"Supervised neglect"? The organisation and provision of dental services outside hospitals under the "classic" National Health Service (NHS) in North West England, 1948-74

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Abstract

The organisation and provision of dental services outside hospitals during the early decades of the National Health Service (NHS) have been characterised by the Health Select Committee as 'supervised neglect'. Rooted in local, regional and national archival sources of policymaking, and using North West England as a geographic case study, this paper examines this characterisation during the 'classic' period of the NHS from its establishment in 1948 to its first major reorganisation in 1974. Despite evident neglect, a narrative of unspectacular yet cumulative change shaped by national government parsimony, local ambition and practitioner initiative is revealed across primary and community dental care through a careful, contextual reconstruction of archival sources.

Keywords

Health policy, National Health Service (NHS), Lancashire, Westmorland, Government

Introduction

In 1993 the Health Select Committee characterised the management of general dental services (GDS) within the National Health Service (NHS) until this date as 'supervised neglect'.[1: vii] Although beyond its term of reference, this characterisation could easily be extended beyond primary community dental services, reflecting the broader subordination of dentistry outside hospitals to medicine within the political imagination of NHS policymakers.

The very circumstances of the 1993 report reflect this subordinate consideration of NHS dentistry. The timing of the new contract negotiations and implementation lagged behind those for General Practitioners (GPs) and hospital consultants in 1990, negotiated and agreed separately as part of reforms introducing market mechanisms into the NHS in 1991. The dental contract in this newly reformed service landscape was an afterthought, largely maintaining the existing fee-for-item piecework model of the GDS, notwithstanding a limited number of new incentives to improve practices and treatment availability.[2:1] The Health Select Committee report publication followed the failed imposition of this new dental contract in 1992, arising from the rapid, unilateral reduction in rates for items of service by 7%. This was attributed as an 'overpayment' by the government, blaming poor forecasting by the Dental Rate Study Group (DRSG) which was tasked with determining payments based on the statistically average – but entirely fictitious – dental practice.[3:1]

It is rare for governments to so spectacularly fail to learn from history given its nuance, but this narrative repeats precisely the failures of 1948. Following nationalisation and the introduction of a standardised payment model to General Dental Practitioners (GDPs) for items of service, the government uniformly reduced them by 20% in 1949, alarmed at dentists' rising incomes in a contractual model.[4] The introduction of charges for prescription dentures in 1951 as part of wider economy measures further reduced the volume of available work, and income, for dentists.[5:362] This also reflected a concern that the quantitative extension of treatment to new patient groups was being achieved at the expense of their quality.

1992 repeated 1948, and subsequent failures of the new NHS market mechanisms to deliver in dentistry contributed to growing professional disaffection.[6] Inappropriate performance measures, inadequate incentives beyond priority services and delays in payment through contract systems were all problems firmly rooted in dentistry since nationalisation.[7:11] These issues and professional disaffection contributed to the 2006 GDP contract which brought dentistry into the NHS organisational fold for the first time under the primary care umbrella. The Dental Practice Board (DBP), which had been responsible for administering contractual payments as the Dental Estimates Board (DEB) since 1948 was disbanded, with its itemised model of fee-for-service replaced with a cost-and-volume system mirroring wider NHS commissioning.[8] The damaging impacts of these reforms for patients given the subordinate position of dentistry was recognised at the time,[9-10] with its underlying policy logic of improving the accessibility and availability of dental services through localised purchasing producing precisely the reverse.[11]

The history of the 2006 GDP contract reflects political attempts to resolve unfinished business in dental services from 1991 and, by extension, 1948. The historical legacy of 2006 cannot be appraised without reference to this inheritance. The contemporary rejection of the NHS's commissioning service model for dentistry outside hospitals, and its disconnect between strategic ends and operational means in pursuit of prevention over intervention, cannot be extricated from the longstanding question of the organisation and provision of primary and community dentistry within the NHS being subject to 'supervised neglect'.

In order to move from this top-down narrative and its sweeping generalisations of the GDS to the question of supervision, neglect, and a broader picture of other dental services outside hospitals within the NHS, the paper is structured as follows. First is discussion of chronology, offering a sense of the historical policy narrative from the establishment of the NHS in 1948 to its first major reorganisation in 1974, often considered its 'classic' period given its underlying stability. Second is the issue of geography which provides a regional, empirical case study of the organisation and provision of primary, secondary and community dental services in North West of England. Geography overlaps with chronology, and an understanding is given in relation to the different boundaries and jurisdictions of different NHS organisations. These are then used to structure the following three sections of the paper. First, an outline of regional hospital dentistry in relation to dental educational needs and the expansion of the dental workforce. Second, a sketch of the GDS in Lancashire and Westmorland within North West England. Third, consideration of priority services for mothers, infant and school children provided by local health authorities (LHAs), particularly the school dental service (SDS). The paper concludes by bringing together these traces to identify mundane, unspectacular yet cumulative change in the place of dentistry within the first twenty-five years of NHS despite prevailing 'supervised neglect'.

Policy Chronology and the 'Classic' NHS

The twenty-five-year period from the creation of the NHS in 1948 to its first major reorganisation in 1974 is viewed by historian Rodney Lowe as its 'classic' era.[12] This view is not a vindication of its original organisational model but a reflection of a particular set of political, policy and economic circumstances. A combination of 'pragmatism and principle' which produced stability and continuity.[13:244] Although contested, there was a broad cross-partisan political consensus to maintaining a centralised, universal taxpayer funded model of health.[14-15] This system was underpinned by a commitment to paternalistic, technocratic planning which foregrounded clinical autonomy over executive management.[16:167-204] The economic circumstances of the 'classic' NHS were propelled by two divergent processes. Firstly, a state commitment to full employment, an industrial strategy balancing labour and corporate interests, and sustained market intervention. Secondly, a broad adherence to austerity and frugality punctuated by episodes of investment and modernisation.[17, 18:223-252] These circumstances afforded a degree of stability which mark it out from subsequent reforms.

Unlike doctors, who dominated administrative structures and processes contributing to the character of the NHS nationally, regionally and locally,[19] dentists lacked comparable influence.[20, 21:90-1] Dentistry, like medicine and nursing, maintained a parallel structure of governance alongside lay administration from top to bottom, although smaller and more diffuse under the Chief Dental Officer (CDO) when first appointed in 1956.[22:436] This appointment, its bureaucratic staff and administrative responsibilities grew incrementally in tandem with those of the Chief Medical Officer (CMO) as workloads and portfolios increased.[23, 24:74-75] Nationalisation also created conduits for professional advice into government decision-making through the Central Health Services Council (CHSC) and its twelve constituent representative specialty committees including the Standing Dental Advisory Committee (SDAC). Unusually, this afforded greater influence for the GDS compared with their medical counterparts, who had neither an advisory committee of their own, nor a voice on any of the others. Envisaged as providing a 'vital strategic role', the SDAC – like the other eleven advisory committees – foundered as the government was unwilling to delegate 'real responsibility', and its activities became bogged down in disputes over fluoridation, dental ancillaries, and the disproportionate needs of hospital dentistry.[25:103] More significant was the establishment of the General Dental Council (GDC) in 1956, empowering dentists with the equivalent self-regulation and professionalisation found in medicine.[26-27] Whilst such governance arrangements afforded dentists a formal role within NHS decision-making at all levels, their influence was limited by their subordinate position to medicine.

