics, benefit design and workplace conditions.	**Combine company-wide and local evidence to identify specific priorities,** rather than relying on averages alone.
Match the response to the source of the problem	At a US technology workplace, an intervention combined supervisor training with greater employee control over when and where they worked. It improved schedule control, supervisor support and aspects of work-family conflict without increasing working hours or perceived job demands.	Where working conditions contribute to strain, changes to work design and management may be part of the response.
Decide what success looks like	During a period of significant organizational change, a US natural-gas company set three objectives for its response: reduce employee stress; sustain physical and emotional energy; and create an approach capable of reaching senior leaders and frontline employees. It measured resilience behaviours before the programme and one year later.	**Define the intended outcomes, measures and timeframe upfront,** so there is a clear basis for assessing whether the response worked.
Decide what the evidence changes	A US hospitality company collects employee feedback, benefit and programme data and other workforce measures then uses the findings to develop solutions and hold external partners accountable.	**Use results to inform what happens next.** Measurement should guide changes to programme design, the mix of support and decisions about providers, not simply report how many employees participated.

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The new test of human capital: the workplace operating model must catch up



Workplace stress and living with mental health challenges are no longer exceptional disruptions. They are part of the operating environment for American businesses. But much of the employer response was built for problems that announce themselves through a request for help, a healthcare claim or an absence. By the time the impact becomes visible, an employee—and the business—may have been carrying it for some time.

Companies routinely describe their people as their greatest asset and productivity as a strategic priority. Protecting both now requires more than support after the cost appears. It requires businesses to recognize risks to workforce capacity earlier, act where they have influence and use evidence to decide what needs to change.

How American businesses adapt will help determine whether their commitments to people and productivity hold up under this new reality. Workforce mental health has changed. The operating model must catch up.

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Appendix: methodology note

Introduction

This methodology note sets out the approach for estimating the annual cost associated with workplace stress, anxiety and depression to US businesses, including how these costs vary across industries.* The analysis focuses on the working-age population (adults aged 18-64) and takes an employer perspective, capturing costs through four channels: absenteeism; presenteeism; employer turnover; and employer-borne healthcare expenditure.

The framework treats workplace stress and mental health conditions as distinct but interacting factors. Workplace stress can affect workforce outcomes among employees with or without a mental health condition, while mental health conditions can affect workforce outcomes and healthcare use regardless of whether an employee also experiences workplace stress. Where workplace stress and a mental health condition occur together, their effects may overlap and compound.

In this analysis, workplace stress refers broadly to an experienced psychological state or response associated with work, rather than exposure to any single workplace stressor.

The analysis focuses specifically on anxiety and depression as primary mental health conditions. These conditions were selected because they are the most prevalent among the US working-age population and there is sufficient evidence linking them with workforce outcomes and healthcare expenditure to support quantitative analysis.[42,43] Focusing on specific conditions also allows the model to use condition-specific prevalence and impact estimates rather than treating poor mental health as a single, broad exposure. Throughout this methodology note, 'mental health conditions' refers specifically to anxiety and depression.

The analysis addresses the following core question: what is the annual cost associated with workplace stress, anxiety and depression to US businesses? In addition, it explores how the total cost varies across industries, how it arises through different cost pathways, and how much is associated specifically with workplace stress.

