

Economic value of adult social care in Cornwall

Prepared for Cornwall Council

March 2026



About the authors



Alma Economics combines unparalleled analytical expertise with the ability to communicate complex ideas clearly.

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About the commissioning organisation



This report has been jointly commissioned by Cornwall Council's People Commissioning and Economic Development services.

Contents

Abbreviations	1
List of acronyms	1
List of definitions	1
Executive summary	4
Findings	5
Policy implications	6
Limitations	6
1. Introduction	7
1.1. Background	7
1.2. Structure of the document	8
2. Methodological approach	9
2.1. Overview of the suggested approach	9
2.2. Sector Definition	10
2.3. Impacts and approach to quantification	11
2.4. Indirect and induced effects	13
2.5. Estimating the socioeconomic impact of the sector	13
3. Findings	16
3.1. Macroeconomic impact findings	16
3.2. Socioeconomic impact	23
4. Technical appendix	25
4.1. Macroeconomic impact	25
4.2. Socioeconomic impacts	29
5. References	35

Abbreviations

List of acronyms

Acronym	Definition
A&E	Accidents and Emergencies
ASCOF	Adult Social Care Outcomes Framework
ASCS	Adult Social Care Survey
ASC-WDS	Adult Social Care Workforce Dataset
BCR	Benefit-Cost Ratio
DALY	Disability-Adjusted Life Year
EBITDAR	Earnings Before Interest Taxes Depreciation Amortisation and Restructuring or Rents
FTE	Full-Time Equivalent
GOS	Gross Operating Surplus
GVA	Gross Value Added
INA	Immediate Needs Annuities
PA _s	Personal Assistants
PSSRU	Personal Social Services Research Unit
QALY	Quality-Adjusted Life Year
SCRQoL	Social Care-Related Quality of Life

List of definitions

Key term	Definition
Adult Social Care Survey	The Personal Social Services Adult Social Care Survey is an annual survey of all service users 18 and over who have received long-term support services in England. The aim of the survey is to understand how effective adult social care services are in supporting their users (NHS Digital, 2023).
Benefit-Cost Ratio (BCR)	The ratio of the estimated value of benefits compared to costs. If the BCR exceeds 1, this indicates that £1 of expenditure returns more than £1 of benefit.

Day care	Care provided for service users in a day care centre (non-residential) or the provision of activities outside the home.
Direct effects	The economic effects created by the operation of the adult social care sector itself. These include the earnings of employees in the sector, the gross operating surplus of independent care providers, and the number of jobs created.
Direct payment recipient	An individual who receives payment from the Government or local authority to pay for their own care, rather than having prescribed care provided to them.
Disability-Adjusted Life Year (DALY)	DALYs measure years lost and years lived adversely due to illness, disability, or injury. One DALY is equal to losing one year of healthy life due to premature death.
Domiciliary care	Care provided in a service user's own or family home.
Earnings Before Interest, Taxes, Depreciation, Amortisation, and Restructuring or Rents (EBITDAR)	EBITDAR is a standard measure of operating profitability for the private sector. EBITDAR focuses on a company's main operations, excluding expenses such as taxes, rent, and non-cash expenses. This facilitates comparison across companies as it minimises differences arising from factors not related to the core operations of a company.
Formal carer	Someone employed to provide paid help to adults with disabilities and or physical or mental illnesses.
Full Time Equivalent (FTE)	An FTE is equal to the hours a person employed full-time would work in a week. While this varies across countries, in England it is equal to 37 hours. As a result, a person working 0.5 FTEs, works half as many hours as a person employed full-time would (i.e. 18.5 hours per week).
Gross Operating Surplus (GOS)	The GOS is defined as income minus operating costs. It captures the income generated through profits and rents by independent providers of adult social care after subtracting, for instance, staff costs, costs associated with day-to-day services, and transportation costs.
Gross Value Added (GVA)	The amount of goods and services that have been produced, minus the cost of all inputs and raw materials that are directly attributable to that production.
Independent care	Private and voluntary sector providers of adult social care.
Indirect effects	Indirect are the effects created by the demand for intermediate goods and services by adult social care to provide its services.
Induced effects	Induced are the effects created by changes in the purchasing behaviour of individuals directly and indirectly employed in the adult social care sector.
Informal carer	Someone who provides unpaid help to a friend or family member needing support, perhaps due to illness, older age, disability, a mental health condition or an addiction (Department of Health & Social Care 2018).

Loss ratio	The loss ratio is a term used in the insurance sector, defined as the losses an insurer incurs from paying claims as a percentage of premiums earned. It represents the proportion of the income an insurer gains that is then claimed by insurance customers.
Macroeconomic impact	The macroeconomic impact includes the contribution of the adult social care sector to the economy, including wages of carers and operational profits of providers (direct impact), as well as the demand and income generated in other sectors because of adult social care (indirect and induced impacts).
Non-regulated care	Employers in the adult social care sector which are not subject to inspections or regulation.
Nursing care	Support provided to individuals with a higher level of needs. This support is delivered by specially trained carers and overseen by nurses.
Personal assistants (PAs)	Personal assistants are people hired directly by someone who requires support. They can also be employed by a family member or representative when the person they are supporting does not have the physical or mental capacity to be the employer. A PA works directly with the individual they are supporting in a person-centred way to enable them to live their life according to their wishes and interests.
Private care	Employers in the adult social care sector owned by for-profit private enterprises.
Public care	Employers in the adult social care sector owned and operated by local authorities and the NHS.
Quality-Adjusted Life Year (QALY)	A measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One quality-adjusted life year (QALY) is equal to 1 year of life in perfect health.
Regulated care sector	Employers in the adult social care sector which are inspected and regulated by the national social care inspectors.
Residential care	Care provided in a residential setting rather than in a service user's own or family home.
Social Care-Related Quality of Life (SCRQoL)	SCRQoL is part of the Adult Social Care Outcomes Framework (ASCOF) and Adult Social Care Survey (ASCS) captured in metric "1A: Quality of life of people who use services". This measures the care users' reported experience in eight outcome domains covering control, dignity, personal care, food and nutrition, safety, social participation and accommodation.
Socioeconomic impact	The socioeconomic impact includes wider benefits to society, not captured in the macroeconomic models, such as wellbeing of adults receiving care.
Voluntary care sector	Service providers in the adult social care sector run by not-for-profit organisations.

Executive summary

Headline findings

- Overall, the adult social care sector in Cornwall is estimated to support approximately **22,700** full-time equivalent (FTE) **jobs and generate around £991.3 million in** Gross Value Added (GVA) when considering direct, indirect, and induced impacts, excluding informal care.
 - The sector directly supports approximately 14,500 FTE jobs in Cornwall (or 57,200 if we include informal care), generating around £455.8 million in GVA (or £1.6bn including informal care).
 - The estimated labour productivity in the sector is around £31,400 per FTE, which is higher than England (£26,300).
 - The indirect impact of adult social care is estimated at approximately 5,300 FTEs and £217.4 million in GVA, while the induced impact is estimated at around 2,900 FTEs and £318.2 million in GVA
- The total socioeconomic benefits of adult social care in Cornwall are approximately £3.7 billion, compared with total costs of around £1.5 billion. **This implies that for every £1 spent on adult social care, around £2.37 in socioeconomic benefits are generated.**
 - This is a marginally higher return per £1 spent than the national average of £2.36.

As of 2024/25, around 19,000 people worked in the adult social care sector in Cornwall, making it one of the largest employers in the economy. In 2022/23 alone, adult social care generated approximately 4.4% of the total GVA in Cornwall (Atkinson, Baloyo and Willocks, 2023; Cornwall Chamber of Commerce, 2024). The sector encompasses a diverse range of services tailored to support adults with care and support needs, spanning across public, private, and voluntary sectors. The demand for adult social care is expected to grow in Cornwall, driven by an ageing population. Forecasts suggest that, to meet this rising demand, the adult social care independent sector workforce in Cornwall will need to increase by approximately 30–35% by 2035 (Atkinson, Baloyo and Willocks, 2023).

Recognising the importance of the adult social care sector, and in light of the completion of the first phase of the Independent Commission on Adult Social Care, Cornwall Council commissioned Alma Economics to conduct research to better understand the economic and social value of the adult social care sector and how to harness it. This analysis aims to support evidence-based decision-making and clarify the sector's contribution to Cornwall's economy and society.

For this project, our team developed two types of models: one focusing on macroeconomic impacts and the other on socioeconomic impacts. Both models consider a wide range of care settings (e.g., residential, domiciliary, and day care) and types of service provision (e.g., local authority, private, voluntary), including informal care, across regulated and non-regulated sectors. The socioeconomic model accounts for costs and benefits to society as a whole, going beyond financial impacts. As a result, there may be additional benefits (such as employment gains) created by the operation of the

adult social care sector that are not included in the socioeconomic model (as per Green Book guidance). Those identified in this research are discussed qualitatively or incorporated in the macroeconomic model.

Findings

The macroeconomic analysis estimates the economic contribution of the adult social care sector through its **direct impacts**, including the wages of care workers and the operating surplus of independent care providers. Our findings suggest that the sector directly supports approximately **14,500 full-time equivalent (FTE) jobs in Cornwall**, generating around **£455.8 million in Gross Value Added (GVA)**. This corresponds to an estimated **labour productivity of around £31,400 per FTE**.

When the contribution of informal carers is included, the direct economic value rises substantially, with approximately **57,200 FTEs contributing around £1.6 billion in GVA**, demonstrating the size of the informal sector. However, it is worth noting that this increase is also driven by the assumption that the value that informal carers create can be proxied by the cost of replacing them with formal carers (see the methodology and technical annex for more details).

Beyond its direct impact, adult social care also generates economic activity across the wider economy through **indirect and induced effects**. Indirect effects arise from the sector's demand for goods and services from other industries, such as medical supplies or training, supporting jobs and income in those sectors. Induced effects occur when employees in social care and its supply chain spend their wages on goods and services, such as groceries or transport, further supporting economic activity across the wider economy. In Cornwall, the **indirect impact of adult social care is estimated at approximately 5,300 FTEs and £217.4 million in GVA**, while the **induced impact is estimated at around 2,900 FTEs and £318.2 million in GVA**.