The first major reorganisation of the NHS in 1974 wrought havoc across the NHS, although dentistry emerged relatively unscathed with GDPs and Local Health Authority (LHA) Dental Officers (DOs) not as impacted as others competing for limited posts given prevailing workforce shortages.[28:125-154] Whilst the lives of General Practitioners (GP) in medicine were transformed through the 1965 Family Doctor Charter and 1966 contract which improved professional status, remuneration, patient ratios and list sizes and – above all – training,[29],[30:19-20] there was no such revolution for GDPs. Practice remained remarkably stable beyond developments in technology and technique. The itemised model of fee-for-service providing a ceiling on practice modernisation, prevention, and concentration.[31] Hospital dentistry, and oral and maxillofacial surgery, were equally slow to develop in organisational terms, and it was only with dual dental and medical accreditation guidelines from 1982, specialty exams from 1985, and formal association in 1994 that this changed. As a result, 1974 was in many ways not a significant year in the history of dentistry, and the 'supervised neglect' outlined by the Health Select Committee continued throughout the 1980s until the crisis of 1992, However, the global financial crisis of 1973-74 caused retrenchment in welfare spending and drove a more aggressive, and radical politics of cost containment across the NHS, including efforts to curb dentistry through interrogation of its piecework model.[32]

'What often passed unnoticed was the steady progress made' during the twenty-five year period from 1948 to 1974, despite evident 'supervised neglect'.[33:397] Owing to its stability and the confluence of changes in 1974, this period serves as a convenient chronology through which to examine the organisation and provision of dentistry outside hospitals in the formative years of the NHS.

Policy Architecture and Organisational Geography

North West England provides the geographic case study through which the policy chronology is followed. The North West 'as a regional descriptive or analytical category ha[s] a very limited pedigree' according to John Walton, who sees the label as a 'convenient administrative or descriptive sub-division' rather than related to locality, identity or culture.[34:292-293] Within the region spanning Lancashire, Cheshire, Westmorland and the towns and cities contained by these county borders is a rich seam of work using oral history to situate working-class experiences of life, inequality and health during the twentieth century,[35-36] including oral health and attitudes to dentists, dental services and professional care.[37-38] They speak to the limitations of dentistry in shaping oral health, and emphasise wider issues of diet, sugar, nutrition, toothbrushing, prevention, and above all inequalities, which are vital to understanding continuity and change over time.[39]

Whilst recognising these wider dimensions and their significance to the history of oral health and dentistry, and the artificiality of separating them, the focus here is to situate the North West of England as an organisationally-defined territory, or territories, within the policy architecture of the NHS during its 'classic' era. These determine how dental services were organised, funded and provided, and enable us to trace its unspectacular yet otherwise invisible cumulative changes over twenty-five years.

The organisational structure of the 'classic' NHS was divided into three separate spheres. Firstly were nationalised hospitals. These were, in fact, further bifurcated, making four separate spheres. Organisational responsibility for administering hospitals was divided between teaching and service purposes. Teaching hospitals were run by Boards of Governors (BoGs) whose function was to enable medical and dental education and research, principally within university centres. For the North West these were Liverpool and Manchester, each having a medical and dental school linked with designated beds and professorial units across several teaching hospitals, although their territorial influence was limited to their conurbations where students were placed. BoGs reported only to the Ministry of Health and the Minister, being otherwise independent in organisational terms, even if their teaching hospitals and specialised tertiary services also served patients from local and regional catchments. Service hospitals were managed by Regional Hospital Boards (RHBs), who oversaw a patchwork of Hospital Management Committees (HMCs) responsible for running hospital groups and secondary care within a defined district. Again, for the North West the RHBs were centred on Liverpool and Manchester, with Manchester's geographic reach stretching north to Barrow and Westmorland, and south to Cheshire. Liverpool's population, territory and number of HMCs was half the size of Manchester. This pattern reflected the outcome of an influential wartime survey produced collaboratively between the Ministry of Health and Nuffield Provincial Hospitals Trust using historic hospital referral flows with an

ambition to rationalise, centralise and concentrate services on districts.[40] This secondary care pattern also impacted tertiary service catchments, including regional specialist oral and maxillofacial units whose establishment coincided with the wartime revolution which engendered the NHS.

Outside hospitals were LHAs, anchored in Victorian local government boundaries between county boroughs serving towns and county councils the hinterland. These provided community and social services, although a 'dispirited rump' of their pre-nationalised municipal peak, which in dental terms were priority services for mothers and infants and the School Dental Service (SDS).[5:374] The number of small cotton towns which emerged and expanded during industrialisation created a patchwork of county boroughs across the county of Lancashire which posed organisational and functional problems despite a complex system of divisionalisation. Local government politics did not help surmount these difficulties.[41:102] Primary health services contracting GDPs were governed by Executive Councils (ECs), whose territorial boundaries matched LHAs and local government, effectively perpetuating National Insurance Committees (NICs) which preceded ECs in all but name. Their problems of size mirrored those of LHAs but without decentralisation of functions, perpetuating longstanding geographic tensions since the creation of NICs in 1911.[42:163] Nationalisation inherited and then perpetuated organisational structures and patterns of provision by necessity rather than design given the volume of work required by both government and the civil service to introduce the NHS by 1948.[43]

Beyond this broad organisational outline were deeper tensions within the policy architecture which shaped the provision of dental services. Whilst the North West was divided into two regions, each centred on a university and historic patient catchments, it actually comprised three territories for the purpose of service organisation.[44] Civic rivalry between Liverpool and Manchester over placement hospitals for medical students, postgraduate training positions, and tertiary service catchments at the inception of the NHS sealed the fate of Preston and its subregion – encompassing north Lancashire and Westmorland – becoming subsumed into Manchester RHB.[45] Compounding this was further competition between Preston and the towns of Blackburn, Blackpool, Burnley, Lancaster and – later, as a new town – Chorley and Leyland, which inhibited the designation of a natural centre for the subregion through which they could obtain organisational independence.[46:316-335] Victorian industrialisation, manufacturing specialisation by town, and the decline of the textile sector also shaped the social geography of Lancashire and its cotton towns,[47, 48:78-118] which made it a relatively unattractive destination for doctors and dentists, further impacting service organisation and provision.[49-50]

The relative unattractiveness of the North West as a career destination integral to understanding service inter-relationality despite functional divisions. shortages and patient overlap across services led to displacement whereby inaccessibility or absence in one produced demand in another, such as the dental care of children between the SDS and GDS. Access to hospital dental and tertiary oral and maxillofacial surgical specialties reflects a further tension between specialty – particularly with plastics and ear nose and throat (ENT) surgery – and spatiality – primarily between the teaching centre and its geographic periphery. Furthermore, the use of dental therapists and hygienists within the SDS was a response to enduring staff shortages and their attendant limited coverage throughout the 'classic' NHS. . Their introduction and slow expansion raised associated questions of role and skill substitution which were inextricable from debates over professionalisation and specialisation, although these predated the NHS..

Organisational and territorial subordination within the regional policy architecture of the NHS in the North West profoundly impacted dental service development for the counties of Lancashire and Westmorland and its constituent towns comprising the Preston subregion or system within the North West. This area forms the basis of the case study for the remainder of the paper. The following three sections exploring each branch of the 'classic' NHS as applied to the case study in turn, focusing on teaching hospitals and dental education in relation to the supply of dentists; the GDS; and LHA priority provision and the SDS. Dental services inside are more complex given specialisation which cut across teaching and service functions. Whilst recognising that 'the hospital dental service is something of a Cinderella' in the words of one senior civil servant at the Ministry of Health in 1952,[51] this experience was less familiar to oral and maxillofacial surgery as an emerging specialty which grew in size, status and scope over the same period.[52] The establishment of the Faculty of Dental Surgery within the Royal College of Surgeons in England in 1947, and its associated Fellowship reflecting higher training, standards and recognition,[53] along with inclusion within the postgraduate medical federation,[54] supported such specialisation.[55] Their organisation,

development and provision is beyond the scope of this paper, which examines dental services outside hospital settings.

Crucially, national decision-making within central government as told through policy documents does not map neatly onto these regional disputes and localised issues shaping the provision of services. They are for more iterative, cumulative and complex, and beyond the oversight of one single organisation or individual.[56:512] Accordingly, this paper draws upon archival sources of central, regional and local organisations, universities and their dental schools, the personal papers of key individuals, and obituaries from the dental and professional press to understand the organisation and provision of dental services, and the extent to which they were the product of 'supervised neglect'.

