Introduction

The development of a coherent and effective national community care policy has defeated successive governments. Numerous official reports, most recently those by the Audit Commission in 1986 and the National Audit Office in 1987, have documented the chief obstacles.

The Audit Commission's critique triggered a review of community care policy by the government's health adviser, Sir Roy Griffiths. The Griffiths report applies only to England although its references to social security and residential care apply across the United Kingdom. Moreover, the four health departments have said they will jointly consider the Griffiths report.

Since the appearance of the report in March 1988 the government has given no indication of how it intends proceeding, if at all, with the proposals. In contrast to the silence from central government, the proposals have generated considerable comment and discussion among the agencies most likely to be affected by their implementation.

In order to gauge the reactions to the Griffiths proposals the King's Fund Institute sampled opinion across health and social services in the United Kingdom by conducting a survey of health and social services managers, and a scan of principal practitioner journals.

In what follows, the views expressed are not necessarily shared by the authors of this briefing.

Resolving the problem

At the close of 1986 the Audit Commission's report *Making a Reality of Community Care*, documented the chief impediments to the development of a coherent and effective national community care policy. This triggered Sir Roy Griffiths' review of community care commissioned by the former Secretary of State, Norman Fowler.

The Audit Commission's report provides a trenchant critique of attempts to implement community care policies in England and Wales. The Commission concluded that despite some £6 billion being spent on services for the priority groups progress was slow and uneven across the country. Five obstacles were identified to account for this state of affairs.

- Compartmentalised health and local government budgets which hampered the desired shift in resources from health to social services and did not match the requirements of community care policies
- The absence of bridging finance to meet the transitional, or 'hump', costs involved in shifting from institutional to community care
- The distorting effects of the public funding of private residential care, which is now running at around £1 billion per year and still growing rapidly – perversely, this offers incentives for residential rather than domiciliary based care.
- Delays, difficulties and boundary problems caused by a fragmented organisational structure.
- The absence of staffing and training arrangements to ensure appropriate supply of trained community based staff, and to ease the transfer of staff into the community.

Since the publication of the Audit Commission report the National Audit Office has also been very critical, and more recently the Public Accounts Committee (PAC) has added its powerful voice to demands for change.

Faced with a barrage of criticism by the PAC at the beginning of 1988, Michael Partridge, the then Second Permanent Secretary at the DHSS, acknowledged the key role of central government in reshaping community care policy.

We see ourselves as responsible for the overall strategic policy, for the overall strategic guidelines, for the overall strategic determination of the amount of resources put in. It is by no means perfect and I would think that it certainly can be improved. Indeed if it was not in considerable need of improvement we would not have asked Sir Roy Griffiths to do a special report on it.

Against this background the Griffiths Report advocates three key principles which should underpin community care policy.

- *The effective targetting of resources* – so that the right services are provided to the people who need them most
- *More voice and choice for the consumer* – so that the views of people in receipt of help are taken more seriously and they can choose from a wider range of services
- *A suitable domestic environment* – so that wherever possible people should be supported in their own homes.

Griffiths makes a number of detailed recommendations about how these objectives might be achieved. The most important are listed in Box 1.

BOX 1 THE GRIFFITHS AGENDA

- A clearer strategic role for central government including a Minister for Community Care
- A more facilitative and enabling role for social services departments as lead agencies
- The continuing need for collaboration at local level between different agencies including the development of care management
- New methods of financing community care including a specific community care grant
- A single gateway to publicly-financed residential care
- Greater encouragement for experiments to promote new forms of more pluralist provision
- Restricting housing involvement to a 'bricks and mortar' role
- Encouraging joint or shared training between different professions
- Exploring the introduction of community carers to carry out basic care tasks
- Establishing a better balance between policy aspirations and the availability of resources
- Facilitating more consumer choice
- Clarifying the respective responsibilities of health and social care

Survey of Health and Social Services Managers

Health and local authorities are the principal agencies involved in the delivery of community care services and the key strategic managers are Regional and District General Managers (GMs) and Directors of Social Services (DSSs). It was decided to survey those managers and directors across the United Kingdom to elicit their views about the need for reforming community care policy and their attitudes to the Griffiths Report as offering a suitable framework for change. Unit General Managers were not included because of our concern to maintain some approximate balance between health and social service interests.