Overall, the adult social care sector in Cornwall is estimated to support approximately 22,700 FTE jobs and generate around £991.3 million in economic value when considering direct, indirect, and induced impacts, excluding informal care. This represents around 6% of Cornwall's total GVA, highlighting the sector's significant role in the local economy.

However, the value of adult social care extends beyond its contribution to economic output and employment. The sector also generates substantial benefits for individuals and society, including improvements in the wellbeing and quality of life of people receiving care, reduced demand for NHS services, and increased peace of mind for the wider population. To estimate these wider impacts, we compared the costs and benefits of adult social care to a hypothetical scenario in which both formal and informal care services did not exist. **The results suggest that the total socioeconomic benefits of adult social care in Cornwall are approximately £3.7 billion, compared with total costs of around £1.5 billion. This implies that for every £1 spent on adult social care, around £2.37 in socioeconomic benefits are generated.**

The findings for Cornwall suggest that the direct GVA for adult social care accounts for approximately 1.5% of the national GVA of the sector. This is slightly higher than Cornwall's share of the national population (around 1%), indicating a relatively greater contribution to economic activity on a per capita basis. On a per FTE basis, Cornwall has higher labour productivity than England (£31,400 compared to £26,300). This is largely due to proportionately higher estimated wages and earnings in day care and gross operating surplus in residential care. Notably, the sector in Cornwall generates a slightly higher return per £1 spent than the national average (£2.37 compared to £2.36), reflecting the efficiency and scale of the sector relative to its size.

Policy considerations

In terms of investment priorities, considering that the domiciliary care sector generates the highest value (also relative to England's domiciliary care sector), it could be a priority for future policymaking. Informal carers also contribute significantly, but their compensation does not reflect the value they provide or the costs the Government would incur to replace them with formal carers, offering the same amount of care. Overall, the adult social care sector makes a substantial contribution to the economy and society, so the choice of priorities is ultimately for decision makers.

Limitations

Finally, it is important to note that our analysis is subject to several assumptions and limitations due to data gaps. Future research would benefit from:

- A robust, publicly available dataset including estimates for the number of employees and wages in the non-regulated sector. While Skills for Care produces some of these estimates upon request, they are not publicly available.
- A mapping of care services that do not fit under residential, nursing, domiciliary, and day care services, such as Cornwall's "Shared Lives". These services would be included in an "other" category, similar to our national report. Improvements in data availability (e.g. number of employees, earnings, number of individuals receiving this type of support) would allow these types of care services to be fully incorporated into a similar analysis in the future.
- Increased transparency on the profits of independent sector providers of adult social care. There were no readily available estimates for Earnings Before Interest, Taxes, Depreciation, Amortization, and Rent costs (EBITDARs) in this sector in Cornwall, particularly for care home providers.
- Disentangling land costs associated with adult social care provision from other services. This would allow future researchers to include these in the socio-economic analysis, as in the national model.
- More detailed data on hospital admissions originating from adult social care settings. Hospital admissions for people aged over 65 were used as a proxy, however specific data would provide a more accurate basis for analysis.

1. Introduction

In light of the ongoing Independent Commission on Adult Social Care, Cornwall Council has commissioned Alma Economics to analyse the economic and social value of the Adult Social Care sector in the area. The findings of this project will support evidence-based decision-making and clarify the sector's contribution to Cornwall.

The chapters in this document are: 1. Introduction, 2. Methodological approach, 3. Findings, 4. Technical appendix, and 5. References.

1.1. Background

The adult social care sector is a key pillar of Cornwall's economy and plays a central role in supporting local communities. Its importance is expected to increase further in the coming years, driven by demographic change. Between 2002 and 2021, Cornwall and the Isles of Scilly experienced a 42% increase in the population aged over 65, compared to just a 1% increase in those aged 0–15 (Economy and Skills Service, 2023). As the population continues to age, demand for adult social care services is projected to grow substantially. Forecasts suggest that, to meet this rising demand, the independent sector workforce in Cornwall will need to increase by approximately 30–35% by 2035 (Atkinson, Baloyo and Willocks, 2023).

Adult social care is already one of the largest employment sectors in Cornwall and a significant contributor to the local economy. In 2022/23, the sector generated approximately 4.4% of the total GVA of the area (Atkinson, Baloyo and Willocks, 2023; Cornwall Chamber of Commerce, 2024).¹ In 2024/25, the sector comprised an estimated 19,000 posts. However, vacancy rates remain a challenge, with approximately 7% of posts unfilled, the majority of which are in home care services (Skills for Care, 2025a).²

In light of the ongoing Independent Commission on Adult Social Care, including the completion of its first phase, Cornwall Council has commissioned this work to better understand the economic and social value of the adult social care sector and how to harness it. This analysis is intended to support evidence-based decision-making and clarify the sector's contribution to Cornwall.

1.1.1. Research questions

This work aims to answer the following research questions:

1. Quantify the value of the sector to the Cornish economy in terms of jobs, businesses and investment opportunities.
2. Evaluate long-term economic and social outcomes (e.g., employment, quality of life).

¹ Calculations by Alma Economics.

² Calculations by Alma Economics.

3. Provide suggestions on how any evidence gaps could be addressed in the future to facilitate further local Cornish and national comparisons, and wider recommendations on how Cornwall Council could further strengthen and broaden the modelling going forward.
4. How can we measure and articulate the economic value of social care.
5. What asks of national government should Cornwall Council be putting forward in order to optimise the sector's ability to deliver good quality care for their residents. The investment needed into ASC in Cornwall to secure the ability to continue to deliver high quality services aligned to population need.

1.2. Structure of the document

This document presents our methodological approach and key findings across the macroeconomic and socioeconomic analysis of the adult social care sector in Cornwall. The document includes the following sections:

- [Chapter 2](#) briefly outlines our methodological approach, including (i) the definition of the sector used; (ii) the groups of interest analysed; (iii) the direct, indirect, and induced effects considered; and (iv) the types of impacts included in the socioeconomic costs and benefits.
- [Chapter 3](#) presents key findings across the macroeconomic and socioeconomic analysis.
- [Chapter 4](#) is the Technical Appendix, detailing our methodology, sources, and assumptions used to arrive at the direct, indirect, and induced value of the sector, as well as the benefit-cost ratio from its operation.
- [Chapter 5](#) presents the sources referenced throughout the report.

2. Methodological approach

This analysis follows the methodological approach established by Alma Economics in its national report for England. This consists of (i) a thorough desk-based review to identify Cornwall-specific ASC impacts and underlying data; (ii) creating two types of models: one including macroeconomic impacts and another focusing on socio-economic ones.

In the context of this analysis, social care is defined as “[...] the support provided to adults (both older people and people of working age) with physical disabilities, learning disabilities, or physical or mental illnesses, and their carers. This may include personal care (such as support for eating, washing or getting dressed) or help with domestic routines (such as cleaning or going to the shops) .” (Foster, 2024)

This analysis considers a wide range of care settings (e.g. residential, domiciliary, and day care) and types of service provision (e.g. local authority, voluntary, private), including informal care, across the regulated and non-regulated sectors.

The macroeconomic impact of the sector consists of direct, indirect, and induced effects. The direct impact has been estimated using Gross Value Added (GVA), as the total value of wages and earnings of employees of the adult social care sector and the gross operating surplus of independent care providers. We also estimated the socioeconomic costs and benefits of the adult social care sector, encompassing both direct and indirect costs, as well as tangible and intangible benefits. The socioeconomic model accounts for costs and benefits to society as a whole, going beyond financial impacts. As a result, there may be additional benefits (such as employment gains) created by the operation of the adult social care sector that are not included in the socioeconomic model (as per Green Book guidance). Those identified in this research are discussed qualitatively or incorporated in the macroeconomic model.

It is also worth noting that approximately 50% of adult social care funding in Cornwall is provided by the Council itself, with the remainder coming from healthcare, private funders, and other commissioners. As a result, half of the resulting benefits could be directly attributed to the Council’s funding.

2.1. Overview of the suggested approach

Our methodological approach closely followed related work previously undertaken for Skills for Care and Development. We built upon the existing England-specific model developed for Skills for Care, adapting and refining it to reflect the specific context and requirements of Cornwall.

Our approach comprised three distinct phases. During Phase 1, we undertook a scoping exercise to explore the local adult social care data landscape. This included engaging directly with Cornwall Council to identify available data, as well as reviewing relevant publicly available sources. Through this process we confirmed: (i) what data is available; (ii) degree of disaggregation; (iii) time period covered; (iv) who holds the data; and (v) populations covered. Once our analysis plan was finalised, we carried out economic modelling in Phase 2 to update the direct, indirect, and induced impacts, while also quantifying broader well-being benefits. In particular, Phase 2 consisted of:

- Calculating the **macroeconomic impact** of adult social care in Cornwall using quantifiable impacts. These include direct, indirect, and induced impacts (explained in a following section of this chapter).
- Estimating the **socioeconomic costs and benefits** of the adult social care sector in Cornwall.

It is important to note that our analysis is subject to several assumptions and limitations due to data gaps. Future research would benefit from:

- A robust, publicly available dataset including estimates for the number of employees and wages in the non-regulated sector. While Skills for Care produces some of these estimates upon request, they are not publicly available.
- A mapping of care services that do not fit under residential, nursing, domiciliary, and day care services, such as Cornwall's "Shared Lives". These services would be included in an "other" category, similar to our national report.
- Increased transparency on the profits of independent sector providers of adult social care. There were no readily available estimates for the EBITDARs in this sector in Cornwall, particularly for care home providers.
- Disentangling land costs associated with adult social care provision from other services. This would allow future researchers to include these in the socio-economic analysis, as in the national model.
- More detailed data on hospital admissions originating from adult social care settings. Hospital admissions for people aged over 65 were used as a proxy, however specific data would provide a more accurate basis for analysis.