Dental Education and Workforce Expansion

The 1946 Teviot and 1956 McNair Reports shaped dental education, postgraduate training and career opportunities for dentists throughout the 'classic' NHS.[57-58] These effectively mirrored the 1944 Goodenough and 1957 Willink Reports which served the same purpose for doctors.[59-60] They were underpinned by identical principles of controlling numbers at each stage through central quotas over dental and medical school places, then junior doctor appointments and progression, and finally by RHB and BoG consultant appointments. The latter being important as, in medical terms, the numbers of doctors becoming GPs or moving into other non-hospital roles were not factored into planning by numbers,[61:19] instead conceptualised as attrition and to take up such positions, reflecting a deeper division in British medicine.[62:310-314] Such an outlook also prevailed in dentistry, with oral surgery seen as the pinnacle and route around which postgraduate training was envisaged, rather than the GDS, LHA priority services or SDS, despite governmental and professional recognition that most would move into such positions.

The official historian of the NHS, Charles Webster, reads the McNair Report as a 'depressing account of the state of dentistry' which failed to restore professional confidence in the newly nationalised service given lasting resentment over Penman reductions.[5:365] The report committed to expanding the numbers of dental students to meet demand, unlike Willink for medicine, which reduced numbers given professional fears over labour market saturation. Here was a clear point of difference between dentistry and medicine in workforce planning.[63] Despite this, there remained a dissonance between the ambition and realisation of dental student number expansion. Cumbersome central government negotiation between the GDC, Ministry of Health, University Grants Committee (UGC) and Treasury led to delays and glacially slow progress.[64-65] Liverpool and Manchester both received expanded student numbers. These increases were mainly to meet recognised dental workforce shortages throughout the north of England, except in oral surgery and hospital dentistry, where the London schools continued to shape specialised supply.[66:210-214] Whilst the University of Lancaster – opened in 1964 to address gaps in regional higher education[67] – tried and failed to establish a medical school,[68] it never countenanced a dental school. Dental student numbers and increases stemming from McNair are shown in figure 1, below.

[Figure 1. Dental school intake increase, 1956-66]

Compounding government delays was the public perception of dentistry. 'The aura of instability surrounding the early service reduced its attractiveness to potential recruits' according to Webster, with places routinely unfilled despite competition. Even in London.[5:364] This national picture was found locally with students 'reluctant to come forward' in Liverpool, associating dentistry with 'unpleasant work, poor working conditions, and low remuneration' compared with medicine.[69:430-431] Notwithstanding these problems, the staff: student ratio within dental education across all UK dental schools was reduced from 48 in 1938/39 to 13.1 in 1961/62. A fourfold increase mirroring a similar one found in medicine, from 31.3 to 7.4 over the same period.[70:xix] They constituted unspectacular but evident improvements in the supply of dentist for service and education. Such gains must be contextualised. The ambitions of McNair to nearly double dental educational capacity were not reached for two decades. By 1976 an intake of 942 against a target of 954 was attained, although officials acknowledged it was already inadequate to meet

demand given historic shortages and unmet need.[71:22] Ratios of dentists per population remained stable.[72:737] Here, the position of dentistry was undoubtedly sustained supervised neglectful.

Despite delays and doubts over costs, a new dental school was established at Cardiff. This reflected 'deep laid plans' since the establishment of the Welsh National School of Medicine (WNSM) in 1893.[73:57] These ambitions intensified throughout the interwar years as other civic redbrick universities gained them alongside medical schools.[74] The politics of Welsh nationalism surrounding the WNSM suppressed these aspirations[75:154-156] until rekindled by Teviot and McNair. Their impact on the North West being important given its historic relationship of health services to North Wales,[76:251-254] including the recruitment of doctors and dentists, with many heading choosing to head South rather than East as the school at Cardiff grew.

Within Manchester and Liverpool, policies which modernised dental education and increase numbers were similar and threefold. First, both concentrated teaching beds from several former voluntary teaching hospitals into new purpose-build sites or extensions of existing premises.[77:40, 78:81, 79] These were administered between BoGs and their respective universities, opening in Liverpool in 1969 and Manchester in 1972. Second, given an emphasis on expanding numbers of dentists, both focused on increasing the number of educators and demonstrators. These new faculty were scarcely ahead of the peers, producing something of a hand-to-mouth existence throughout the 'classic' period.[80:59] Third, developing research capacity beyond the interests of individuals was not afforded priority. Whilst an acute regional problem in the North West, this outcome reflected the subordinate position of dentistry within national funding bodies, particularly the Dental Subcommittee of the Medical Research Council.[81:209, 82:86-90] Prioritising clinical concentration and dental education at the expense of research reflected pragmatism and cultures of neglect rather than an intentional outcome.

Ultimately, the requirements of dental education, their linked teaching beds and new or – as was the case for Manchester – enlarged dental hospitals in the North West during the 'classic' NHS were shaped to serve national targets and the needs of their university centres, not their wider regional population. Teaching and service were firmly separated in the organisational imagination, with undergraduate dental education and their associated hospital beds coming within the purview of Liverpool and Manchester BoGs respectively, rather than RHBs.[83] Increases in dental student numbers did slowly trickle down to more unpopular and underserved regional peripheries but this was often through local graduates training and remaining rather than others attracted by new opportunities under the NHS. It is to their experiences that we now turn.

General Dental Services and Heavy Metal Piecework

The organisation and provision of dentistry outside hospitals within the GDS is inseparable from the issue of pay given the fee-for-item piecework model. Pay was, in the words of Webster, a 'slumbering leviathan' in dentistry during the early years of the NHS,[84] with government efforts to contain expenditure and curtail availability shaping dental services across all three service branches, but especially in GDS.[85] The politics of pay in the dental profession will be discussed first, followed by their realisation in the North West of England, particularly Lancashire, Westmorland and the towns they contain.

Dentists and oral surgeons working in hospitals were largely assuaged through the 1948 Spens award which embedded comparability into hospital medical and dental pay.[86] The report and the system it created was 'primarily viewed as a means of rewarding the elite of the profession' which excluded generalists and buttressed distinctions based on professional hierarchies.[5:316] The system did not include general practitioner contracts for either dentists or doctors, with the 1947 Spens report on the GDS and its recommendations on pay producing a sense of professional optimism with the NHS.[87] Officials were, in the words of Webster, 'slow to bring dentists' earnings under control' given the scale of unmet need inherited by the nationalised service and the greater political and administrative attention given to battles with the hospital consultants.[5:361] Accordingly, the sense of professional optimism surrounding Spens in 1947 was duly and brutally quashed by the 1949 Penman reductions, being widely regarded as a 'breach of faith'.[5:362] Compounding this misery was the 1952 Danckwerts award for GPs. This backdated pay based on prewar levels for items of service, assuaging their own grievance against the government, but firmly contributing to perceptions of differential treatment by GDPs.[5:197-198] However, disquiet remained across both medicine and

dentistry. This fuelled the 1960 Pilkington Report and the establishment of the Doctors and Dentists' Review Board (DDRB) as an independent arbiter intended to provide political distance from perennial pay disputes.[88] Whilst it created 'valuable breathing space' over the issue, its annual review system and continued claims from different professional quarters for parity, along with running battles with the Treasury, continued to cause perennial problems for the Ministry of Health regardless of the government's political hue.[84:155]

The character of pay negotiations stemmed from the government's view of dentistry within a nationalised service. Relative to medicine, the GDS obtained a low profile within the Ministry. This continued its previous marginalised from the National Health Insurance Commission (NHIC) for England, the body responsible for regulating payments to GPs prior to 1948.[5:357-358] The resulting cost estimates used by officials during wartime discussions thus became a 'flawed yardstick' given limited prewar experiences and inflated postwar expectations.[89:244] More than other services, dentistry relied upon labour intensive model of delivery for which its workforce was not planned to meet.[89:226] The gap between the two supported policy shifts towards priority provision for certain groups – maternity and child welfare and schoolchildren, both previously provided by local health authorities – rather than universalism.[89:228] Where they had been undertaken by GDPs rather than LHAs prior to nationalisation, it was part of social work practice among the poor, with charities and organisations paying for dentures or remedial treatment to improve the outward image and self-esteem of women, primarily mothers.[90, 91:59-60] Whilst a political success in managing an administrative problem and containing costs for both service, education and postgraduate training, it legitimated fiscal stringency for dentistry and inveighed against equity and accessibility.[92] This culture of treatment by government opened the door to charges for dentures – exempting priority groups – in 1951 as an economy measure which further suppressed demand through deterrence.[93] Once introduced, they became hard to retreat from, even for later left-wing Secretary of State Barbara Castle in 1974.[84:596-597] It was another example of battles over 'paper figures and symbols' fought by politicians and senior civil servants which shaped the scope and scale of the welfare state.[94:211]