A simple questionnaire was sent to general managers and directors in August and the results tabulated at the end of September. The target groups, categorised by designation and country, are shown in Table 1. It should be noted that regions are found only in England and that the management of health and social services is combined in Northern Ireland.

TABLE 1 · TARGET AUDIENCE

COUNTRY	RGMs	DGMs	DSSs	TOTAL
ENGLAND	14	190	108	312
WALES	–	9	8	17
SCOTLAND	–	15	12	27
N. IRELAND	–	4	–	4
TOTAL	14	218	128	360

Managers and directors were asked to answer four questions only to ensure a good response rate. The questions are shown in Box 2.

In questions 1-3, respondents were asked to indicate their degree of support or opposition on a 5-point scale. A 'no opinion' option was also available. Question 4 was open-ended, and some of the comments received are reproduced in the following section.

BOX 2 SURVEY QUESTIONS

Q1. How important do you think the need for central government action is in relation to national community care policy?

Q2. Do you consider the Griffiths Report, *Community Care: Agenda for Action*, provides an effective basis for reforming community care policy?

Q3. How strongly does your Authority/Board support or oppose the Griffiths proposals?

Q4. Are there *particular* proposals in the Griffiths Report which you personally support or oppose?

Overall, the response rate to the questionnaire – illustrated in Table 2 – has been very good and no follow-up to the original request for information was thought to be necessary. Eighty per cent, or 288 from 360 approached, of the managers and directors returned completed questionnaires. The response rate was slightly higher in England than elsewhere in the UK and proportionately more directors than managers responded, but the survey results can be taken to represent the main body of opinion amongst these groups in the UK.

TABLE 2 · RESPONSE RATES (Pecentages)

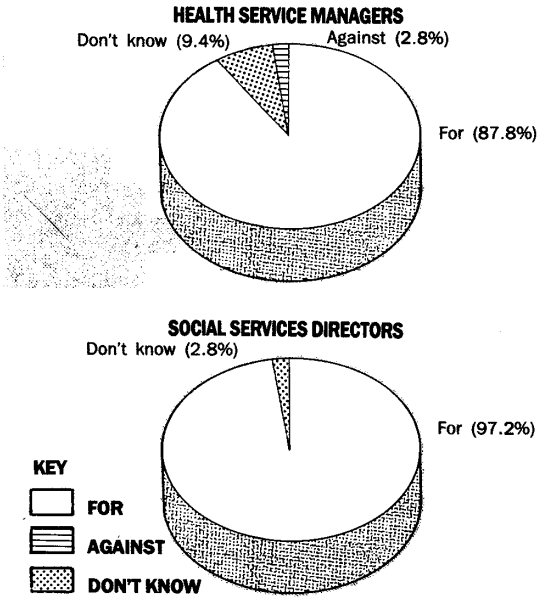
COUNTRY	RGMs	DGMs	DSSs	TOTAL
	%	%	%	%
ENGLAND	64.3	79.5	87	81.4
WALES	–	66.7	87.5	76.5
SCOTLAND	–	80	58.3	70.4
N. IRELAND	–	50	–	50
TOTAL	64.3	78.4	84.4	80

Results

Question 1 asked respondents to indicate the importance they attached to the need for central government action in relation to national community care policy. The results are strikingly clear; 91.3 per cent of directors and managers responding to the survey support the view that action is required. The differences between the views of health and social services managers are illustrated in Figure 1. Directors more strongly favour change, but managers are not far behind. There are no significant differences in the responses between people from the four home countries. Overall, therefore, the results are consistent with the proposition that community care is a problem; change is essential.

FIGURE 1

CHANGE AND COMMUNITY CARE: DIFFERENCES BETWEEN HEALTH AND SOCIAL SERVICES



Question 2 sought to elicit the strength of support for, or opposition to, Sir Roy Griffiths' report, *Community Care: Agenda for Action*, as a basis for reforming policy. The survey responses categorised by country are shown in Table 3. Although Griffiths specifically addressed himself to the situation in England, strong support for his proposals can be found elsewhere in the UK.