2.2. Sector Definition

Social care does not have an established definition, and the range of people's care needs is wider than any definition. For the purposes of this work, we used the following definition "*Adult social care is the support provided to adults (both older people and people of working age) with physical disabilities, learning disabilities, or physical or mental illnesses, and their carers. This may include personal care (such as support for eating, washing or getting dressed) or help with domestic routines (such as cleaning or going to the shops).*" (Foster, 2024) This is the same definition used in our work for Skills for Care.

It should be noted that this definition may vary depending on the country and context. In England, the Care Act 2014 defines care and support as the provision to meet adults' and carers' needs for care and support, as well as the provision of services, facilities or resources, or other steps under local authorities' duties to individuals' wellbeing (UK Government, 2014).

2.2.1 Groups of interest

This study focuses on the same groups of interest as those in the model developed for Skills for Care, in line with previous work by ICF (2018d). In particular, we included the following groups as part of adult social care: (i) regulated providers across the private, public, and voluntary sectors; (ii) non-regulated providers; and (iii) personal assistants. However, we recognise that informal care is a significant part of adult social care. To that end, we went beyond the ICF methodology and analysed the economic contribution of informal carers and the financial support provided to them.

We also accounted for different care settings in both the regulated and non-regulated sectors. In particular, we collated data on the following:

- Residential
- Nursing
- Domiciliary (or homecare)
- Day care³

2.3. Impacts and approach to quantification

Following a detailed literature and evidence review, we identified the direct, indirect, induced, and wider impacts of adult social care. These impacts were consistent with those applied in our previous work for Skills for Care and were reviewed to ensure they were appropriate and applicable to Cornwall. The direct, indirect, and induced impacts were used to calculate the macroeconomic impact of the adult social care sector in Cornwall, while the wider socioeconomic impacts were used in our socioeconomic impact analysis.

The section below presents the impacts we quantified, the indicators used, and the underlying rationale. This analysis was conducted for the year 2024/25. All figures are reported in current values. Estimates were adjusted using GDP deflators.

2.3.1. Gross Value Added (GVA)

Indicators:

- **Wages and earnings** of employees of the adult social care sector.
- **Gross Operating Surplus** to capture income generated by the sector, other than wages.

GVA is the standard metric to estimate the macroeconomic impact of a sector. GVA measures “*The value generated by any unit engaged in production and the contributions of individual sectors or industries to GDP. It is measured at basic prices, excluding taxes less subsidies on products*” (Office for National Statistics, n.d.). There are alternative approaches to calculating GVA, namely income, expenditure and output approaches. However, based on all ICF reports, the three approaches to calculating GVA would have yielded similar results (ICF, 2018a; 2018b; 2018c; 2018d; 2018e).⁴

As a result, we followed our previous approach for Skills for Care, which aligns with the KD Network Analytics and Skills for Care (2021) report and Office for National Statistics (2017), and calculated GVA using the income approach (i.e. quantified the total income generated by the sector).

We chose the income approach because the required indicators are readily available, consistently defined, and robustly calculated.

³ We recognise that other forms of care, including Shared Lives, are also part of the adult social care provision in Cornwall. However, due to limited available data, these services were not included in this analysis. Cornwall Council report that just over 100 people are supported through Shared Lives, indicating that this form of care represents a relatively small share of the overall adult social care population in Cornwall.

⁴ The KD Network Analytics and Skills for Care (2021) report notes that “in theory, and with perfect data, all three methods give the same answer”.

2.3.2. Labour productivity

Indicators:

- **GVA**
- **Full Time Equivalent (FTE)**

The Green Book emphasises the importance of productivity as a key metric of macroeconomic value (HM Treasury, 2022). In this context, we focused on labour productivity (GVA produced for a given measure of labour). There are different approaches to calculating labour productivity. For instance, the Office for National Statistics (2023) calculates productivity as GVA per hour worked, per worker, or job. To ensure comparability with our national estimates for Skills for Care, we calculated labour productivity as GVA per FTE.

2.3.3. Avoided financial costs to the NHS

Indicators:

- **Hospital admissions**
- **Accidents and Emergencies (A&E) admissions**
- **Discharges from acute care**

Care workers can help prevent hospitalisation and accidents, reducing the frequency of emergency attendances. Furthermore, social care arrangements are a prerequisite for discharge from acute care. As a result, without adequate adult social care capacity, the NHS will incur additional costs due to having to accommodate medically fit individuals who could otherwise have been discharged. It should be noted that, due to a lack of Cornwall-specific data, some of these estimates were derived by combining international evidence from the Netherlands with England-specific figures (further details are provided in the technical appendix).

2.3.4. Peace of mind benefits

Indicator:

- **Loss ratio of providers of private long-term care**

We suggest that adult social care provides a peace-of-mind benefit to the population, due to the certainty that support will be available if and when needed. Evidence for this comes from Forder (2011), showing that individuals often pay higher premiums than the claims they receive, reflecting the additional value they place on security and reassurance. This demonstrates that people are willing to accept a financial cost in exchange for the assurance that care will be accessible when required. Consequently, we can estimate the magnitude of the peace-of-mind benefit by evaluating the monetary sacrifice individuals are willing to make for insurance coverage. We expect that adult social care also provides peace of mind to the general population by ensuring that support will be available when needed.

2.3.5. Quality of life and wellbeing

Indicators:

- **Social Care-Related Quality of Life (SCRQoL) as captured in the Personal Social Services Adult Social Care Survey (ASCS):** The Green Book emphasises the importance of wellbeing

in policy appraisal and evaluations and suggests various metrics (HM Treasury, 2022). Following our previous work for Skills for Care and the KD Network Analytics and Skills for Care (2021) approach, we quantified and monetised the impact of adult social care on the SCRQoL.⁵ We used the adjusted SCRQoL, following Forder et al. (2016) to account for (i) external factors that might influence the quality of services and (ii) different preferences across the SCRQoL metrics.

- **Quality of Life Adjusted Years (QALYs):**⁶ Access to social care significantly reduces the likelihood of individuals experiencing injuries and falls, thereby preventing the deterioration of their health. Thus, social care may improve health outcomes for those receiving care. Health outcomes are typically measured in terms of quality-adjusted life years (QALYs), which can be quantified and monetised. QALYs represent the additional healthy years gained by individuals due to receiving support. As per HM Treasury (2022) Green Book guidance, QALYs can be monetised by applying a £70,000 value (in 2020 prices) for each QALY gained. For instance, if an intervention has been found to create 0.4 QALYs (i.e. 40% of a year in perfect health and wellbeing), that means that the monetary benefit of the intervention is £28,000 in 2020 prices.

2.4. Indirect and induced effects

As mentioned at the beginning of the chapter, the adult social care sector generates additional value through indirect and induced effects on top of its direct economic impact.

Indirect effects arise in the adult social care sector from purchases of goods and services needed to deliver its activities, such as medical supplies, staff training, cleaning services, and equipment. These purchases support employment and economic output (GVA) beyond the sector's direct operations. Induced effects are generated when people employed in adult social care, or in the businesses supplying it, spend their earnings on other goods and services (beyond those needed for the sector's operation), creating further economic activity throughout the wider economy. Examples include transportation fees, groceries, and clothing.

2.5. Estimating the socioeconomic impact of the sector

This section outlines the approach used to estimate the economic and social costs and benefits of adult social care in Cornwall. In subsection 2.5.1, we present our methodological approach, including the analytical scenario and types of impacts. In subsection 2.5.2, we outline our approach to estimating the costs and benefits included in our analysis.

Our approach accounted for both direct and indirect costs, as well as both tangible and intangible benefits that can arise from the sector. The direct costs concerned the financial investment needed for the day-to-day operations of the sector, such as the labour costs of care workers. Indirect costs include the non-cash side effects of adult social care that arise indirectly from the operation of the sector and are not part of the operating expenses. In particular, we included the salaries of formal carers who would need to be paid to provide the same level of care currently offered by informal

⁵ The SCRQoL is a standardised measure capturing care users' experiences of using care services and is a part of the ASCS. Additional details are available in the Technical Appendix.

⁶ HM Treasury (2022).

carers. Tangible benefits, such as the reduction of Accidents and Emergencies (A&E) admissions, were quantified and monetised based on avoided costs. Intangible benefits, such as peace of mind benefits, were monetised using evidence from the international literature on people's preferences and willingness to pay for such benefits. In the absence of robust UK-specific evidence, we followed the KD Network Analytics and Skills for Care (2021) report, which also used international evidence to supplement evidence gaps.

2.5.1. Analytical scenario

In order to quantify and assess the costs and benefits associated with adult social care, we needed to establish a benchmark for comparison. Consequently, we compared the costs and benefits of the adult social care sector (considered as the baseline) against a hypothetical scenario where both formal and informal adult social care services are non-existent (the analytical scenario).

In the analytical scenario, we assumed that some individuals would receive no support, while others would resort to the NHS for the care that would otherwise be provided by adult social care. Those deprived of support would likely experience adverse health and wellbeing outcomes due to the lack of care, potentially leading to heightened incidences of injuries or illnesses compared to the baseline scenario where adult social care services are available. Moreover, individuals turning to the NHS would place an additional strain on the healthcare system, prolonging their stay in NHS facilities due to the absence of adult social care support.

It is important to note that, while informal carers in the UK are often forced to reduce their working hours or quit their jobs, this dynamic may differ in Cornwall. Cornwall currently has a relatively small number of outstanding purchases (requests) for social care packages, suggesting a limited backlog in access to formal care. While this may indicate perceived or experienced barriers to accessing social care, it could also suggest that few individuals are required to take on informal caring roles at the expense of working hours. Regardless of that, Green Book guidance suggests that employment effects should not be included in cost-benefit analysis – thus, we would not account for informal carers dropping out of work in our analysis, even if that were the case in Cornwall.

2.5.2. Socioeconomic costs and benefits

We considered the following costs and benefits for the baseline scenario where adult social care exists:

Costs:

- Salaries of formal carers: Earnings of people providing formal care.
- Replacement cost of informal carers: The equivalent costs required to provide the level of care offered by unpaid carers.
- Resources spent on the delivery of adult social care: Expenditure on other non-labour costs, such as buildings.⁷

⁷ Due to limited data, land costs were excluded from this model. However, they were included in our previous work for Skills for Care estimates for England, and this difference should be borne in mind when comparing the findings of this report with those estimates.