Estimating the business costs of workplace stress, anxiety and depression

Conceptual framework

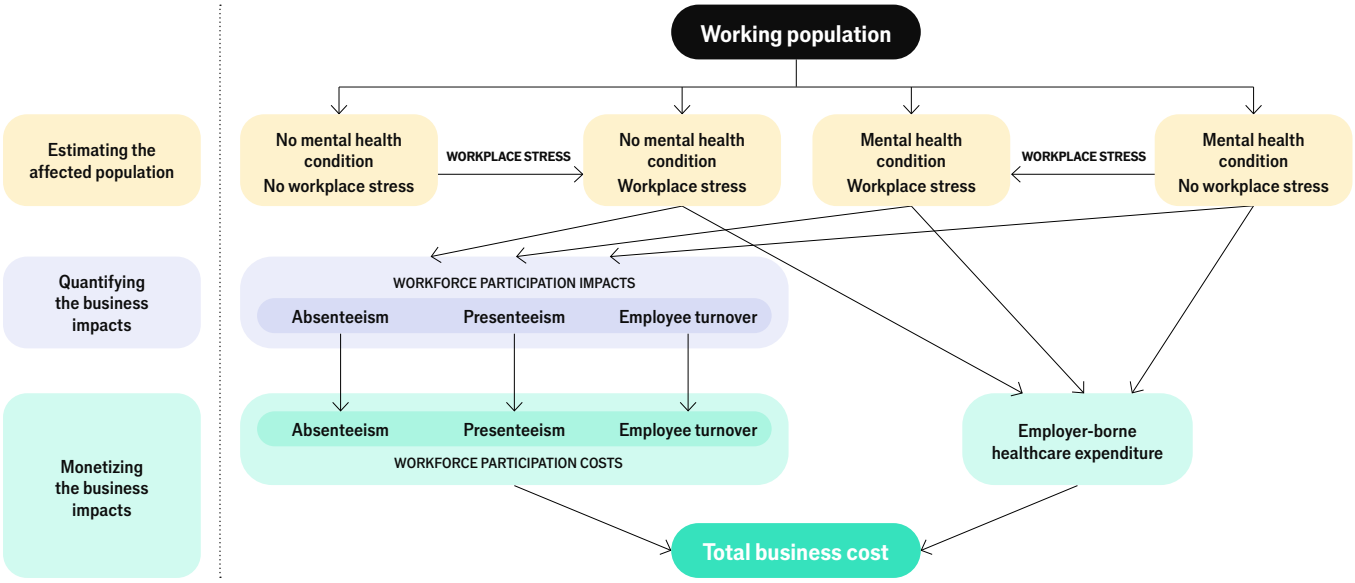
Figure 1 sets out the conceptual framework for the analysis. The model quantifies how workplace stress, anxiety and depression translate into business costs through four pathways: absenteeism; presenteeism; employee turnover; and employer-borne healthcare expenditure.

The first stage of the analysis estimates the number of employees experiencing workplace stress, anxiety and depression, including where workplace stress and a mental health condition overlap. Next, it estimates

* Industry-level estimates are reported for 11 broad industry groupings based on the US BLS supersector classification. This level of aggregation was selected to provide meaningful differentiation between industries while remaining consistent with the level of granularity supported by the other data inputs and assumptions in the model.

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Figure 1. Conceptual model



the associated business impacts through working time lost to absenteeism and presenteeism, and employee loss to turnover. Finally, these impacts are translated into monetary values and combined with additional employer-borne healthcare expenditure to estimate the total annual cost to US businesses.

The analysis is conducted by industry, classified using Bureau of Labor Statistics (BLS) data.[44] This allows the model to reflect differences across industries in the prevalence of workplace stress, anxiety and depression, workforce size, wages, healthcare expenditure and other inputs.

Estimating the affected population

The analysis begins with the US employed population aged 18-64, using BLS data to estimate the employed population by industry. It then estimates the prevalence of workplace stress, anxiety and depression within each industry.

Workplace stress and mental health conditions (anxiety and depression) are treated as distinct but overlapping. For modeling purposes, anxiety and depression are treated as mutually exclusive categories. In practice, the two conditions can

Table 1. Six mutually exclusive population groups used in the model

Mental health condition	Workplace stress experience	
	No workplace stress	Experiencing workplace stress
No anxiety or depression	No workplace stress, anxiety or depression	Workplace stress only
Anxiety	Anxiety without workplace stress	Anxiety + workplace stress
Depression	Depression without workplace stress	Depression + workplace stress

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co-occur. This simplifying assumption is made to maintain mutually exclusive population groups and to avoid double-counting employees and their associated business impacts. The model therefore divides the employed population into six mutually exclusive groups (Table 1).