TABLE 3 · GRIFFITHS AND COMMUNITY CARE: DIFFERENCES BETWEEN HOME COUNTRIES* (Percentages)

	Strongly Agree				Strongly Disagree
COUNTRY	1	2	3	4	5
	%	%	%	%	%
ENGLAND	24.4	37.0	20.5	13.4	3.9
WALES	38.5	38.5	7.7	7.7	7.7
SCOTLAND	15.8	47.4	36.8	–	–
N. IRELAND	50.0	50.0	–	–	–

* Excluding one (0.4%) English respondent who expressed no opinion.

FIGURE 2
GRIFFITHS AND COMMUNITY CARE: DIFFERENCES BETWEEN HEALTH AND SOCIAL SERVICES

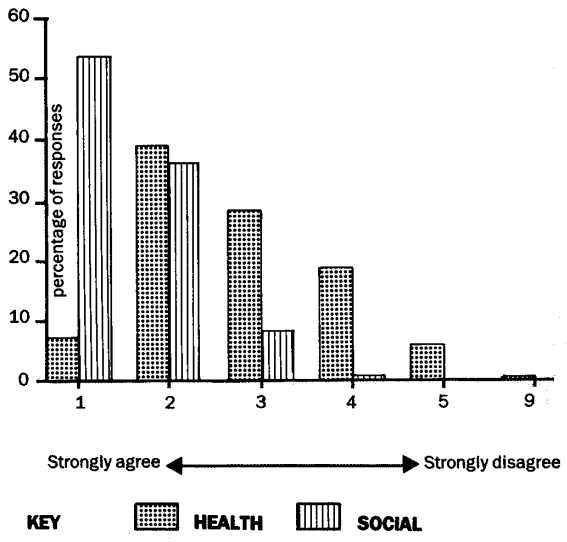


Figure 2, however, highlights marked differences between health service managers and social services directors in their response to Griffiths. A significant minority of managers are opposed to Griffiths and nearly one-third have chosen to reserve their position. Moreover, even the largest group of managers who favour Griffiths are relatively lukewarm in their support. The directors, in contrast, are strongly in favour of Sir Roy's framework. These differences between directors and managers are illustrated in sharper focus in Figure 3. Important though these variations are, however, they should not mask the fact that the single largest body of managers as well as an overwhelming majority of directors favour the Griffiths solution.

Question 3 sought to identify the formal views of health authorities and social services committees as distinct from the opinions of their chief officers. The results are illustrated in Figure 4. Once again the contrast between health and social services in the degree of support for Griffiths is apparent. But health authorities are more inclined to support than oppose. One of the most interesting points to note, however, is the large proportion of health authorities (60 per cent) and social services committees (31 per cent) who have reserved their position, almost certainly until a clearer lead emerges from central government.

Two principal conclusions emerge from this modest survey.

- There is a widespread consensus amongst health service managers and social services directors that the time is overdue for a change in central govermment policy with respect to community care.
- Positive support for the Griffiths proposals can be found both in the NHS and local authorities in all parts of the UK, although enthusiasm is greatest among social services directors.

FIGURE 3
GRIFFITHS AND COMMUNITY CARE: DIFFERENCES BETWEEN HEALTH AND SOCIAL SERVICES

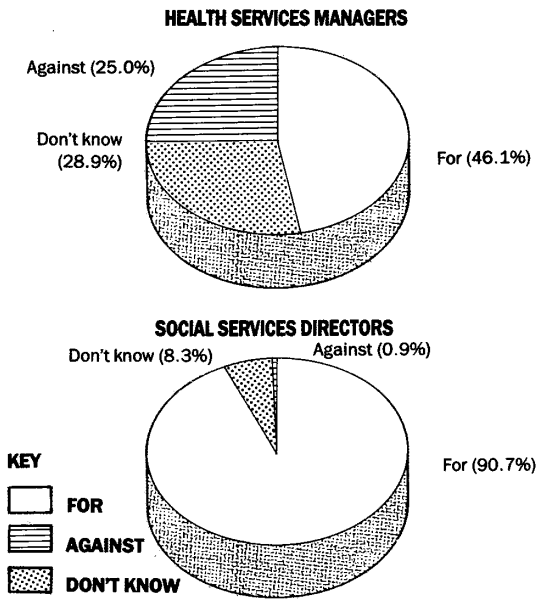
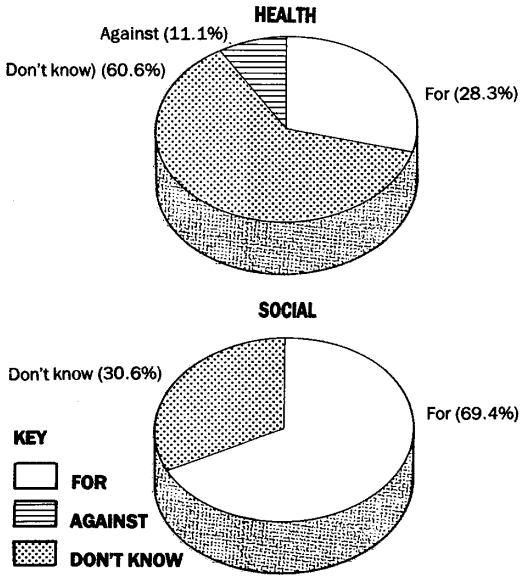