Benefits:

- Improved wellbeing due to receiving social care: The improved wellbeing benefit relates to satisfaction with social care services. It captures care users' reported experience in eight outcome domains of control, dignity, personal care, food and nutrition, safety, social participation and accommodation. It does not include the impact of avoiding injuries on wellbeing or quality of life.
- Improved health/quality of life due to not getting injured and being hospitalised (prevention): This benefit reflects the impact on quality and quantity of life due to injuries avoided through social care. This does not include the 8 domains mentioned above.
- Increased peace of mind benefits for the general public: The peace of mind benefits concern a different population compared to the previous two. While the aforementioned benefits apply to adults receiving social care, the peace of mind benefits apply to the general public in Cornwall, reflecting the benefit of knowing adult social care exists if needed (similar to insurance).
- Reduced NHS costs due to prevented hospitalisation and emergencies: As mentioned in the second benefit, adult social care helps prevent injuries. Apart from the impact on health and quality of life of adults in care, this also creates savings for the NHS through avoided hospitalisations.
- Increased efficiency in care provision from adult social care compared to the NHS: There is evidence that adult social care enables medically fit people to leave the hospital. The lack of available adult social care placements is one of the main reasons for delayed hospital discharges. As a result, the existence of the adult social care sector helps free up NHS capacity and could prevent additional discharge delays if sufficient placements were available.

3. Findings

The adult social care sector (excluding informal care) in Cornwall consists of approximately 22,700 Full Time Equivalents (FTEs) and creates approximately £991.3 million in economic value across direct, indirect and induced impacts. The estimated Gross Value Added (GVA) is equivalent to approximately 6% of Cornwall's total GVA in 2024 (Office for National Statistics, 2025d).

The direct impact constitutes the largest portion of this macroeconomic value, around £455.8 million in GVA and 14,500 FTEs. As a result, each FTE in the adult social care sector creates approximately £31,400 in value (labour productivity). Including informal care in the calculations increases the direct GVA to almost £1.6 billion, with the number of FTEs rising to around 57,200. Consequently, labour productivity is approximately £27,900 per FTE.

The adult social care sector also creates employment and economic value in other sectors due to the demand for intermediate goods and services (e.g. medical supplies) to provide care (indirect effects). Our analysis suggests that the indirect effects of formal care create 5,300 FTEs in other sectors, generating approximately £217.4 million in GVA. Furthermore, the spending of individuals directly or indirectly employed in the formal adult social care sector creates additional employment and economic value in other sectors (induced effects). In particular, the induced effects create 2,900 FTEs and generate £318.1 million in GVA.

The adult social care sector also generates wider impacts on society, beyond employment and GVA. Our analysis suggests that the socioeconomic benefits of the adult social care sector in Cornwall are approximately £3.7 billion, while the costs are £1.5 billion. This means that for every £1 spent in adult social care in Cornwall, £2.37 in benefits are generated.

This chapter presents our findings across the macroeconomic and socioeconomic analyses. A detailed presentation of the underlying methodology and sources is included in the Technical Appendix.

3.1. Macroeconomic impact findings

3.1.1. Formal care

To estimate the total macroeconomic impact due to the operation of the adult social care sector in Cornwall, we considered direct, indirect, and induced effects.

Direct impact

The direct impact consists of GVA and employment. GVA was estimated using (i) the wages and earnings of all carers across provision types and care settings; and (ii) the Gross Operating Surplus (GOS) of private and voluntary residential, nursing, and domiciliary care providers. The table below presents estimated results for the wages and earnings of formal carers in Cornwall.

Wages and earnings

The results suggest that the total value of wages and earnings in the adult social care sector in Cornwall, excluding informal care, is approximately £373.8 million⁸. Similar to what was observed in our previous work for England, workers in domiciliary and residential care are the most significant contributors to this value, with earnings of £157.5 million and £120.1 million respectively (Alma Economics, 2024a).

Considering that the domiciliary care sector generates the highest value (also relative to England's domiciliary care sector), it could be a priority for future policymaking. Informal carers also contribute significantly, but their compensation does not match the value they provide and the avoided costs the Government would have to incur to replace them with formal carers, offering the same amount of care.

Table 1. Income of formal carers in Cornwall, thousand pounds, 2024/25 ^{9 10 11}

Type of care	Local Authority Provision	Independent provision	Total
Residential care	£750.9	£119,307.2	£120,058.1
Nursing care	Not applicable	£55,608.4	£55,608.4
Domiciliary care	Not applicable	£157,511.4	£157,511.4
Day care	Not applicable	£26,573.8	£26,573.8
Total excluding personal assistants and informal care	£750.9	£359,000.8	£359,751.7
Personal assistants	Not applicable	Not applicable	£14,124.9 ¹²
Total including personal assistants but excluding informal care	£750.9	£359,000.8	£373,876.6

Gross Operating Surplus (GOS)

The table below presents the results of our analysis of the GOS of private and voluntary providers by type of care. The results suggest that the total GOS in the adult social care sector is approximately £81.9 million. Residential and nursing care providers constitute the vast majority of the total GOS, with £61.6 million and £12.1 million respectively. A similar trend was also observed in our previous work at the national (England) level (Alma Economics, 2024a).

⁸ All figures presented have been rounded, so adding individual lines may not always add up to the quoted total.

⁹ All nursing care provision is regulated in Cornwall.

¹⁰ Day care is not inspected by CQC, as a result all day care provision is non-regulated. Estimates for day care are considered to be of lower confidence due to limited data availability and greater uncertainty in underlying assumptions.

¹¹ Includes other residential and non-residential care provision by both CQC and non-CQC regulated providers.

¹² Personal assistants employed through commissioning organisations are included in the relevant provision types. The remaining personal assistants are hired by direct payment recipients. As a result, we quote only the total figure and do not break this down into private, public, or voluntary provision.

Table 2. Gross Operating Surplus of private and voluntary providers by types of care, million pounds, 2024/25

Type of care	GOS
Residential	£61.6
Nursing	£12.1
Domiciliary	£8.2
Total	£81.9

Total direct impact

The total direct impact, consisting of GVA and employment, is presented in the table below. We also calculated labour productivity, defined as GVA per FTE.

The findings suggest that there are approximately 14,500 direct FTEs in the sector, producing around £455.8 million in direct GVA. This results in labour productivity in the adult social care sector being almost £31,400 per FTE.

Table 3. Total direct impact and productivity, 2024/25

Type of impact	Excluding informal care
GVA (million pounds)	£455.8
Number of FTEs	14,500
Productivity (per FTE)	£31,400

Indirect and induced impacts

The adult social care sector also generates employment and economic value in other sectors due to demand for intermediate goods and services (e.g. medical supplies) required to provide care (indirect effects). In addition, spending by individuals directly or indirectly employed in the adult social care sector generates further employment and value in other sectors (induced effects).

As shown in Table 4, the operation of the adult social care sector generates significant indirect and induced impacts. In particular, the presence of the adult social care sector results in the generation of 5,300 FTEs and £217.4 million of GVA across other sectors. Similarly, there are around 2,900 FTEs created due to the spending of individuals directly or indirectly employed by adult social care, which leads to an additional value of £318.2 million.

Table 4. Indirect and induced GVA and employment (excluding informal care), 2024/25

Type of impact	Indirect	Induced
GVA (million pounds)	£217.4	£318.2
Number of FTEs	5,300	2,900

Total macroeconomic impact

The following table summarises the direct, indirect, and induced impacts of adult social care in Cornwall. These figures represent the total macroeconomic value of the sector in terms of GVA and

employment. The table excludes the contribution of informal carers, who are typically family members or friends providing care informally.

As shown below, the existence of the adult social care sector in Cornwall creates approximately 22,700 FTEs and £991.3 million of value across direct, indirect and induced impacts.

Table 5. Direct, indirect, and induced impacts excluding informal care, 2024/25

Type of impact	Direct	Indirect	Induced	Total
GVA (million pounds)	£455.8	£217.4	£318.2	£991.3
Number of FTEs	14,500	5,300	2,900	22,700

Sensitivity analysis

This subsection presents a sensitivity analysis of the estimates of the gross operating surplus, direct GVA, and total GVA. As described in the [methodology section](#) and detailed in the [technical appendix](#), our calculations involve several assumptions. To explore the importance of these assumptions to our final results, we varied one key assumption in our macroeconomic impact calculations. Namely, we tested the sensitivity of results to changes in Earnings Before Interest, Taxes, Depreciation, Amortisation, Restructuring, or Rent (EBITDAR), which is used in the GOS calculation.

In particular, we compared the baseline estimates (i.e. the results presented in the previous sections) to the results where EBITDAR is varied by 20% above and below the baseline estimate. Varying the baseline estimate by a fixed percentage is a common sensitivity analysis technique (e.g. Hamby, 1995), while the magnitude of the percentage was an arbitrary choice.

As such, we calculated the GOS, as well as the direct and total GVA, for 2 alternative EBITDARs: (i) baseline -20%, (ii) baseline +20%. The results suggest that the total GVA varies by approximately £69.9 million in the lower bound and £48.6 million in the upper bound of our estimates.

Table 6. Total macroeconomic impacts with varied assumptions, million pounds, 2024/25

Scenarios	GOS	Direct GVA	Total GVA
Baseline	£81.9	£455.8	£991.3
Baseline - 20%	£49.7	£423.6	£921.4
Baseline + 20%	£104.2	£478.1	£1,039.9

Informal care

Informal carers, like formal ones, generate significant value in the sector. This subsection presents the estimates of direct, indirect, induced, and total macroeconomic impacts, including the contribution of informal carers. In particular, if informal carers in Cornwall were replaced with formal carers, it would cost around £1.14 billion to maintain the same level of care¹³, as shown in the table below.