The size of these groups is estimated in two stages. The analysis first estimates the prevalence of anxiety, depression and workplace stress by industry. It then uses evidence on the overlap between workplace stress and each mental health condition to divide the industry populations across the six groups (Table 2). Accounting for this overlap is important because employees experiencing both workplace stress and a mental health condition may have different patterns of workforce participation and healthcare use from those experiencing either alone.

Quantifying the business impacts

The next stage of the analysis estimates how workplace stress, anxiety and depression are associated with three workforce outcomes across industries:

- **Absenteeism:** measures working time lost when employees are absent from work, expressed as the number of working days lost annually
- **Presenteeism:** measures productive working time lost when employees continue to work while unwell but operate below their usual capacity. The analysis estimates the number of days worked while unwell and adjusts these for the estimated degree of productivity impairment to derive equivalent productive working days lost
- **Employee turnover:** measures the number of employees leaving their jobs over the course of a year

For each outcome, the analysis follows the same approach to estimate business impacts by industry for each population group. It starts by establishing an industry-level baseline for each outcome. This represents the average outcome across the whole workforce in that industry (Table 3a): the average number of days absent per employee; the average equivalent productive days lost for presenteeism per employee; and the average employee turnover rate.

The analysis then estimates how this industry-level outcome differs across the six workforce population groups described above. The industry-level baseline outcome includes all employees, including those experiencing workplace stress, anxiety or depression. It is therefore treated as a weighted average outcome across the six groups, based on the share of employees in each group.

Table 2. Data source for prevalence of anxiety, depression and workplace stress

Measurement	Data source
Prevalence of anxiety, by industry	2023 National Health Interview Survey[45]
Prevalence of depression, by industry	Sussell et al (2025)[46]
Prevalence of workplace stress, by industry	2022 General Social Survey, Quality of Worklife survey module[47]
Combined odds of anxiety and stress	Seidler et al (2022)[48] and estimated calculation
Combined odds of depression and stress	Seidler et al (2022)[49] and estimated calculation

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Further, the six groups are not assumed to experience the same outcomes. Evidence from published academic literature is used to estimate how much higher absenteeism, presenteeism or turnover is among employees experiencing workplace stress, anxiety or depression. These differences are represented using multipliers, with employees experiencing neither workplace stress nor a selected mental health condition used as the reference group (Table 3b).

The industry-level outcome for the reference group is calculated such that the population-weighted average across all six groups equals the observed industry-level baseline:

$$Outcome_{ref,i} = \frac{Outcome_i}{\sum_{g=1}^{6} p_g * m_g}$$

where:

- $Outcome_{ref,i}$ is the estimated outcome for employees with neither workplace stress nor a selected mental health condition in industry *i*
- $Outcome_i$ is the industry-level baseline in industry *i*
- p_g is the share of the industry's employees in group *g*
- m_g is the multiplier for group g relative to the reference group

Monetizing the business impacts

The final stage of the analysis translates the estimated impacts of workplace stress, anxiety and depression into annual costs to US businesses. The total business cost captures:

1. The monetized value of the workforce impacts quantified above (absenteeism, presenteeism and turnover)
2. Additional employer-borne healthcare expenditure associated with workplace stress, anxiety and depression

For each of the affected workforce groups, the analysis estimates the additional cost relative to what businesses would incur if those employees

Table 3. Baseline data and multipliers used to quantify workforce impacts

Assumption	Absenteeism	Presenteeism	Employee turnover
(3a) Industry-level baseline	By industry: average annual working days absent[50]	By industry: average annual days working while sick, adjusted for a 23% productivity impairment[51,52]	By industry: average employee turnover rate[53]
(3b) Group-specific multipliers			
No stress or selected mental health condition	1 (reference)	1 (reference)	1 (reference)
Workplace stress only	1.69 [estimated from Boles, Pelletier, Lynch[54]]	2.03 [estimated from Boles, Pelletier, Lynch[55]]	1.33 [estimated from Rubenstein et al[56]]
Anxiety only	1.43 [estimated from Duong et al[57]]	1.36 [estimated from Duong et al[58]]	1.14 [estimated from Graff, Taylor, McBurney[59]]