FIGURE 4
GRIFFITHS AND COMMUNITY CARE: DIFFERENCES BETWEEN HEALTH AUTHORITIES & SOCIAL SERVICES COMMITTEES



Sampling Practitioner Opinion

To sample wider opinion on the Griffiths proposals, the principal practitioner journals and specialist features in the national press were scanned. Key points are presented briefly in descending order of importance as determined by the number of citations (see Box 3). There is considerable overlap between many of the issues raised by commentators in the media and those mentioned by managers and directors in the Institute's survey.

BOX 3
KEY ISSUES CITED BY PRACTITIONERS

- Resources
- Social services departments as lead agencies
- Care management
- Minister for Community Care
- Health care/social care divide
- Collaboration and planning
- Training
- Information and monitoring
- Community carer
- Housing
- Voluntary organisations
- Private sector

Resources

Two aspects of the financing of community care gave rise to most comment: grant aid for community care and the level of funding.

There is wide support for the proposed community care grant. It is seen as a mechanism for easing restrictions on local authority spending on community care services resulting from worries about rate-capping. However, anxiety has been expressed about the source of funds for that part of the community care budget not financed by specific grants. Moreover, while the community care grant could encourage local authorities to plan services more effectively, it could also give central government more control. Some observers believe that the direct grant proposal leaves too many questions unanswered. In general the funding proposals are seen as too imprecise and, in the view of a DGM in our survey, 'give licence for social services to proceed more slowly than is desirable'.

The community care grant part of the Social Fund would be transferred to SSDs under Griffiths' proposals. This has provoked widespread concern since it would put SSDs in the frontline of difficult decisions about claims. Several DSSs in the survey were opposed to SSDs taking on an income support role.

For the private and voluntary sectors any move of resources from the present system of board and lodgings payments to local authority control is seen as disastrous. Loss of choice for residents and the right of appeal could occur if a local authority, following an assessment of need, is not prepared to finance the 'top-up' for residential care in a private home. In addition there have been calls for cash payments to be available in lieu of a care package that local authorities would provide.

The level of funding, however, is the issue that has been most hotly debated. Griffiths' remit precluded him from commenting on the overall level of resources. Yet, many believe that without extra resources care in the community will make very little progress.

At a more specific level, unless the amount of money allotted to community care from the Social Fund is increased there are fears that the pressures will be overwhelming. Also, the decrease in housing benefit could result in residential care becoming a more attractive alternative than domiciliary care and proposed changes in the role of housing authorities would reinforce this.

Will resources match obligations?

Echoing Griffiths' comment that 'you cannot make bricks without straw', the main concern about resources is over whether 'they will match obligations'. As one DSS put it: 'the crucial issue will be the release of funds of adequate proportions to make community care a viable option'.

Local Authority SSDs as Lead Agencies

Putting responsibility for community care firmly into the hands of local authorities is for the most part welcomed as long overdue. The voluntary sector in particular feels that a 'lead agency' will be beneficial. Other groups support the proposal because public services will become less patchy and inconsistent, and those in need of care will be clearer about where to go when they need help.

Health service managers are less enthusiastic about the lead agency proposal. They are concerned that local political control or interference 'would make it difficult to discharge an objective service overview function'; that SSDs 'lack management firepower'; and that many SSDs 'are even more hidebound/ bureaucratic than the NHS'. One DGM said that 'the management culture in most local authorities is not sufficiently advanced to be able to handle the tasks required at this stage'.