¹³ It is worth noting that informal carers may provide lower-intensity or non-specialist tasks, suggesting that informal care does not directly substitute formal care. However, in the absence of robust data on the types of activities carried out, we assumed that they provide the same level of care as formal carers. This is an established approach used in our national reports for Skills for Care and Development, enabling comparisons with England.

Table 7. Replacement cost of informal carers in Cornwall, million pounds, 2024/25

	Informal care ¹⁴	Total excluding informal care	Total including informal care
Wages and earnings	£1,141.6	£373.9	£1,515.4

The table below shows the total direct impacts including informal care. In particular, there are more than 57,200 FTEs in the sector, which would contribute around £1.6 billion, with a labour productivity of £27,900 per FTE.

The inclusion of informal carers reduces labour productivity in Cornwall's macroeconomic model, as the replacement cost of one informal carer is assumed to be equal to the earnings of a formal carer. However, in Cornwall, an informal carer's FTEs are lower than those of a formal carer. As a result, the numerator of the productivity ratio, i.e. the total GVA including both formal and informal care, will not increase proportionately to the denominator, which is the FTEs of both formal and informal carers.

Table 8. Total direct impacts (including informal care), 2024/25

Type of impact	Excluding informal care	Including informal care
GVA (million pounds)	£455.8	£1,597.3
Number of FTEs	14,500	57,200
Productivity (£ per FTE)	£31,400	£27,900

The table below presents GVA and FTEs with the addition of informal carers. The indirect GVA, including informal carers, is approximately £234.0 million, and the associated indirect FTEs are 8,300. The induced GVA amounts to approximately £342.4 million, while the induced FTEs are around 4,400.

Table 9. Indirect and induced GVA and employment (including informal care), 2024/25

Type of impact	Indirect	Induced
GVA (million pounds)	£234.0	£342.4
Number of FTEs	8,300	4,400

Finally, the table below collates and aggregates the aforementioned direct, indirect, and induced impacts of the sector, including informal care. In total, the adult social care sector creates approximately £2.2 billion of GVA and 69,900 FTE jobs.

Table 10. Direct, indirect, and induced impacts (including informal care), 2024/25

Type of impact	Direct	Indirect	Induced	Total
GVA (million pounds)	£1,597.3	£234.0	£342.4	£2,173.7
Number of FTEs	57,200	8,300	4,400	69,900

¹⁴ The replacement cost of informal carers has been assumed to be equal to the average earnings of all adult social care employees, weighted by the number employed in each care setting and type of provision. This was then converted to an FTE basis using the ratio of FTEs per informal carer.

3.1.2 Comparison with the English report

This section presents a comparison of the macroeconomic findings for Cornwall and England. Findings for England were taken from our previous work for Skills for Care (Alma Economics, 2024a).

The following caveats should be noted when comparing findings between the two analyses (both for the macroeconomic and socioeconomic models):

- The England model is based on 2023 data. To enable comparison with Cornwall, the 2023 estimates were inflated to current prices using GDP deflators. As a result, the analysis assumes that the size of the sector nationally has remained unchanged since 2023.
- While Cornwall offers care services beyond residential, nursing, domiciliary, and day care (e.g. Shared Lives), these were not included in our analysis due to data limitations. As a result, the Cornwall model does not include any services under the “other” types of care that were included in England. However, given the relatively small size of the “other” care category compared to the other types of care, this is not expected to materially affect the results.
- Land costs were not included in the socioeconomic model costs for Cornwall due to data limitations. However, in the national model, land costs represented less than 1% of total costs, suggesting that their exclusion is unlikely to materially affect the estimates.

Table 11 summarises the direct, indirect, and induced impacts of the ASC sector, excluding informal care, in England and Cornwall. The findings suggest that Cornwall’s ASC GVA represents 1.5-1.6% of England’s, consistently across direct, indirect and induced impacts. A similar pattern is observed when comparing ASC FTEs in England and Cornwall, with the latter representing approximately 1.4% of England’s total FTEs.

This share is slightly higher than the population size difference between Cornwall and England (roughly 1%), which may suggest that Cornwall’s ASC sector generates relatively more economic value per capita than England’s. This is further evidenced by calculating and comparing the labour productivity of the direct impacts (i.e. GVA per FTE). England’s labour productivity (excluding informal care) is £26,300, compared to Cornwall’s £31,400. In our model, the higher labour productivity is driven by differences in both wages and GOS within the care sector. In particular, Cornwall shows proportionately higher wages and earnings in day care, alongside higher GOS in residential care, which increases overall output per worker.¹⁵

Compared with other UK nations, Cornwall’s labour productivity is higher than in Scotland, Wales, and Northern Ireland, according to estimates from our work for Skills for Care and Development.

¹⁵ The higher GOS in residential care reflects both higher unit costs, derived from Cornwall’s Market Sustainability Plan, and a higher assumed EBITDAR margin (24% in Cornwall compared to 13% in England). This EBITDAR estimate is based on scaling from domiciliary care margins using relative revenue differences. Additionally, higher wages in day care may be influenced by assumptions around staffing levels. In particular, FTEs are estimated using staff-to-service-user ratios in non-regulated care, potentially resulting in higher implied earnings per worker. It should be noted that our day care estimates are of lower confidence due to the underlying assumptions used to address data gaps.

(Alma Economics, 2024c, 2024d, 2024b).¹⁶ In Scotland (£30,400), the difference is driven by proportionately lower wages and earnings in day care and lower GOS in care homes compared to Cornwall. In Wales (£29,800), the difference arises due to proportionately lower GOS in domiciliary care and lower wages and earnings in day care. In Northern Ireland (£28,600), the lower figure is driven by proportionately lower wages and earnings in domiciliary care, as well as lower GOS in both residential and domiciliary care. Nonetheless, care should be taken when drawing direct comparisons across nations, as differences in care provision, funding models, and service delivery can significantly affect the underlying productivity estimates.

Table 11. Direct, indirect, and induced impacts excluding informal care in England, 2023 (current prices)

Type of impact	Direct	Indirect	Induced	Total
GVA (million pounds)				
England	£29,384.1	£14,368.8	£20,680.1	£64,433.0
Cornwall	£455.8	£217.4	£318.2	£991.3
Number of FTEs				
England	1,042,500	379,500	204,200	1,626,100
Cornwall	14,500	5,300	2,900	22,700

Table 12 compares the direct, indirect, and induced impacts in England and Cornwall, including informal care. The results are broadly similar to those excluding informal care, although Cornwall represents a slightly smaller share of England's impacts. Specifically, Cornwall's direct impact, including informal care, represents 1.3% of England's (compared to 1.5% excluding informal care), while the indirect and induced impacts account for 1.4% of England's (reduced from 1.5% excluding informal care). This suggests that, relative to formal carers, England has a larger number of informal carers compared with Cornwall. As a result, when informal care is included, England's ASC GVA and FTEs increase proportionally more than Cornwall's.

Table 12. Direct, indirect, and induced impacts (including informal care) in England, 2023 (current prices)

Type of impact	Direct	Indirect	Induced	Total
GVA (million pounds)				
England	£117,914.0	£16,100.4	£23,172.2	£157,186.6
Cornwall	£1,597.3	£234.0	£342.4	£2,173.7
Number of FTEs				
England	4,611,200	681,100	366,500	5,658,700
Cornwall	57,200	8,300	4,400	69,900

¹⁶ To enable comparison with Cornwall, the 2023 estimates were inflated to current prices using GDP deflators. As a result, the analysis assumes that the size of the sector nationally has remained unchanged since 2023.

3.2. Socioeconomic impact

The second part of our analysis examines the costs and benefits of the adult social care sector, relative to a hypothetical scenario in which both the formal and informal care sectors cease to exist. High-level findings are presented below, with additional details on sources and methodology provided in the [Technical Appendix](#).

3.2.1. Costs

The following table presents the main costs associated with the adult social care sector in Cornwall. As indicated below, the total cost of the adult social care sector in Cornwall is estimated to be approximately £1.5 billion in 2024/25. As observed in our previous work covering England overall, the most significant cost within the adult social care sector is related to the value generated from informal care, which equals the cost of replacing informal carers with formal care staff offering the same volume of care (£1.1 billion in 2024/25).

Table 13. Costs due to the operation of adult social care, million pounds, 2024/25

Salaries of formal carers ¹⁷	£381.4
Replacement cost of informal carers	£1,141.6
Resources spent on the delivery of adult social care	£18.2
Total costs	£1,541.1

3.2.2. Benefits

As shown below, the total socioeconomic benefits of the adult social care sector in Cornwall, including informal care, are estimated to be around £3.7 billion in 2024/25. The most significant benefit is the improvement in wellbeing due to receiving social care, estimated at approximately £3.3 billion in 2024/25. A similar analysis for England also found wellbeing improvements as the largest contributing benefit (Alma Economics, 2024a). This benefit represents the monetary value that care users would be willing to pay to achieve improvements in outcomes such as safety, personal care, and accommodation (as captured by the SCRQoL). The size of this benefit can be explained by: (i) the magnitude of the impact that care services have on wellbeing; (ii) the monetary value of wellbeing impacts; and (iii) the size of the populations affected (i.e. the entire population receiving unpaid care and those receiving formal care, excluding nursing care).

¹⁷ Please note that there is a small discrepancy between the total salaries of formal carers in the socioeconomic and macroeconomic models. This discrepancy arises because the macroeconomic impact model uses earnings per FTE, whereas the socioeconomic model uses earnings per person. The total earnings differ because the macroeconomic model calculates earnings per FTE based on care setting and provision type, while the socioeconomic model uses weighted average earnings to determine earnings per person. We chose different earnings measures for each model due to their distinct purposes. The macroeconomic model employs earnings per FTE for a more accurate bottom-up approach. In contrast, the socioeconomic model serves as a legacy tool for projecting future costs and benefits. To this end, using earnings per carer would be more suitable for projections as it allows the application of growth rates of cared-for individuals and carers.