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Anxiety + workplace stress	1.85 [Estimated from individual stress and anxiety effects, accounting for overlap; minimum set at the higher individual estimate]	2.03 [Estimated from individual stress and anxiety effects, accounting for overlap; minimum set at the higher individual estimate]	1.35 [Estimated from individual stress and anxiety effects, accounting for overlap; minimum set at the higher individual estimate]
Depression only	2.50 [estimated from Stewart et al[60]]	4.18 [estimated from Stewart et al[61]]	1.29 [estimated from US Bureau of Labor Statistics[62]]
Depression + workplace stress	3.03 [Estimated from individual stress and depression effects, accounting for overlap; minimum set at the higher individual estimate]	4.97 [Estimated from individual stress and depression effects, accounting for overlap; minimum set at the higher individual estimate]	1.54 [Estimated from individual stress and depression effects, accounting for overlap; minimum set at the higher individual estimate]

experienced neither workplace stress nor a selected mental health condition. The resulting estimates therefore capture the incremental cost associated with workplace stress, anxiety and depression, rather than the total cost of absenteeism, presenteeism, turnover or healthcare expenditure among affected employees. All estimated costs are expressed in 2026 US dollars.

Monetizing absenteeism, presenteeism and employee turnover

For absenteeism, presenteeism and turnover, the analysis first estimates the additional impact for each affected population group compared with the group experiencing neither workplace stress nor poor mental health. For example, this could be the additional days absent, additional productive working time lost, or additional employee turnover. This additional impact is then multiplied by the number of employees in each affected group and the relevant monetary value to estimate the associated business cost.

The monetary value differs across the three outcomes:

- **Absenteeism:** Additional working days lost are valued using average daily employee wages by industry, obtained from the BLS.[63]
- **Presenteeism:** Additional equivalent productive working days lost are valued using average daily employee wages by industry, obtained from the BLS.[64]
- **Employee turnover:** Additional employee turnover is valued using the estimated cost to the employer of replacing an employee, which could include costs associated with recruitment, hiring, onboarding or lost productivity during the transition. Industry-specific turnover costs, expressed as a percentage of annual wages and obtained from the Washington Center for Equitable Growth,[65] are applied to average annual employee wages by industry from the BLS.[66]

Estimating additional employer-borne healthcare expenditure

Employer-borne healthcare expenditure is estimated using the same general approach as the workforce participation outcomes. The analysis first establishes average annual employer-borne healthcare expenditure per employee by industry (Table 4a). This industry average includes employees across all six population groups and therefore represents a weighted average.

Evidence on differences in healthcare expenditure associated with workplace stress, anxiety and

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depression is then used to estimate healthcare expenditure for each of the six groups. As with the workforce participation outcomes, employees experiencing neither workplace stress nor a selected mental health condition are used as the reference group, and differences in healthcare expenditure for the other groups are estimated using multipliers (Table 4b).

For each affected group, the analysis then calculates the additional healthcare expenditure relative to the group with no stress and no mental health condition. This difference in per-employee expenditure is multiplied by the number of employees in each group to estimate the additional healthcare expenditure borne by employers.

Table 4. Baseline data and multipliers used to estimate healthcare expenditure

Assumption	Healthcare expenditure
(4a) Industry-level baseline	Average annual employer-borne healthcare expenditure per employee, by industry, estimated from private insurance expenditure and employer contributions to insurance premiums reported in the Medical Expenditure Panel Survey[67]
(4b) Group-specific multipliers	
No stress or selected mental health condition	1 (reference)
Workplace stress only	1.46 [estimated from Goetzel et al[68]]
Anxiety only	1.99 [estimated from Chang, Mark, Brandenburg[69]]
Anxiety + workplace stress	2.28 [Estimated from individual stress and anxiety effects, accounting for overlap; minimum set at the higher individual estimate]
Depression only	1.94 [estimated from Schousboe et al[70]]
Depression + workplace stress	2.29 [Estimated from individual stress and depression effects, accounting for overlap; minimum set at the higher individual estimate]

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Finally, the additional costs of absenteeism, presenteeism, employee turnover and employer-borne healthcare expenditure are summed across all affected population groups within each industry. Industry-level estimates are then aggregated to produce the total annual cost of workplace stress, anxiety and depression to US businesses.