SSDs . . . 'lack management firepower'

Such fears were fairly common among health service managers. Another maintained that local authorities of a different political persuasion from central government would seek to embarrass the government. 'They already do so but Griffiths' proposals would really allow them to go to town. There could be a complete breakdown in community care'. One DSS shared some of this concern: 'Griffiths may have underestimated the political interference of local politicians'. Nevertheless, enthusiasts believe that the proposed enabling role for SSDs will allow them to make objective assessments of need and remove their 'monopoly provider' image. Giving more responsibility to local authorities will strengthen their capacity to regulate and monitor performance as well as apply quality controls which do not always exist at present. On the other hand, health service managers expressed concern over how far SSDs could be trusted to provide appropriate services with adequate health care input. A common view is the need, as one DGM put it, 'to protect many of the existing health initiatives particularly in mental health and elderly services'.

For health authorities a lead agency role for SSDs could mean a greater focus on acute care although 'ring-fenced' health authority budgets (earmarked funds) for community care would mean that priority group services would have more protection than at present. However, health authorities are unlikely to support transferring approximately 20 per cent of their budget that currently goes into community care to local authorities. Some go as far as to say that even if the transfer of funds was made compulsory it would still not happen. It is certainly clear that health authorities do not approve of the proposal to transfer joint finance to local authorities. For their part, SSDs may be unwilling to receive hospital patients who are highly dependent but who do not need acute care. Some observers feel Griffiths has fudged the issue of funding long term care in the NHS geriatric and psychiatric wards. Local authority incentives to leave people in hospital would remain, as would incentives for relatives to leave people in institutions/hospitals where care would be 'free'.

A note of caution is sounded amidst general support for the

lead agency proposal. Restricting local authorities to an enabling role only is seen by some commentators as misconceived and as likely to be strongly opposed by many authorities. Unlike other agencies, SSDs have considerable experience in providing the major community care services. One DSS was anxious that an emphasis on care brokerage rather on care provision could 'erode standards of care and expose the most vulnerable to abuse as a result of the emphasis on private sector provision'.

A deeper worry is whether a lead role will mean much in practice. A DGM in our survey said that 'responsibility without power is a real danger'.

Another concern centres on the ability of local authorities, and especially social services, to take on this new role. The increased burden on social workers may be too much for them to provide good community care. Extra staff will be required and local authorities will need support in assuming their new responsibilities.

Care Management

Reactions to the promotion of care management have ranged from the very enthusiastic to the extremely sceptical. There is basic support for the concept, but anxiety over how it is to be implemented and its impact on consumers is evident. One DSS said that 'the enormity of the task should not be underestimated. Assessing caring needs is not quite so simple as estimating market demand for consumables. No one dies if the local supermarket runs out of baked beans!'

Supporters of the proposal focus on the advantages of an individual in need being able to turn to one person rather than a multitude of agencies.

It is widely felt that some form of consumer advocacy should be built into the system as well as a complaints procedure and the right to a second opinion. Any increase in professional power must be guarded against.

On the face of it, care management will expand dramatically the role of social workers. But pressures on the social work profession, for example over child sexual abuse, may make it sensible to consider splitting child and family services on the one hand and services for the priority groups on the other.

A Minister for Community Care

A Minister for Community Care has been welcomed as a way of focussing attention on care in the community. A Minister would symbolise commitment to community care and the needs of the priority groups. He or she may also ensure that resources are linked to clear policies or at least put the question of resources on a firmer footing.

An opposing view is that the Minister would be ineffectual in much the same way as the already existing Minister for the Disabled is alleged to be. It could also hasten the erosion of local autonomy. Some commentators go further and state that ministerial contempt for local government could result in over-centralisation.

Doubts are expressed over whether the Department of Health has the capacity to approve and monitor plans. A DGM in the survey claimed that the problems with Family Practitioner Committees and the 'messy paper chase of the planning system' did not give grounds for optimism. In response to this problem, there is strong support, particularly among social services managers, for a national community care development agency which could undertake many of the essential central functions envisaged by Griffiths.