Table 14. Benefits due to the operation of adult social care, million pounds, 2024/25

Improved wellbeing due to receiving social care	£3,276.4
Improved health/quality of life due to not getting injured and being hospitalised	£10.2
Increased peace of mind benefits for the general public	£58.2
Reduced NHS costs due to prevented hospitalisation and emergencies	£289.1
Increased efficiency in care provision from adult social care compared to the NHS	£23.4
Total benefits	£3,657.2

3.2.3. Net benefits and Benefit-Cost Ratio (BCR)

Overall, the analysis suggests that the benefits of the adult social care sector significantly outweigh the costs. In summary, the adult social care sector in Cornwall creates more than £2.1 billion in net benefits (i.e. total benefits minus total costs). Furthermore, the adult social care sector achieves a BCR of £2.37, suggesting that for every £1 spent in adult social care in Cornwall, £2.37 of benefits are generated.

3.2.4. Comparison with England

Table 15 presents a comparison of the socioeconomic impacts in England and Cornwall. As with the macroeconomic model, this comparison is based on our previous work for Skills for Care (Alma Economics, 2024a). The results suggest that Cornwall's costs and benefits represent 1.3% of England's total ASC socioeconomic value. This share is beyond what would be expected based on relative population sizes (i.e. Cornwall is roughly 1% the size of England), suggesting that on a per capita basis, Cornwall's ASC sector generates higher benefits than the national average. This difference can mainly be traced to the "increased efficiency in care provision from ASC compared to the NHS" (1.5% of England's figure), which in turn originates from a higher incidence of potentially avoidable delayed discharges among care home residents in Cornwall (additional details on this calculation can be found in the technical annex).

Cornwall's share of the benefits compared to England is slightly higher than the share of the costs, which is also reflected in a marginally higher BCR for Cornwall (2.37 compared to 2.36). As a result, Cornwall's ASC sector has a marginally higher return for each £1 spent, compared to the national average.

Table 15. Costs and benefits due to the operation of adult social care in England, 2023 (current prices)

	England	Cornwall	Cornwall relative to England (%)
Total costs (million pounds)	£119,889.4	£1,541.1	1.3
Total benefits (million pounds)	£282,433.8	£3,657.2	1.3
Benefit-Cost Ratio	2.36	2.37	N/A

4. Technical appendix

This appendix presents in detail the calculations and data sources used to estimate the macro and socioeconomic impact of the adult social care sector in Cornwall. [Section 4.1](#) of this chapter outlines our approach to calculating the macroeconomic impacts. In particular, [subsection 4.1.1](#) explores the direct benefits resulting from the operation of the adult social care sector, namely the Gross Value Added (GVA). [Subsection 4.1.2](#) briefly outlines our approach to calculating the productivity benefits, while [subsection 4.1.3](#) describes our methodology for calculating the indirect¹⁸ and induced¹⁹ impacts of adult social care, consisting of GVA and employment. **The direct, indirect, and induced effects together constitute the total macroeconomic impact of the adult social care sector.** [Section 4.2](#) in this chapter outlines our approach to calculating the wider socioeconomic costs ([subsection 4.2.1](#)) and benefits ([subsection 4.2.2](#)) of the adult social care sector, as described in the previous chapter.

4.1. Macroeconomic impact

4.1.1. Direct effects

Gross Value Added

To calculate GVA, we summed the total earnings and profits generated by the adult social care sector. This includes:

- **Wages and earnings** of the employees in the regulated and non-regulated sectors, as well as personal assistants and informal carers. We first collated data on the number of jobs and FTEs in the adult social care sector. These were then multiplied by the average earnings per FTE for each type and setting of care.
- **Gross operating surplus** in the independent sector across care settings. Our aim was to capture the additional value generated by the sector due to the profits of private and voluntary providers, beyond wages and earnings. To that end, we applied average profitability ratios (EBITDAR)²⁰ to the care home and domiciliary care placements provided by the independent sector. Day care was not included in this calculation because no information is available on its profitability.

¹⁸ Indirect are the effects created by the demand for intermediate goods and services by adult social care to provide its services (ICF, 2018d).

¹⁹ Induced are the effects created by changes in the purchasing behaviour of individuals directly and indirectly employed in the adult social care (ICF, 2018d).

²⁰ Earnings Before Interest Taxes Depreciation Amortisation and Restructuring or Rents (EBITDAR) is a standard measure of operating profitability for the private sector (Competition & Markets Authority, 2017).

Detailed technical discussion

Number of jobs and FTEs

Regulated sector

Data on employees from all care settings analysed for the regulated sector was taken from the Adult Social Care Workforce Dataset (ASC-WDS) (Skills for Care, 2025b). As publicly available data was used, only data on the regulated sector was available. It should be noted that the available data aggregates Cornwall and the Isles of Scilly, although the scope of this analysis relates to Cornwall only. The data have been used on this basis, given the very small population of the Isles of Scilly relative to Cornwall, and therefore, the negligible impact this aggregation is expected to have on the overall results.

Non-regulated sector

As employee and FTE data were not available for the non-regulated sector, we used the 2024/25 Skills for Care regional summary of adult social care in Cornwall and the Isles of Scilly to estimate the relative size of the workforce (*A summary of the adult social care sector and workforce in Cornwall and Isles of Scilly 2024/25*, 2025). The report indicates that 70% of care-providing locations in the region are CQC-regulated and 30% are non-regulated. This implies that the number of non-regulated locations is approximately 42% of the number of regulated locations (30% divided by 70%). We applied this proportion to the regulated workforce FTEs, assuming that the distribution of FTEs across the regulated and non-regulated sectors broadly mirrors the distribution of locations. To estimate the number of employees in the non-regulated sector, we assumed that the ratio of FTEs to total placements is equal across the regulated and non-regulated sectors. As such, the ratios from the regulated sector were used.

A different approach was taken for day care services, as these services are not regulated in England and therefore comparable ASC-WDS data were not available. We therefore relied on Cornwall Council data on the number of adults receiving day care.²¹ To estimate the associated FTEs for day care, we calculated the ratio of FTEs per adult receiving non-regulated independent residential and domiciliary care services.²² We then applied this ratio to the number of adults receiving day care. As such, we assumed that the FTE-to-service-user ratio in non-regulated independent residential and domiciliary care is the same in day care provision. To estimate the corresponding number of employees, we applied the average FTE-to-total employees ratio in the unregulated sector (for which ASC data are available). As such, estimates for day care are considered to be of lower confidence due to more limited data availability and greater uncertainty in underlying assumptions.

Informal carers

The number of informal carers and the hours of care provided were taken from Office for National Statistics (2023b) census data. We calculated separately the number of informal carers claiming carer's allowance using Department for Work and Pensions (2024) benefit statistics, although the allowance was not included in the direct economic contribution. While carer's allowance is not explicitly exclusive to informal carers, the criterion of maximum net income of £196 per week makes it unlikely that a significant number of claimants are formal carers, given their median gross weekly income is £472 (UK Government, no date; Office for National Statistics, 2025a). As a result, we assumed that all claimants of carer's allowance are informal carers receiving support from local authorities.

²¹ These figures relate to independent provision only as Cornwall does not directly provide day care services.

²² Nursing care was excluded as it is not regulated, meaning that comparable figures on FTE-to service user ratio for the non-regulated sector are not available.

Personal assistants

To calculate the number of personal assistants (PAs) in adult social care we used the 2024/25 Skills for Care summary of adult social care in Cornwall and the Isles of Scilly (*A summary of the adult social care sector and workforce in Cornwall and Isles of Scilly 2024/25*, 2025). This report provides estimates of the total number of adult social care job posts in the area, as well as the proportion working for direct payment recipients.²³ To estimate FTEs, we relied on Skills for Care figures on the average usual hours worked by PAs in a week (Skills for Care, 2025c). We then divided this average weekly hours figure by the standard number of hours that count as one FTE (i.e. 37), to convert total hours worked into the equivalent number of full-time posts. As Cornwall-specific estimates were not available, England-level data were used.

Wages and earnings

Regulated sector

The wages and earnings of employees in the regulated sector were taken from the ASC-WDS (Skills for Care, 2025b). Similar to data on the number of employees and FTEs, only data on the regulated sector was publicly available.

Non-regulated sector

We assumed that wages per FTE in the non-regulated sector are the same as the equivalent wages in the regulated sector, for each type of care. This assumption is informed by our previous work in the ASC sector which suggests that the wages do not differ substantially between regulated and non-regulated provision on an FTE basis (i.e. maximum 6% difference). For day care, we assumed that earnings per FTE are equal to the average of earnings for residential and non-domiciliary care.

Informal carers

The earnings estimate for the formal sector employees was used to calculate the value of informal care. In particular, we used the average earnings of employees in the formal sector, weighted by the number of employees in each setting, as a proxy for the compensation that formal carers would receive to offer the same volume of care. This was then converted to an FTE basis using the ratio of FTEs per informal carer, calculated above. Any benefits or allowances received by informal carers were not included in the direct economic contribution, as we were interested in the value of the output produced by informal carers.

It is worth noting that informal carers may provide lower-intensity or non-specialist tasks, suggesting that informal care does not directly substitute formal care. However, in the absence of robust data on the types of activities carried out, we assumed that they provide the same level of care as formal carers. This is an established approach used in our national reports for Skills for Care and Development, enabling comparisons with England.

EBITDAR

Domiciliary care

We relied on the Fair Cost of Care report for domiciliary care in Cornwall (2022) showing the aggregate mark-up on operating costs for domiciliary care providers with published accounts (LaingBuisson,

²³ As with the ASC-WDS, the figures are aggregated for Cornwall and the Isles of Scilly. These aggregate figures have been used given the very small population of the Isles of Scilly relative to Cornwall, and therefore the minimal impact this aggregation is expected to have on the overall results.

2022).²⁴ The mark-up is defined as EBITDA divided by (Revenue minus EBITDA), enabling us to derive EBITDA for domiciliary care providers. The report also includes data on rents and operating costs, from which we calculated rents as a proportion of operating costs. These were then added to EBITDA to estimate EBITDAR. For modelling purposes, EBITDAR was expressed as a percentage of revenue. Further details on the estimation of revenue are provided below.