Further shaping the NHS was the administrative apparatus intended to govern dentistry, particularly the GDS. In medicine, the distribution of GPs was controlled by the Medical Practices Committee (MPC), which used incentives to recruit to unpopular areas and control practices in areas with existing provision through the regulation of list sizes. The frugal basis of incentives and weak control systems, combined with decisions being taken through details supplied by ECs and Local Medical Committees (LMCs), severely curtailed its ability to render a universal service.[95] Despite its evident shortcomings, there was no MPC for dentistry. Existing inequalities between London and the provinces, and between provincial centres and their peripheries – including Manchester and its Preston subregion – remained acutely and deeply entrenched as a result.[96-97] For example, the 1979 Royal Commission on the NHS highlighted a difference of 1 GDP to 5445 patients in the Northern Regional Health Authority (RHA) – successors to RHBs from 1974 – which masked differences of 1:3522 in Newcastle compared with 1:7317 in Sunderland.[98] Although figures are not readily available for Manchester and the textile towns in its provincial periphery, it is clear that a similar dynamic existed. Political and technocratic will was limited to move beyond these restrictions and effect change was limited throughout the 'classic' NHS, contributing to feelings of 'supervised neglect' within dentistry.

The 1956 Guillebaud Report, interrogating the costs of the NHS under a sceptical Conservative government, identified this problem of inequality and inaccessibility, yet was content to maintain it owing to the lack of available dentists at that time – or even in the pipeline for the future – to provide a universal service.[99:178-179] Along with contributing to cost containment. Its recommendations instead focusing on ensuring adequacy in oral health, without offering a benchmark or definition.[100:25] Dental distribution ultimately remained 'a major problem' without any prospects of resolution throughout the 'classic' NHS.[101] This reflected an absolute lack of dentists, and the inability of the policy apparatus to ensure they went where they were most needed.

As a result, an inverse care law prevailed within NHS dentistry. Moreover, better served areas were able to undertake more treatments, and a greater range, rather than simply seeing more patients. This meant average costs for ECs in London were twice what they were per patient when compared with Lancashire, being slightly over 40 shillings in London against just under 20 for Lancashire. The Victorian units of administration served to skew this within Lancashire, with both Burnley and Wigan – each having their own far EC with fewer dentists, a smaller area and lower population – having some of the highest rates of pay per dentist in the country.[66:200-8] Such areas were also beset by problems of slum clearance and suburbanisation which shifted practice populations and locations.[102:167-

[73, 103:150-52] Practice location masks another dynamic of access to NHS dentistry, with areas of high GDP concentration nationally, regionally and locally more likely to offer private services for treatments deemed too expensive or outside the scope of the GDS, offering another reliable source of income to certain dentists outside the NHS.[104:41-3] This ensured there was an enduring symbiosis between private practice and dentistry not found in medicine and GPs.[105:112]

Compounding this subordinate position was the contractual relationship between the government and GDPs as independent providers of services, through which agreements were brokered to secure the dental fitness of patients. Dentists were not employees to be directed, but providers whose behaviour was shaped by incentives. Under the contractual system, they were 'caught between a cost-conscious state and a profit-seeking market' with no obligation or compulsion to perform unprofitable or time-consuming treatments.[106:123] The piecework model of contracted dental service for GDPs based on dental fitness firmly entrenched quantity over quality. Payments were made through ECs whose interests were focused on administrative and accounting oversight rather than patient welfare, and a lack of responsibility for them as consumers of services distorted the contract model and organisational relations.[96:124]

Even within ECs dentistry often played second fiddle to the interests of GPs and pharmacists as shown in Figure 2. This represents the overall costs of each heading within Westmorland EC throughout the 'classic' NHS, showing the impact of the Spens and Penman settlement on dentistry, significant shifts with the introduction of patients charges in 1952 and 1968 – following their abolition in 1966 – and pay awards for GPs in 1952 and 1960, along with the 1968 implementation of the scale of charges and fees outlined and agreed in the Family Doctor Charter.

[Figure 2. Westmorland Executive Council, Annual expenditure by heading, 1949-73]

Despite the lack of voice and means to ensure patient welfare through ECs, there remained high satisfaction with those accessing the GDS despite its somewhat notorious 'fill and drill' approach.[107:105-109] It was this which created a so-called 'heavy mental generation' of patients with high volumes of mercury amalgam fillings and the lack of conservative or preventive options.[108] Satisfaction was not universal, and the unmet dental needs of the elderly remained a public health concern as identified in 1960s Stockport given associated impacts on diet, health and social outlook.[109:31] These concerns and the continued shortcomings of dentistry were recognised in further reports on the topic undertaken by Manchester RHB.[110:59-62] A similar position prevailed with regards to the dental care of patients in long stay geriatric, chronic and mental institutions falling under the purview of hospital dentistry provided by RHBs.

By the mid-1950s an equilibrium was reached within the GDS over meeting the backlog of treatment against the numbers of available dentists and the payment mechanisms for treatment. Catering for priority groups remained the focus of dental adequacy at a population level given the impossibility of a universal model within policy-making assumptions.[5:362-364]

Serving to control costs and limit the scope of adult treatment within fill-and-drill practice was the remnants of insurance processes inherited from NICs. Previously a negligible part of the work of the NHIC, the Dental Benefits Council (DBC) was constituted with the 1928 National Health Insurance Act, although it was the 1936 one which expanded entitlements. This became the Dental Estimates Board (DEB) with the establishment of the NHS, serving to nationalise, centralise and increase its role in administering payments to GDPs.[111:18-39] The DEB retained the power of the DBC to approve or deny treatments for patients based on their estimated costs, with the 'unstated duty of safeguarding public funds' shaping its activity.[112:57]. Whilst routine heavy metal work fell below the cost limit, the estimate system served as a disincentive for more complex procedures, appliances and conservation through the time taken to assess patients, submit forms, have them appraised and audited – even renegotiated or refused – and with no obligation for patients to be treated on such terms within the NHS.[111:45-47] Mirroring medical influence of administration, the dental profession dominated the DEB. Audits of the cost, time and resources outlined in estimates were not made by the office of the CDO or the Ministry, but senior GDPs – often EC or Local Dental

Committees (LDCs) representatives – working as dental advisors at regional and national level, supplementing the modest lay administrators of the DEB based in Eastbourne.[111:85] The bureaucracy of the DEB which restricted services for adults, combined with a narrowing of universal treatment on priority groups only, delimited the scope of the GDS throughout the 'classic' NHS.

The impact of the creeping expansion of dental school places outlined above meant that by 1977 there were around 14,000 dentists working for the GDS. They were only able to cover around half of the population based on their determination of need.[98:106] Unlike GPs, there was no system of loans for practice improvement or expansion, let alone encouragement into health centres, nor list controls or permissive powers to encourage partnerships or group practice. 'The dentist is by training, if not by nature, an individualist',[112:ix] and GDPs remained largely impervious to the weak range of incentives offered in this direction throughout the 'classic' NHS.[113:377] The result was a 'labour intensive industry with a low degree of market concentration' leaving most dental practices 'fragmented, small-scale businesses, often single handed'.[114:21] Like GPs, GDPs constituted a professional 'nation of shopkeepers'.[106:113] The sustained splendid isolation of dental practice, rather than in larger aggregate units, and its attendant neglect in policy terms, created the groundwork for the failures of commissioning and the primary care model of the 2006 contract.