The Health Care/Social Care Divide

The Griffiths distinction between community and health care is seen as oversimplistic. Doubt is expressed over whether such a clear cut division can be made especially when mentally ill people and elderly people, for example, are likely to need regular medical care as well as social care. The false dichotomy may result in difficulty in obtaining health care for those in the community. Community care is a collaborative enterprise and rigid boundaries between health and social care will not aid the pursuit of common objectives. Community care and hospital services are best viewed as a continuum. DGMs are divided on the issue. One believed that the Griffiths proposals would 'free the health service of the long stay responsibilities in order to concentrate on the acute side'. Another DGM was 'totally opposed' to losing control over the placement of elderly patients to the local authority. 'It will cause enormous problems to acute hospitals whose problem is discharge, not admissions'.

One of the main criticisms concerns the position of community nurses who are barely mentioned in the Griffiths Report. District nurses, community psychiatric nurses, and health visitors all have a part to play in the community care team but they are not discussed and as a result have been left wondering what their fate is to be if Griffiths is implemented.

Collaboration and Planning

If collaboration is to succeed there is a need to involve all the groups that will either provide or receive care in the community. Under Griffiths' proposals, voluntary and private bodies would become major providers of care and an effort should be made to involve them from start to finish in the planning process. Housing authorities/associations must also be involved in community care as many existing joint housing projects are a result of collaboration with housing associations both in the building of them and in their management.

The most important partnership is that between health and local authorities, to co-ordinate the transfer of both patients and funds back into the community. Health service managers in our survey expressed concern that under the Griffiths proposals joint initiatives could be 'wound down'. There is suspicion that local authorities cannot be trusted to deliver on community care. Others, principally those involved in community health services and in local authority social services, are more concerned about the risk of 'planning blight' as health authorities withdraw from, or put on ice, developments pending a response from central government to Griffiths.

Co-ordination is required at central as well as local levels. While Griffiths specifically mentions the DHSS, not only has it now been split into two departments but other departments' policies impact on community care. Attention needs to be given to how improved inter-departmental coordination can be achieved.

Another barrier to effective collaboration is professional rivalry. It has proved difficult to overcome and there is nothing to suggest that the problem will go away with the implementation of Griffiths. It is regarded as a major criticism of the call for greater collaboration that Griffiths offers no insight into how this problem can be tackled effectively.

Reviewing progress with the Welsh Office's All Wales Strategy (AWS) for People with a Mental Handicap, one observer points out that much of what has been proposed in the Griffiths report has already been 'piloted' in Wales. A DSS in Wales said that experience of the Strategy 'favourably colours our view of Griffiths and having our Secretary of State would make it easier for us to "go ahead" in Wales'.

Consumer Choice

Consumer choice is generally recognised as vital but as being non-existent in reality. The Griffiths Report is regarded as ambivalent on the subject. It takes more account of individual need but many believe that the increased professional power

'. . . it is high time the service fitted the consumer not the other way around'

that will emerge is inimical to consumer choice. For example, will it be the consumer's views or the 'best buy' which will prevail in needs assessment and care management? Further, local authorities under financial constraints may not be able to

put the individual consumer first. Griffiths, it is claimed, has not made it sufficiently clear how consumer choice and cost-effectiveness can be balanced. Nevertheless, it is generally accepted that responsiveness to consumer interests could be improved. As one DSS put it, 'it is high time the service fitted the customer not the other way around'.

Vouchers and credits are another mechanism for allowing individuals to determine their own access to services, but not all consumers can make an informed choice without knowing the full range of possibilities.

Training

To the regret of many commentators, training is mentioned only briefly in the Griffiths Report. The proposals will dramatically change the role of the social worker and, with new types of carers also envisaged, training is vital. It is essential that extra funds are provided to train existing staff or to increase the numbers employed. Local authorities do not presently have the trained staff or organisational structure to manage community care efficiently.

Information and Monitoring

The absence of adequate management structures and information systems within local authorities to provide the kind of community care services proposed by Griffiths is mentioned by a broad cross-section of commentators. Establishing the necessary information systems will take time. As an interim measure, valuable information could be gathered by contacting users, voluntary agencies and informal carers.

Monitoring is also felt to be important to the achievement of effective community care, and would prevent disasters like the Nye Bevan Lodge scandal. In this sense increased accountability seems to be welcomed. However, some point out that the Griffiths Report is very vague about monitoring quality of care.

In the area of inspection, support for an independent national inspectorate has been expressed, in preference to local authorities assuming full responsibility. Often standards demanded from private homes are higher than those found in local authority homes. A national inspectorate would end this anomaly.