Residential and nursing care

As an aggregate mark-up on operating costs was not available for care homes, we assumed that care home and domiciliary care providers face similar operating costs. As such, we assumed the percentage difference in EBITDAR (expressed as a percentage of revenue) between care homes and domiciliary care reflects the percentage difference in revenues between these types of care.

Output of the independent sector²⁵

To calculate the Gross Operating Surplus, we multiplied the EBITDAR for the domiciliary and homecare settings, calculated in the previous step, by the revenue of the private and voluntary sectors in the respective care settings.

Revenues were calculated by multiplying the number of occupants in private and voluntary residential, nursing and domiciliary care settings by the relevant unit costs. To determine this, it was first necessary to estimate the total number of adults receiving regulated care, as set out in [Section 4.2.1](#) of this appendix. These total estimates are presented separately, as they were also used elsewhere in the modelling. For revenue calculations, we then needed to determine the share of adults receiving care in private and voluntary provision within regulated care. Due to limited data, we used the relative distribution of independent sector and local authority FTEs as a proxy. As Cornwall Council does not directly provide nursing or domiciliary care, all individuals receiving these services were assumed to be in private and voluntary provision.

Unit cost data were taken from Cornwall's Market Sustainability Plan 2023-25 (Cornwall Council, no date a). As published unit costs are only available for 2021/22, these were projected to 2024/25 using growth rates derived from the expected price ranges for residential, nursing and domiciliary care available up to 2023/24.

4.1.2. Productivity

Following our previous work for Skills for Care and ICF's previous report (2018d), we calculated labour productivity as GVA per FTE. GVA, including the contribution of informal carers, was calculated as a standalone benefit, while FTE was an intermediate output in the calculation of GVA. These indicators were then divided to calculate labour productivity.

4.1.3. Indirect and induced impacts

The indirect and induced impacts on GVA and employment were estimated using impact multiplier tables. Type I multipliers were used to estimate the indirect impacts on employment and GVA, while Type II multipliers were used for induced impacts.

²⁴ Although this figure excludes providers without published accounts, their omission is unlikely to materially affect the results, as Cornwall Council does not commission providers that do not publish accounts.

²⁵ We follow the definition of Skills for Care, where independent care provision includes both private and residential care.

To calculate the indirect impact, we used Input-Output tables produced by the Office for National Statistics (2022b), which include Type I GVA and employment multipliers. As the ONS does not produce industry-specific multipliers at the local level, we relied on figures for England as a whole. These multipliers were then applied to the direct GVA impact, as calculated in the previous section, but excluding informal carers (explained in the last paragraph of this subsection).

However, the ONS does not produce Type II GVA or employment multipliers. As a result, to estimate the induced impact due to the operation of the adult social care sector, we leveraged a time series of direct and induced GVAs produced by KD Network Analytics and Skills for Care (2021). In particular, we first calculated the Type II GVA multiplier by dividing the induced by the direct impact for each year from 2012 to 2020. This calculation showed that the Type II GVA multiplier is relatively stable across years, allowing us to use the 2020 multiplier from the KD Network Analytics and Skills for Care (2021) report. Similarly, we estimated the induced employment impact by calculating the Type II employment multiplier for 2016 from the ICF (2018a) report. Both Type II multipliers were then applied to the direct and the indirect GVA and employment, excluding the contribution of informal carers (explained in the last paragraph of this subsection).

In both the indirect and the induced impact, we have not included the contribution of formal carers as calculated in the direct impact. This is because indirect and induced impacts are created from realised spending, which cannot be achieved by the value of replacing informal carers with formal care staff (i.e. our proxy for their direct impact). As a result, to estimate the indirect and induced impact of informal carers we used Carer's Allowance payments, as these are realised earnings that could be spent and affect other sectors. The number of carer's allowance recipients and the amount claimed have been calculated using DWP data, as described in an earlier section (Department for Work and Pensions, 2024).

4.2. Socioeconomic impacts

4.2.1. Number of adults receiving care

In this section we provide a detailed technical description of the approach used to estimate the number of adults receiving care. We present this description before *setting out* our approach to *estimating* the socioeconomic costs and benefits, as these estimates were used as inputs to both the macroeconomic and socioeconomic models. In the macroeconomic model, they were used to estimate EBITDAR for residential and nursing care ([Section 4.1.1](#)). In the socioeconomic model, they informed the estimation of avoided NHS costs, as well as quality of life and wellbeing benefits.

Formal care

We relied on data provided by Cornwall Council on the number of adults receiving funded, regulated care by service type in 2025/26. These figures were adjusted to the year of analysis (2024/25) using estimated population growth rates for those aged 65 and over as a proxy. Population growth rates were derived from ONS data on people aged over 65 (Office for National Statistics, 2025c). As ONS data is available only until 2023, we relied on Cornwall Population Projections to forecast this growth rate to 2024 (Cornwall Council, no date b).

In addition to adults receiving funded care, our model also included self-funded adults as they form a substantial proportion of individuals receiving care. To estimate the number of self-funded adults receiving care, we used the most recent ONS estimates of the share of self-funders in regulated care homes in Cornwall (Office for National Statistics, 2023a, 2023b). As the ONS figures are reported for

care homes overall rather than separately for residential and nursing care, this share was applied to both service types. ONS does not provide equivalent estimates for domiciliary or day care services. Therefore, for domiciliary care we relied on ONS estimates for community-based care. As day care is conceptually more closely aligned with non-residential support than accommodation-based care, we assumed that the same self-funding share applies to both domiciliary and day care services.

After estimating the number of adults receiving funded and self-funded regulated care, we estimated the number of adults receiving non-regulated care by applying the observed ratio of carers to service users. As equivalent direct data on service users in the unregulated sector were not available, this approach assumes that the distribution of carers across regulated and non-regulated settings is broadly representative of the distribution of service users across these settings.

Informal care

The number of people receiving informal care in Cornwall was estimated by applying the distribution of carers by number of people supported to the total number of informal carers.

We used findings from the Caring in Cornwall: A Strategy and Business Case for Children, Young People and Adults report, which indicates that over 68% of adult carers care for one person (Brumby, Berriman and Carne, 2025). These results are based on the Caring in Cornwall Survey. Although the specific questions asked in this survey were not available, we assumed that two response options were offered for the relevant question: (i) caring for one person; and (ii) caring for more than one person. We therefore assumed that the remaining 32% support more than one person.

To translate this into total numbers of people receiving care, we applied this distribution to the total number of informal carers. Specifically, we multiplied the proportion of carers in each category by the corresponding number of people supported (e.g. one person, two people, etc.), using the distribution of multi-person caring from the State of Caring report for England to allocate those caring for more than one person (Carers UK, 2023).

4.2.2. Costs of adult social care

Below, we present our approach to calculating the socioeconomic costs associated with the adult social care sector.

Salaries of formal carers

One of the main costs of the adult social care sector is the salaries of formal carers. We included the earnings of carers in both the regulated and non-regulated sectors and across the public, private, and personal assistants sectors. These were estimated as described in [section 4.1.1](#) during the calculation of the macroeconomic impact of the sector. The earnings of employees in the regulated sectors were sourced from the ASC-WDS (Skills for Care, 2021). This data source, alongside a series of modelling assumptions, was also used to estimate earnings for the non-regulated and informal sectors.

Replacement cost of informal carers

We understand that informal carers make up a significant share of the adult social care service provision. As a result, we included their contribution both in the costs and benefits of the sector. To calculate the costs due to the existence of informal care, we replicated the approach described in [section 4.1.1](#) of the macroeconomic analysis. In particular, we used the average earnings of employees in the formal sector, weighted by the number of employees in each setting. This figure was assumed to be equal to the value created by each informal carer and was then converted to an FTE basis using the ratio of FTEs per informal carer. The earnings were then multiplied by the number of

FTEs that informal carers provide, as captured in the Census 2021 (Office for National Statistics, 2023c). This means that informal carers create value equal to the earnings that formal carers would make to provide the same level of care.

Resources spent on the delivery of adult social care

Apart from costs associated with wages, we have accounted for additional non-labour cost elements involved in the provision of adult social care. As Cornwall Council directly provides only residential care, we relied on figures supplied by the Council building costs and other costs. Due to a lack of available data, no land costs were included. We recognise that using unit costs for large-scale interventions does not represent best practice in estimating their total costs, as costs are not always linear. For instance, the cost per adult for residential care may decrease as more adults are included due to shared resources and more efficient utilisation of facilities. However, certain costs, such as costs of highly specialised personnel or equipment, might not scale linearly. This is because services, programmes, or interventions can exhibit economies of scale or diminishing returns. However, unit costs represented the best available evidence.

4.2.3. Benefits of adult social care

This section includes our approach to quantifying and monetising socioeconomic benefits. In particular, we included: (i) avoided costs to the NHS, (ii) peace of mind benefits, and (iii) quality of life and wellbeing impacts.

Avoided costs to the NHS

Hospital admissions

Adult social care helps reduce the need for hospitalisation by offering care services. In the analytical scenario without adult social care, we expect an increase in hospitalisations. To estimate the share of hospital admission costs that are avoided through social care, we used evidence from Bakx et al. (2020) showing that a care home admission in the Netherlands reduces the probability of hospital admission by 28%. We then applied this coefficient to the number of admissions from adults receiving adult social care in the baseline scenario. To calculate how many people from adult social care are hospitalised, we leveraged research by Smith et al. (2015), showing that 8.2% of all hospital admissions in England come from care home residents.

We assumed that this share also applies to Cornwall and applied the corresponding coefficient to the total number of hospital admissions in the area. Data from the NHS on total hospital admissions are available specifically for Cornwall; however, these are not disaggregated into elective and non-elective admissions, which we required for the next step of our analysis (NHS England, 2025). To estimate this breakdown, we first compared Cornwall's total admissions with the national total to derive Cornwall's share of overall activity. We then applied this proportion to the national inpatient figures from the NHS National Cost Collection, which are reported separately for elective and non-elective admissions, to estimate the number of elective and non-elective inpatients in Cornwall (NHS England, no date e).