The fragmented and marginalised nature of dental services within the NHS is reflected in the quality and survival of records, which are minimal for both individual practices and ECs which paid them, making it harder to understand the day-to-day experience of the GDS rather than their administration. The following discussion draws on obituaries of several prominent GDPs who practiced in the Preston subregion to grasp the character of both practitioners and their practice. Together, they also highlight the important of local associational, social and political life within the dental fraternity, also in evident within provincial medicine.[115]

Geoffrey Wood (1932-2008) encapsulated professional pathways and character of local GDP for many. Born in the Rossendale Valley and attending first Bacup and Rawtenstall, then Manchester Grammar School, he qualified from Manchester in 1956 before buying a practice in a working-class district of the area he was raised and developing it over the course of his career.[116] A. Trevor Salter's (1930-99) story is similar. He was born and raised in Blackpool and, having graduated from Liverpool in 1954, tried careers in academic and hospital dentistry – in between national service – before joining a partnership in his native town in 1959.[117] Derrick W. Torkington (1921-2000) preceded Salter, having been raised in Lytham St Annes and graduating from Liverpool in 1938. After a brief period in hospital dentistry and the dental branch of the Royal Air Force (RAF) during the Second World War, he established a practice in his hometown on demobilisation.[118] Edgar Cowperthwaite (1923-2018) was, like Wood, a grammar school product originally from Rochdale who was educated in Lancaster. Following wartime interruptions to his career, Cowperthwaite atypically graduated from Leeds in 1952, working briefly in the SDS in Skipton before taking up the practice of his own dentist in Lancaster as his health declined.[119] Such routes were not incompatible with the changing wrought by nationalisation. Howard Wall (1923-2017) was the son of a Preston dentist also educated at Preston Grammar before qualifying from Liverpool. Following several posts working for the university dental hospital in different capacities and wartime service as a dental assessor for recruits, Wall returned to Preston where he 'embraced the philosophy of the NHS' in running the practice for the next 35 years.[120]

Perhaps embodying incremental change despite supervised neglect and enduring cultures of rugged individualism within dentistry were Frank Parrott and Ken Bowker, who shared a partnership for many years in Clitheroe. A Mancunian educated at Manchester Grammar who qualified from Manchester, Parrott was, like Wood, a firmly regional product.[121] J. Ken Bowker (1918-2013) on the other hand was Parrot's longtime partner, having established the practice he later joined in 1947. Bowker was originally from Clitheroe and educated at its grammar school. Following Allison and Wishart, Bowker was an Edinburgh graduate with membership of the RCS, honing his skills in the Royal Army Dental Corps during campaigns in North Africa and the Middle East. This equipped him to work as clinical assistant to Fred Monks, one of two oral surgical consultant appointments for the Preston subregion of Manchester.[122-123] For 23 years he worked as a clinical assistant to Monks for sessions held at Clitheroe Hospital[124] This was part of Blackburn HMC, with 3 other local GDPs supporting Monks' clinical sessions at Blackburn Royal Infirmary, Queen's Park Hospital and Accrington Victoria Hospital.[125] Although overstretched and unable to serve patients for workforce and bureaucratic reasons largely shaped by policy anxieties over pay, GDPs were indispensable

in ensuring the viability of consultant-led oral surgery and hospital dentistry across the Preston subregion, highlighting interdependency through place across the different branches of the NHS.

There were other interconnected currents changing the face and location of the GDS: feminisation and expansion. Feminisation of dentistry, like medicine, occurred first through growing numbers in the newer dental schools, moving into positions low on the professional hierarchy. Notably the SDS, LHA priority services, and undesirable areas for other GDPs.[126] Change was incremental rather than sudden. Emblematic of its pace was Mary Codling (1937-2021), the daughter of William McFarlane and sister to Ian – both dentists. Better known as McFarlane given the family connection, Mary graduated in 1960 as one of the first cohort of the new Manchester dental curriculum and joined her father's practice following a brief spell in the SDS.[127] Second-generation career opportunities enabling routes into, and through, the profession.

The 1966 expanded cohort at Manchester also included greater numbers of women, many of whom experienced well-documented barriers to professional progression owing to gendered family responsibilities.[128] Pam Watson was one of those, hailing from Manchester, attending the local grammar school and graduating in the expanded cohort, she worked under Geoff Wood until later opening her own practice in 1977 at Ramsbottom once family commitments allowed. As with others, Pam was a stalwart of the provincial professional associational circuit, retaining ties with the dental school as its numbers further increased.[129] A similar position was experienced by Ros Quinn, another of the 1966 cohort. Although not a native to Lancashire or Manchester, she married one she met at dental school – Mike Birkett – with whom she later established a practice partnership together at Bacup.[130] Ros was a contemporary of Stewart Jackson, another of the cohort, whose background, education and graduation reflected the recognisable regional norm. He joined a practice in Burnley, along with the British Dental Association (BDA) branch and LDC, all of which he later inherited and expanded in some capacity.[131] Such graduates were significant in attending to the otherwise neglected position of the GDS in the hinterland of the Manchester region. Not all of those from the region who trained at Manchester chose to stay. Francis Thomas (1926-2007) moved to Lancaster at an early age where he also attended its Grammar School. Thomas embarked upon a career in dentistry upon demobilisation, graduating from Manchester in 1954 and establishing a practice at Barrow-in-Furness in 1960 where he also embedded himself in professional and associational life. He left in 1966,[132] perhaps disenchanted with running battles between Barrow-in-Furness LDC, its EC and the DEB over responsibility for patients for whom treatment had been deemed either too expensive or outside its scope.[133]

Pay, and its underlying system of heavy metal piecework, was integral in shaping the GDS during the 'classic' NHS. Quantity trumped quality, which was a product of supervised neglect. It reflected a lack of substantive incentives, continued cultures of professional individualism, enduring cost containment at every level of the policy apparatus, and persistent failure to recruit sufficient dentists to expand coverage. Solitude for those working in the periphery was broken mostly through professional and associational life, fostering some sense of solidarity. The problems of NHS dentistry were well known but remained largely unchanged. Differences with medicine and the comparable treatment of GPs further exposing the marginal position of GDPs.

Dentistry, the Family, and the Local Health Authority

Dental services provided by the LHA served as enduring state responsibility across nationalisation. This was primarily for school aged children through the SDS, although with statutory rather than permissive powers in terms of maternity and child welfare, a traditional preserve of municipal public health and its professional head, the Medical Officer of Health (MOH).[28, 134] These were expanded in principle through statutory funding for services catering for expectant mothers under Section 22(1) of the 1946 NHS Act. This meant there were separate legislative and fiscal bases for the SHS and priority LHA services even within the same authority, making it two services rather than one. Although staff shortages fuelled significant integration and creativity from innovative MOsH.

The expansive vision of the County MOH for Lancashire to realise a comprehensive community dental service was shared by his staff of dental officers and elected councillors wanting a 'generous' service even before the NHS.[135] This was, like most others, inhibited from its inception with staffing and financial problems which nationalisation inherited. In Manchester the MOH sought to bridge this gap by purchasing mothballed mobile army dental units to

extend facilities to schools across the city catchment.[136] This also overcame capital restrictions which prevented clinic modernisation in the immediate postwar decade, with existing clinics being – in the Ministry's view – 'totally inadequate and is so lacking in facilities that the provision of a satisfactory standard of treatment is impossible'. Notwithstanding the make-do-and-mend pragmatism of the MOH, the scope of ambition remained limited. In late 1954 the Ministry complained that the authority made no progress in developing or implementing a dental education strategy, to which the MOH replied that it 'was of no practical value in Manchester owing to the hard conditions under which many people live'.[136] Such strategising by MOsH – common to their role[137-138] – extended only so far in compensating for more fundamental problems common to dentistry outside hospitals throughout the 'classic' NHS.