Community Carer

The proposed new post of community carer has prompted equal amounts of support and opposition. Support comes from those who feel that the elimination of the more menial tasks carried out by nurses in order to allow them more time for performing duties for which they were trained is a significant improvement in the use of resources. There is concern that, as one DGM put it, the proposal 'must not be lost to the professional cacophony of vested interest. These individuals are essential in a society where family ties and expectations are greatly changing'.

Sensible proposals 'must not be lost to the professional cacophany of vested interest'

There are fears that community carers will be under-trained and inadequately supervised. The proposal is seen by some as a ploy to expand resources by using MSC money for carers as part of the YTS. Many object strongly to the proposal on the grounds that Griffiths has oversimplified what is involved by way of caring in the community.

Housing

Housing is recognised as a vital component of community care but it is not clear in the Griffiths Report where it will figure within the community care infrastructure since there is little discussion of its contribution. Confining housing agencies to a narrow 'bricks and mortar' role could lead to much conflict over the setting up and running of residential schemes thereby, and as one DGM reported, 'reducing the opportunity for creative initiatives'. Many commentators are convinced that the physical and social aspects of housing cannot be divorced.

Informal Carers

There is support for Griffiths' recognition of the over-exploited informal carer. However, there is concern that the Report's proposals might in fact constitute an increasing burden on carers. A rise in the divorce rate, people having fewer children, and the growing propensity of women to work all mean that there are going to be fewer carers in future. Insofar as informal care can be fostered it will need to be supported in a more planned and sensitive way than hitherto. The conclusion reached by many commentators is that the burden of care on the informal carer should be reduced wherever possible.

Voluntary Organisations

There is a clear division among voluntary bodies over whether they want to become major service providers or sub-contractors of public agencies. Many see their innovatory role as an important part of their function. Griffiths' expectations of voluntary bodies are substantial and some observers suggest they are both inappropriate and unrealistic. Transforming voluntary bodies would undermine their basic function, weakening their ability to innovate and fill gaps where they are needed and where statutory authorities often fail. Many voluntary bodies would not be capable of performing the role envisaged by Griffiths. The voluntary sector is not as homogeneous as many assume it to be. Nor does it possess the requisite managerial skills. There is a fear among voluntary bodies that they may be overtaken by the private sector.

The Private Sector

Even those within the private sector see difficulties with a major involvement in community care. There is widespread hostility about the extension of the role of for-profit organisations.

Further expansion of the private sector would be very difficult to regulate. Griffiths, it is claimed, has a 'touching faith' in the feasibility and efficiency of the private sector. It has everything to prove. Some directors of social services expressed

Griffiths has a touching faith in the private sector

reservations about any scheme which required local authorities to contract out services to profit-making organisations. One director said he would be 'much less opposed to proposals on these lines requiring the proportion of services provided through non profit- making, independent organisations to be increased'.

For its part, the private sector is hostile to the prospect of local authority control especially over residential care. Other commentators point to the limited experience of the private sector in domiciliary care provision.

Conclusions

This review of reactions to the Griffiths report demonstrates a number of concerns.

- There is a consensus across health and social services that community care policy at national level demands action from government.
- There is a considerable body of opinion which believes that Griffiths' proposals offer a basis for reform.
- It is recognised that much detailed work remains to be done in respect of many of the proposals.
- Despite differences of opinion over whether the NHS should withdraw from social care functions and over whether SSDs can be trusted as lead agencies, the overwhelming conclusion to emerge is the groundswell of opinion locally on the need for government to *do* something and to use the Griffiths proposals as a basis for action.

The views can best be summed up in the words of a director of social services:

> *something has to be done about community care; current policies, organisational boundaries and financial systems do not allow managers in either the NHS or local authorities to engage properly in the task . . . [there is] a strong sense of frustration at the current inability effectively to get on with the job . . . Griffiths offers the best chance of some action.*

If there is a single clear and unequivocal message to emerge from our quick survey of expert opinion it is that the top priority is for the Government to respond to the agenda for reform mapped out by Griffiths and to give a lead to all those involved in community care whether as planners, managers, providers or recipients.

This briefing has been prepared by David J Hunter, Ken Judge and Sarah Price.

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The Institute is an independent centre for health policy analysis which was established by the King's Fund in 1986. Its principal objective is to provide a balanced and incisive analysis of important and persistent health policy issues and to promote informed public debate about them.

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