Limitations

The estimates should be interpreted in light of several limitations.

First, the analysis captures only a defined subset of the costs associated with workplace stress and mental health conditions. It takes a one-year time horizon and a business perspective, capturing costs borne by employers through absenteeism, presenteeism, employee turnover and employer-borne healthcare expenditure. It does not quantify longer-term effects or broader costs to employees, families, government or society, such as reduced well-being, informal care or lost earnings outside the workplace. The analysis also focuses specifically on anxiety and depression and therefore does not capture costs associated with other mental health conditions. The resulting estimate should therefore not be interpreted as the full business cost associated with employee mental health.

Second, the analysis combines data and evidence from different sources, populations and years. Industry-specific US data are used where available, but some relationships between workplace stress, anxiety, depression and workforce outcomes are drawn from studies that are not industry-specific. Applying these relationships across industries assumes that their effects are broadly transferable between sectors, which may lead to under- or overestimation of industry-level impacts.

Third, the prevalence measures used to estimate the affected population are subject to measurement and reporting limitations. Estimates of workplace stress, anxiety and depression rely on workers reporting or identifying these experiences or conditions. Differences in stigma, diagnosis, access to care or willingness to disclose mental health difficulties may therefore affect observed prevalence across industries. Where these factors result in under-reporting, the model may underestimate the underlying burden and associated costs.

Fourth, the six population groups are modeled rather than directly observed. The size of each group depends on assumptions about the overlap between workplace stress and anxiety or depression. The model also treats anxiety and depression as mutually exclusive groups and therefore does not explicitly account for employees experiencing both conditions, which occurs in practice. Differences in absenteeism, presenteeism, turnover and employer-borne healthcare expenditure across the six groups are estimated using evidence from separate studies rather than observed together in a single population. Where direct evidence on the combined effects of workplace stress and a mental health condition is unavailable, the model assumes that employees experiencing both cannot have a lower associated impact on workforce participation or health expenditure than employees experiencing either alone. These assumptions introduce uncertainty around both the size of each group and the impacts attributed to them.

Fifth, translating the estimated impacts into monetary costs requires additional assumptions. Presenteeism relies on an assumed level of productivity impairment on days worked while unwell; turnover costs are estimated as a percentage of annual wages; and employer healthcare costs assume that the employer share of insurance premiums represents the employer share of privately insured healthcare expenditure. Results are therefore sensitive to these parameters.

Finally, the estimates represent costs associated with workplace stress, anxiety and depression rather than costs that can necessarily be directly attributed to these factors. The underlying studies vary in their ability to account for other characteristics that may influence workforce participation and healthcare expenditure. The results should therefore be interpreted as estimates of the scale of business costs associated with workplace stress, anxiety and depression, rather than precise accounting of costs directly caused by them.

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ECONOMIST ENTERPRISE

London

The Adelphi
1-11 John Adam Street
London WC2N 6HT
United Kingdom
Tel: (44) 20 7830 7000
Email: london@economist.com

Geneva

Rue de l'Athénée 32
1206 Geneva
Switzerland
Tel: (41) 22 566 2470
Fax: (41) 22 346 93 47
Email: geneva@economist.com

Washington DC

1920 L Street NW Suite 500
Washington DC
20002
Email: americas@economist.com

New York

900 Third Avenue
16th floor
New York, NY 10022
United States
Tel: (1.212) 554 0600
Fax: (1.212) 586 1181/2
Email: americas@economist.com

Dubai

Office 1301a
Aurora Tower
Dubai Media City
Dubai
Tel: (971) 4 433 4202
Fax: (971) 4 438 0224
Email: dubai@economist.com

Hong Kong

1301
12 Taikoo Wan Road
Taikoo Shing
Hong Kong
Tel: (852) 2585 3888
Fax: (852) 2802 7638
Email: asia@economist.com

Singapore

8 Cross Street
#23-01 Manulife Tower
Singapore
048424
Tel: (65) 6534 5177
Fax: (65) 6534 5077
Email: asia@economist.com