With LHA boundaries mapping onto territories and jurisdictions unchanged since 1889, if not before, staffing and financial problems in the smaller county boroughs of Lancashire which pock-marked the county council footprint were usually worse than either large city authorities such as Manchester, or Lancashire County Council. The lack of opportunity for progression,[139] limited variety of practice and poor oral health of children,[140:98-102] combined with political parsimony for previously permissive public health functions, [141, 142:160] made LHAs the option of last resort for many dentists. Such was the shortfall and relative unattractiveness that in the late 1950s the government considered deploying dentists on national service into the SDS. The decision was ultimately rejected given the equal need of young recruits and the role medical and dental officers played in managing popular disquiet during the end of the British Empire.[143-144] Despite the consideration of such drastic action at a national level, this was not universal across the country or the North West. A strong municipal tradition of school or public health dentistry, backed with sufficient political clout, could be viable and – as occurred in both Liverpool and Nelson – even inhibit the development of a buoyant GDS.[145:103, 146:38]

Much like the GDS itself, historian John Welshman has observed that there was a 'striking degree of regional variation in effectiveness' within the SDS.[147:323] Both the national and more localised problems outlined above which made the SDS and LHA dental services an unattractive prospect reflected ongoing, unfinished negotiations between the government and the BDA over the professional qualifications required to undertake certain categories of work, with staffing shortages widespread, and more acute in the North West. The politics of professional defence rumbled on with resistance to dental ancillaries, auxiliaries and therapists mobilised to provide the type of dental adequacy highlighted in the Guillebaud Report.[99:183] From 1960 state sanction was granted, but only under the supervision of qualified DOs and confined to the SDS. Numbers remained small given their contested position.[148:48]

LHA dentistry remained the lowest rung of the professional ladder, often a rite of passage for many young dentists looking to obtain experience and build capital to establish themselves in independent practice. Here Figure 3 outlines the impact for this on practice, showing tenure terms for DOs for Westmorland LHA throughout the 'classic' NHS era. The high turnover of recent graduates and new arrivals contrasting with a steady core of senior appointments who both undertook routine work and supervised juniors. This was not always the case, with some able to create space for innovation. Keith Woods (1941-2005) grew up in the Fylde, attending Baines Grammar School and graduated from Sheffield in 1964 with the Gold Medal for Operative Surgery. Woods carved a niche in the dental public health field, mirroring the strategisation of MOsH. First as a junior DO focused on children with physical and mental disabilities – who often fell between the scope of the different branches of the NHS – then as senior DO at the cusp of the 1974 reorganisation – which organisationally combined LHA and SDS services into the Community Dental Service (CDS) – where he used the limited financial and staffing resources to work with other marginalised groups such as prisoners,[149] and was in the vanguard of using epidemiological data to develop services.[150] Necessity serving as the mother of invention in NHS dentistry.

[Figure 3: Westmorland School Dental Officer Staffing, 1944-72]

The work of the LHA DO was unspectacular and otherwise mundane. Dental provision in LHAs, where dentists were salaried and their work practices were not shaped by the piecework contractual model, experienced similar problems of compromising quality to attain quantity, . Westmorland was not atypical, and it was staffed mostly by older dentists, often those progressing through LDS qualification routes, and usually working part-time or

on a sessional basis across more than one LHA. This was particularly common for the small county boroughs of Lancashire, persistently unable to secure full-time of their own beyond senior stalwarts.

This employment model impacted the accessibility of dental treatment, along with the preventive and educational purview of the dental care of mothers and children. In 1957 a report by Miss E. M. Knowles, Senior Dental Officer at the Ministry of Health as part of a larger series of investigations across the country affirmed this situation,[151] although implementing her recommendations in Lancashire around additional peripheral and evening clinics was – again – hampered by staffing.[152:53] Simply increasing the number of sessions did not result in more patients being rendered 'dentally fit'. It only spread an already limited capacity even thinner. This position was repeated across the towns of the county. In Burnley the same year 379 mothers were examined, with 171 out of 279 those needing work being treated, of which 132 were discharged as 'dentally fit'.[153:62-63] Blackburn was comparable to Burnley, with 25 dentures issued by both in 1957, with declining proportions of those seen, treated and considered 'dentally fit'.[154:29] In Preston the pattern was identical, with extractions and fillings providing the mainstay of work undertaken despite few mothers being rendered fit.[155:25] In Blackpool the lack of DOs in the SDS to work outside of their immediate responsibility meant priority dental work for mothers and infants was contracted through local GDPs, with the LHA picking up the cost under NHS terms.[156:25] This pattern was begrudgingly acknowledged by the Ministry, noting that women with worse oral health would actively approach LHAs as they provided free dentures, whilst those wanting more conservative treatment went through the GDS for individual extractions rather than fillings.[157:173] Navigating and negotiating the artificial administrative divisions of the NHS by patients considered a priority reflected the local realities of rationing rather than universalism.

Intensifying the tripartite division of the NHS was the administrative position of dentistry within local authorities. The SDS, like the school medical service which also emerged prior to the NHS, was accountable to the Education Committee rather than the Health Committee within authorities. Permissive municipal dental treatment for mothers and young children nationalised in 1948 was organisationally based in the LHA, yet work was mostly undertaken by DOs employed in the SDS across combined remits. Both reported to the MOH who was, from 1948, also the School Medical Officer in most local authorities. Moreover, to manage the needs of distinct localities given its enormous territorial footprint, both the Education and Health Committees of Lancashire County Council used a divisional model to devolve functions. Neither of these were coterminous. Lancashire being 'an outstanding example of a county in which county district council boundaries played a more decisive part in the process of division than did functional considerations'.[158:18] Local politics and territorial antipathy being prioritised over service considerations, leaving officials to cooperate with one another across such boundaries to develop, organise and provide LHA dental services.[159: 275-276] Despite coterminosity being the basis for the 1974 reorganisation, its implementation did not improve integration in the CDS which emerged.[160-161]

Even within dentistry, already neglected within the NHS, LHA services obtained professional unpopularity, low policy prioritisation, and longstanding staffing and funding problems which inhibited sustained improvement. Sustained labour shortages in such a labour-intensive service 'constituted important elements in the failure to make adequate provision even for priority patients'.[33:397] The failure to prioritise even priority groups seemingly capturing the culture of supervised neglect within NHS dentistry. Yet even here there were unspectacular gains, with reliable routine inspections a barometer of improvement in contrast to more episodic waves of treatment before the NHS.[162:49] A survey towards the end of the 'classic' NHS showed that the state of schoolchildren's oral health remained unsatisfactory – and far from close to fulfilling nebulous notions of adequacy outlined by Guillebaud – but caused no alarm or popular moral panic.[163] Treatment predominated over prevention and education, but neglect of the service was not wholly reflected in neglect of the patient.

Conclusion

Whilst the 1993 Health Select Committee report was referring to the GDS, its accusations of 'supervised neglect' could be levelled at all dentistry within the NHS provided outside hospitals. Across primary and community dentistry throughout the 'classic' NHS from 1948 to its first major reorganisation in 1974, the abiding experience was one of dentists living with the consequences of this marginalisation. In dental education the consensus on increasing numbers was inhibited by bureaucratic delays and a focus on teaching over research in both Liverpool and

Manchester, the university centres servicing the North West. The GDS lacked the same recognition provided to GPs with the Family Doctor Charter, and inequalities remained entrenched and unaddressed in terms of staffing. Despite some working within the hospital dental sector given scattered facilities and limited consultants. This, in turn, impacted the overall quality of service given reliance on quantity of treatment to meet NHS objectives. These were caught between dreams of universalism and the realities of aspiring for adequacy, underpinned by pay, staffing and resources. The SDS and other LHA priority dental services were the bottom of the pile within dentistry, as they were for medicine and public health. Problems of organising and providing services were worsened by administrative disorganisation through territorial boundaries dating back to the Victorian era which were wholly outdated. Whilst staffing elsewhere was evidently poor, within the SDS and LHA it was abysmal.

The 1993 Health Select Committee judgment was made with a view to ushering in epochal changes to NHS dentistry which failed to materialise, sustaining governmental cultures of 'supervised neglect'. Whilst lacking a comparable policy narrative found in medicine of organised professional struggle, of government grappling making a quilt from a patchwork of services,[164:124] and of sweeping capital expansion, the story of dentistry in the NHS should be considered one of unspectacular yet cumulative change despite these evident limitations. Driven by figures such as Bowker and Parrott who pushed for partnership and working within the mixed economy of local dentistry to improve the quality of care for patients, or Woods who embraced the shortcomings of the SDS and public health dentistry to advocate for modernisation, scarcity engendered creativity and pragmatism. Particularly for the doubly neglected periphery of the Manchester region in North West England.