Lastly, the number of avoided admissions from adult social care was monetised using unit costs for elective and non-elective inpatients from the NHS England National Cost Collection (NHS England, 2021). Due to a lack of Cornwall-specific figures, we relied on the unit costs in England, adjusting them for Cornwall using the wage differential. The differential was estimated by comparing median weekly earnings across jobs in Cornwall and England reported in the ONS Annual Survey of Hours and Earnings (Office for National Statistics, 2025b).

A&E admissions

Adult social care also helps prevent Accidents and Emergency (A&E) admissions, reducing the strain on the NHS. Under the analytical scenario, for example, people previously in care would be more likely to get injured and would receive care from the NHS. After exploring different approaches to calculating avoidable A&E admissions, we relied on estimates from Wolters et al. (2019), indicating that 41% of all A&E admissions from care home residents were potentially avoidable. The same percentage for the general population was 27%. We assumed that the 14 percentage point difference in avoidable admissions was due to the support provided by care homes.

We then multiplied this percentage point difference by the average number of A&E admissions per care home resident, per year (Wolters *et al.*, 2019; NHS England, no date b). This calculation results in the number of A&E admissions that could be avoided per person, per year, which we then applied to all adults receiving informal care under the analytical scenario and all adults in non-nursing residential, domiciliary, and personal assistants. Due to data limitations, we used the incidence of hospital admissions among care home residents over 65 as a proxy for the total hospital admissions among all care home residents. Further data limitations meant that this figure was not available specifically for Cornwall and was only reported for England as a whole. To adjust this estimate to better reflect local conditions, we used data provided by Cornwall Council on emergency admissions for individuals aged 65 and over in Cornwall.²⁶ Further information on how the number of adults receiving care was calculated is provided in [Section 4.2.1](#) of this appendix.

Discharges from acute care

The existence of adult social care helps the NHS discharge people from the hospital, increasing the capacity of the NHS to accommodate new patients and reducing costs associated with bed days. As a result, avoiding delayed discharges is associated with reduced costs to the NHS due to fewer bed days.

We estimated two types of delayed discharges that could be avoided due to the existence of adult social care. First, we estimated the number of delayed discharges that could be avoided if adult social care had sufficient placements (hereafter “potentially avoidable delays”). We relied on NHS data from the Acute Discharge Situation report which includes data on the number and reason for delays for the NHS Cornwall and the Isles of Scilly Integrated Care Board (NHS England, no date a).^{27,28} We calculated the total number of delays due to lack of ASC capacity including: (i) Home-based rehabilitation, rehabilitation or recovery services not yet available (Pathway 1), (ii) Other home-based social care service not yet available (Pathway 1), (iii) Housing provision not yet available (Pathway 0 or 1), (iv) Residential/nursing home care not yet available (Pathway 3), (v) Housing adaptations not yet completed (Pathway 1 or 3) and (vi) Awaiting restart of existing social care arrangements (Pathway 0).²⁹

²⁶ Utilising NHS data, we first calculated the share of all emergency admissions in Cornwall that relate to people aged 65 and over and compared this with the equivalent proportion for England. The percentage difference between Cornwall and the national figure was then used to adjust the existing estimate of the average incidence of A&E admissions.

²⁷ Data from the winter months was used to account for potential seasonality in admissions and injuries, which can be influenced by tourism.

²⁸ It should be noted that, in practice, some individuals in Cornwall may use hospitals in East Devon, and vice versa, due to their geographic proximity. While this was considered when determining the most accurate approach to capturing NHS data for the model, this population is likely small and any cross-boundary flows are expected to largely offset each other.

²⁹ It should be noted that these figures are aggregated for Cornwall and the Isles of Scilly. Given the small population given the very small population of the Isles of Scilly relative to Cornwall, and therefore the negligible impact this aggregation is expected to have on the overall results.

The second type of delays we examined were delays that are not realised in the baseline scenario due to the existence of adult social care. These delays are avoided because adult social care offers placements for people medically fit to be discharged. However, in the analytical scenario, these placements are no longer available, leading to additional delayed discharges. The aforementioned Discharge Situation Report provided information on the discharge destinations of each patient, allowing us to estimate the share of all discharges in Cornwall made possible due to the existence of adult social care placements (NHS England, no date c, no date d).

The share of delayed discharges potentially avoidable due to adult social care, as well as the share of those not realising due to adult social care placements were then applied to (i) current NHS patients, (ii) additional NHS patients receiving care previously offered by adult social care, and (iii) additional people entering NHS through A&E that adult social care helped avoid under the baseline scenario. These impacts were then monetised using estimates for excess bed day costs in Cornwall (Department of Health & Social Care, 2017).

Peace of mind benefits

In the absence of Cornwall-specific estimates, we applied the approach used in the national report for Skills for Care, on the basis that there is no evidence to suggest that Cornwall residents would value the insurance-related peace-of-mind benefits of adult social care in a systematically different way from the national population. In particular, we explored alternative approaches to calculating this benefit and concluded that in all reviewed studies, peace of mind benefits were calculated as the difference of insurance payments subtracting the insurance claims paid out. The claims divided by the total insurance payments represent the loss ratio. For instance, if a loss ratio is 40%, this means that someone paying for insurance can expect to get back only 40% of the money they pay in insurance premiums. As a result, the remaining 60% must represent another form of benefit to the insurance buyer, otherwise they would be willing to pay only the 40% they would get back in claims. Research suggests that the remaining value (60% in this case) represents peace of mind benefits.

Forder (2011) explored the peace of mind benefits of Immediate Needs Annuities (INA), one of the few private insurance products in the UK. In simple terms, this examines how much more people are willing to pay for reassurance that their future care costs will be covered. The author concluded that the average person would pay a lifetime cost of care of up to £69,000 through an INA, while they would pay £66,000 without one. The difference of £3,000 (or 4% of the premium) is the minimum peace of mind benefit holders of INAs accept (or equivalently, 96% is the maximum loss ratio). A report by Buckle et al. (2019) on 15 private UK health insurers calculated the medical insurance loss ratio ranging from 59% to 73%. Lastly, evidence from the US long-term insurance market suggests that the loss ratio is between 40% to 60% (Department of Health and Social Care, 2022). Across these studies, the loss ratio refers to the share of premiums returned as claims, with the remainder reflecting the value individuals place on security and reassurance.

Overall, the loss ratios range from 40% to 96% across studies and sectors. Due to the lack of a single, widely accepted loss ratio in the UK, we used the average of the UK's lower and higher bound estimates (i.e., the average of 59% and 96%).

The resulting ratio (78% loss ratio or 22% peace of mind benefit) was multiplied by the outturn position of Cornwall Council for adult social care and support in 2024/25. This figure was provided by Cornwall Council directly. This figure was provided directly by Cornwall Council.

Quality of life and wellbeing benefits

Social care-related quality of life

SCRQoL is part of the Adult Social Care Outcomes Framework (ASCOF)³⁰ and Personal Social Services Adult Social Care Survey (ASCS) captured in metric “1A: Quality of life of people who use services”. This measures the care users’ reported experience in eight outcome domains of control, dignity, personal care, food and nutrition, safety, social participation and accommodation. As a result, the impacts captured are distinct from the wellbeing of avoided injuries, captured in Quality of Life Adjusted Years (QALYs) below, thus avoiding the risk of double-counting.

To ensure that the measured quality of life impact is not affected by non-service-related factors, we used metric “1B: Quality of life of people who use services” from the ASCS, which is the metric 1A adjusted for preferences of service users and external factors that might influence perceived wellbeing. Using this metric follows the methodological approach outlined in Forder et al. (2016). We then used evidence by Stevens et al. (2018) showing that the adjusted SCRQoL is the wellbeing equivalent of a QALY. As a result, we monetised the impact on SCRQoL by applying the monetary value of a QALY (HM Treasury, 2022). Lastly, the monetised impact was applied to adults receiving informal care under the baseline, as well as to those receiving formal care under the baseline but not receiving any support in the analytical scenario.

Quality of Life Adjusted Years

Access to social care significantly reduces the likelihood of individuals experiencing injuries, thereby preventing the deterioration of their health (Crawford et al., 2020). Thus, social care may result in increased “quantity and quality of life”, captured by Quality Adjusted Life of Years (QALYs), by preventing injuries and illnesses (Office for Health Improvement and Disparities, 2020). Under the analytical scenario, people would no longer receive adult social care and would potentially suffer preventable injuries. According to Wolters et al. (2019), the most common avoidable admissions are for pneumonia, urinary tract infections, and fractures or sprains. To estimate the number of these admissions, we applied their incidence rates to the number of potentially avoided A&E admissions due to the existence of adult social care (as calculated in 1.2) for adults who previously received care but would not access any support under the analytical scenario. The impact of these potentially preventable injuries or illnesses on the quantity and quality of life was then monetised to estimate the savings that adult social care generates by preventing injuries.

To estimate the impact of injuries and illnesses on quality and quantity of life, we first applied disability weights³¹ for the most commonly avoided injuries and illnesses in care homes to Disability-Adjusted Life Years (DALYs); (Institute for Health Metrics and Evaluation, 2019).³² To translate DALYs to QALYs, we explored different approaches and ultimately assumed that the gains in QALYs are broadly equal to losses in DALYs, following Bevan et al. (2007). These QALY impacts were then monetised using the latest monetary value for a QALY, which is £70,000 in 20/21 prices according to the Green Book (HM Treasury, 2022).³³

³⁰ The ASCOF measures how well care and support services achieve the outcomes that matter most to people.

³¹ Disability weights are values representing the health impact associated with specific diseases and are generated through consultations with clinicians, experts, or community members. These are applied to Disability Adjusted Life Years (DALYs) to estimate mortality and morbidity of specific diseases (Hagell and Cheung, 2019).

³² QALYs measure equivalent healthy years lived, whereas DALYs measure loss of health. A QALY value of 1 is equivalent to a year in perfect health, while a DALY value of 1 is equivalent to death (National Collaborative Centre for Infectious Diseases, 2015).

³³ Although the Green Book was updated in February 2026, an updated monetary value for a QALY was not included.

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