However, staffing remained *the* underlying problem in delivering such a labour-intensive service as dentistry. This was widely recognised within professional and policy circles at the inception of the NHS in 1948 and throughout its 'classic' period. Universal expectations of coverage free to all at the point of delivery paid for through central government taxation were unfulfilled. Notions of 'adequacy' and of providing treatment only for certain priority groups – mothers and young children, the traditional targets of state intervention – soon prevailed within dentistry. Successive reports recognised the need to expand the dental workforce, but these were realised only slowly and belatedly. This, in turn, inhibited the scope of the service, professional potential and modernisation policies. Tellingly, workforce shortages remained the inescapable main conclusion of the bodies tasked with modernising the organisation and provision of dental services following the 1974 reorganisation.[165- 166] Its consequences informed the horizons of possibility to reform dentistry in 1992 and in 2006, reflecting a legacy of sustained 'supervised neglect' in the NHS, even during its supposed 'classic' zenith.

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References

[1] House of Commons Health Committee. Fourth report: dental services. London: House of Commons; 1993.
[2] Review Body on Doctors' and Dentists' Remuneration. Twenty-second report 1992. London: HMSO; 1992.
[3] Department of Health. Improving NHS dentistry. London: HMSO; 1994.
[4] Penman R. Report of the working party on the chairside times taken in carrying out treatment by general dental practitioners. London: HMSO; 1949.
[5] Webster C. The health services since the war, volume I: problems of health care: the National Health Service before 1957. London: HMSO; 1988.
[6] Bloomfield K. Fundamental review of dental remuneration. London: Department of Health; 1992.
[7] National Audit Office. Reforming NHS dentistry: ensuring effective management of risks. London: TSO; 2004.
[8] Lunt N, Exworthy M. NHS dentistry in Britain: a long overdue check-up. *World Medical and Health Policy*. 2024; 16(4): 774-782.
[9] House of Commons Health Committee, Fifth report: dental services. London: House of Commons; 2008.
[10] Steele J. NHS dental services in England: an independent review led by Professor Jimmy Steele. London: Department of Health; 2009.
[11] House of Commons Health and Social Care Committee. NHS dentistry: ninth report. London: House of Commons; 2023.
[12] Lowe R. Lessons from the past: The rise and fall of the classic welfare state in Britain. In: Oakley A, Williams AS, editors. The politics of welfare. London: UCL Press; 1994. p. 37-53.
[13] Lowe R. Financing health care in Britain since 1939. In: Gorsky M, Sheard S, editors. Financing medicine: the British experience since 1750. London: Routledge; 2006. p. 242-251.
[14] Pilmott B. The myth of consensus. In: Smith, LM, editor. The making of Britain: echoes of greatness. Basingstoke: Macmillan; 1988. p. 129-141.
[15] Gorsky M. The British National Health Service 1948-2008: a review of the historiography. Social History of Medicine 2008; 21(3): 437-460.
[16] O'Hara G. From dreams to disillusionment: economic and social planning in 1960s Britain. Basingstoke: Palgrave Macmillan; 2007.
[17] Ling T. The British stat since 1945: an introduction. Cambridge: Polity Press; 1998.
[18] Cronin J. The politics of state expansion: war, state and society in twentieth-century Britain. London: Routledge; 1991.
[19] Honigsbaum F. Health, happiness and security: the creation of the National Health Service. London: Routledge; 1989.
[20] King R. Dentistry and the new National Health Service of 1948. *Dental Historian*. 1994; 26: 11-21.
[21] Willcocks AJ. The creation of the National Health Service: a study of pressure groups and a major social policy decision. London: Routledge and Kegan Paul; 1967.
[22] Griffith JAG. Central departments and local authorities. London: George Allen and Unwin; 1966.
[23] Gelbier S. Chief Dental Officers for England and the development of dental services in the United Kingdom. Community Dental Health. 2005; 22(3s1): 193-219.
[24] Sheard S, Donaldson L. The nation's doctor: the role of the Chief Medical Officer, 1855-1998. Oxford: Radcliffe; 2006.
[25] Webster C. Psychiatry and the early National Health Service: the role of the Mental Health Standing Advisory Committee. In: Berrios GE, Freeman H (editors) 150 years of British psychiatry. London: Royal College of Psychiatrists; 1991, p. 103-116.
[26] Dussault G. The professionalisation of dentistry in Britain: a study of occupational strategies (1900-1957). PhD thesis: Bedford College; 1981.
[27] Forbes E. The professionalisation of dentistry in the United Kingdom. Medical History 1985; 29(2): 169-181.
[28] Lewis J. What price community medicine? Philosophy, practice and politics of public health since 1919. Brighton: Wheatsheaf; 1986.
[29] Webster C. The politics of general practice. In: Loudon I, Horder J. Webster C, editors. General practice under the National Health Service, 1948-1997. Oxford: Clarendon Press; 1998, p. 20-44
[30] Fry J. General practice and primary health care, 1940s-1980s. London: Nuffield Provincial Hospitals Trust; 1988.
[31] Davis P. The social context of dentistry. London: Croom Helm; 1980.
[32] Schanschieff S. Report of the Committee of Inquiry into Unnecessary Dental Treatment. London: HMSO; 1984.
[33] Lindsey A. Socialised medicine in England and Wales: the National Health Service, 1948-1961. Chapel Hill: North Carolina University Press; 1962.
[34] Walton JK. Imagining regions in comparative perspective: the strange birth of North-West England. In Lancaster B, Newton D, Vall N, editors. An agenda for regional history. Newcastle: Northumbria University Press; 2007. p. 289-302.
[35] Roberts E. A woman's place: an oral history of working-class women, 1890-1940. London: Wiley-Blackwell; 1995.
[36] Roberts E. Women and families: an oral history, 1940-1970. London: Wiley-Blackwell; 1995.
[37] Beier CM. For their own good: the transformation of English working-class health culture, 1880-1970. Columbus, OH: Ohio State University Press; 2008.
[38] Jones CL "Monty, bring the blood can!" Pulling teeth in working-class Lancashire, 1900-48. *Modern British History*. 2024; 35(2): 223-240.

[39] Jones CL, Gibson BJ. Oral health: an interdisciplinary or multidisciplinary approach?. In: Jones CL, Gibson BJ, editors. Cultures of oral health: discourses, practices and theory. London: Routledge; 2022, p. 1-24.
[40] Carling ER, McIntosh TS. Hospital survey: the hospital services of the North-Western area. London: HMSO; 1945.
[41] Bulpitt JG. Party politics in English local government. London: Longman; 1967.
[42] Green LP. Provincial metropolis: the future of local government in South-East Lancashire. London: Allen and Unwin; 1959.
[43] Pater JE. The making of the National Health Service. London: King Edward's Hospital Fund for London; 1981.
[44] Lambert M. A history of the intermediate tier in the English NHS: centre, region, periphery. Social Policy and Administration. 2024; 58(6): 924-937.
[45] Lambert M. Lancashire and South Cumbria New Hospitals Programme: once in a generation or generation gap?. Morecambe Bay Medical Journal. 2021; 8(10): 284-287.
[46] Pickstone JV. Medicine and industrial society: a history of hospital development in Manchester and its region, 1752-1946. Manchester: Manchester University Press; 1985.
[47] Singleton J. Lancashire on the scrapheap: the cotton industry, 1945-70. Oxford: Oxford University Press; 1991.
[48] Freeman TW, Rodgers HB, Kinvig RH. Lancashire, Cheshire and the Isle of Man. London: Nelson; 1966.
[49] Brewster L, Lambert M, Shelton C. Who cares where the doctors are? The expectation of mobility and its effects on health outcomes. Sociology of Health and Illness. 2022; 44(7): 1077-1093.
[50] Brewster L, Chekar CK, Lambert M, Mumford C, Patel T, Rennie N, Shelton C. Medical training pathways and underdoctored areas: a qualitative study of doctors working in areas that struggle to recruit and retain. Health & Place. 2025; 96: 103560.
[51] The National Archives. Standing Dental Advisory Committee, provision of dental treatment in hospitals, 1952-1956. MH 133/289.
[52] Sadler A. The making of British oral and maxillofacial surgery: voices of pioneers and witnesses to its evolution from hospital dentistry. Lincoln: SoreJaw; 2021.
[53] Gelbier S. The Royal College of Surgeons of England, its Faculty of Dental Surgery and the origins of the Faculty of Dental Surgery. British Dental Journal. 2021. 234(3): 177-180.
[54] Harris M. The Eastman jubilee 1948-1998. British Dental Journal. 2000; 188(12): 647-652.
[55] Stevens R. Medical practice in modern England: the impact of specialisation and state medicine. New Haven, CT: Yale University Press; 1966.
[56] Lambert M. Alder Hey's heart of gold: charity, cardiac surgery and the distortion of paediatric provision in a nationalised health service, 1948-91. BMJ Medical Humanities. 2025; 51(4): 509-519.
[57] Teviot C. Final report of the inter-departmental committee on dentistry. London: HMSO; 1946.
[58] McNair AD. Report of the committee on recruitment to the dental profession. London: HMSO; 1956.
[59] Goodenough W. Report of the inter-departmental committee on medical schools. London: HMSO; 1944.
[60] Willink H. Report of the committee to consider the future number of medical practitioners and the appropriate intake of medical students. London: HMSO; 1957.
[61] Parkhouse J. Medical manpower in Britain. Edinburgh: Churchill Livingstone; 1979.
[62] Honigsbaum F. The division in British medicine: a history of the separation of general practice from hospital care, 1911-1968. London: Kogan Page; 1979.
[63] Maynard A, Waker, A. Managing the medical workforce: time for improvements?. Health Policy. 1995; 31(1): 1-16.
[64] House of Commons Estimates Committee. First report: dental services. London: HMSO, 1962.
[65] Shattock M. The UGC and the management of British universities. Buckingham: Open University; 1994.
[66] Coates BE, Rawston EM. Regional variations in Britain. London: B. T. Batsford; 1971.
[67] McClintock M. University of Lancaster: quest for innovation: a history of the first ten years, 1964-1974. Lancaster: University of Lancaster; 1974.
[68] Lambert M. Medical education, workforce inequalities, and hierarchical regionalism: the University of Lancaster and the unrealised medical school, 1964-68. Morecambe Bay Medical Journal. 2022; 8(12): 342-346.
[69] Kelly T. For advancement of learning: the University of Liverpool 1881-1981. Liverpool: Liverpool University Press; 1981.
[70] University Grants Committee. Returns from universities and university colleges in receipt of Treasury Grant academic year 1960-1961. London: HMSO; 1962.
[71] University Grants Committee. Annual survey: academic year 1975-76. London: HMSO; 1977.
[72] Brewster AW, Seldowitz E. Trends in the National Health Service in England and Wales, 1949-60. Public Health Reports. 1962; 77(9): 735-744.
[73] Morgan P. The University of Wales, 1939-1993. Cardiff: University of Wales Press;1997.
[74] Brown WAB. Cardiff Dental School (1964-1971): an orthodontist's viewpoint. Dental Historian. 2012; 55: 26-34.
[75] Roberts A. The Welsh National School of Medicine, 1893-1931: the Cardiff years. Cardiff: University of Wales Press; 2008.
[76] Webster C. Devolution and the health service in Wales, 1919-1969. In: Michael P, Webster C, editors. Health and society in twentieth century Wales. Cardiff: University of Wales Press; 2006. p. 240-269.
[77] Hopper J. The history of the Liverpool Dental Hospital, 1860-1960. Liverpool: United Liverpool Hospitals; 1960.
[78] Cook ALM. Liverpool's Northern Hospital, 1834-1978. Liverpool: Liverpool Area Health Authority (Teaching); 1981.

[79] Manchester University Archives. Manchester University Dental Hospital, 17 March 1972. GB 133 MMC/9/29/2/5.
[80] Pullan B, Abendstern A. A history of the University of Manchester, 1951-73. Manchester: Manchester University Press; 2000.
[81] Landsborough Thomson A. Half a century of medical research, volume one: origins and policy of the Medical Research Council (UK). London: HMSO; 1975.
[82] Landsborough Thomson A. Half a century of medical research, volume two: the programme of the Medical Research Council (UK). London: HMSO; 1975.
[83] The National Archives. Ministry of Health, policy: designation of teaching hospitals, 1946-48. MH 93/1.
[84] Webster C. The health services since the war, volume II: government and health care: the National Health Service, 1958-1979. London: HMSO; 1996.
[85] Gelbier S. Establishment of general dental practice in the National Health Service. Journal of the History of Dentistry. 2005; 53(2): 43-49.
[86] Spens W. Report of the inter-departmental committee on the remuneration of consultants and specialists. London: HMSO; 1948.
[87] Spens W. Report of the inter-departmental committee on the remuneration of general dental practitioners. London: HMSO; 1947.
[88] Pilkington WH. Royal Commission on doctors' and dentists' remuneration, 1957-1960. London: HMSO; 1960.
[89] Cutler T. Dangerous yardstick? Early cost estimates and the politics of financial management in the first decade of the National Health Service. Medical History. 2003; 47(2): 217-238.
[90] Edwards R, Gillies V. Insights from the historical lived experience of a fragmented economy of welfare in Britain: poverty, precarity and the Peck family, 1928-1950. Genealogy. 2020; 4(1).
[91] Bradley K. Poverty, philanthropy and the state: charities and the working classes in London, 1918-79. Manchester: Manchester University Press; 2009.
[92] Cutler T. The politics of National Health Service expenditure in the 1950s. In: Gorsky M, Sheard S, editors. Financing medicine: the British experience since 1750. London: Routledge; 2006, p. 201-220.
[93] Watkin B. The National Health Service: the first phase, 1948-1974 and after. London: George Allen and Unwin; 1978.
[94] Tomlinson JD. Welfare and the economy: the economic impact of the welfare state, 1945-51. Twentieth Century British History. 1995; 6(2): 194-219.
[95] Butler JR, Knight R. General practice manpower and health service reorganisation. Journal of Social Policy. 1974;3(3): 235-250.
[96] Richards ND. Dentistry in Great Britain: some sociologic perspectives. The Milbank Memorial Fund Quarterly. 1971; 49(3): 133–169.
[97] Scarrot DM. Changes in the regional distribution of general dental service manpower. *British Dental Journal*. 1978; 144(11): 359-363.
[98] Merrison A. Royal Commission on the National Health Service. London: HMSO; 1979.
[99] Guillebaud CW. Report of the committee of enquiry into the cost of the National Health Service. London: HMSO; 1956.
[100] Klein R. The new politics of the NHS: From creation to reinvention. Oxford: CRC Press; 2013.
[101] Allsop J, May A. The emperor's new clothes: Family Practitioner Committees in the 1980s. London: King Edward's Hospital Fund for London; 1986.
[102] Beattie DR. Blackburn: the development of a Lancashire cotton town. Halifax: Ryburn; 1992.
[103] Fletcher M. The making of Wigan. Barnsley: Wharncliffe Books; 2005.
[104] Bulman JS, Richards ND, Slack GL, Willcocks AJ. Demand and need for dental care: a socio-dental study. London: Nuffield Provincial Hospitals Trust; 1968.
[105] Higgins J. The business of medicine: private health care in Britain. London: Macmillan; 1988.
[106] Griffith B, Iliffe S, Rayner G. Banking on sickness: commercial medicine in Britain and the USA. London: Lawrence and Wishart; 1987.
[107] Political and Economic Planning. Family needs and the social services. London: Political and Economic Planning; 1961.
[108] Ettinger RL. Cohort differences among aging populations: a challenge for the dental professions. Special Care in Dentistry. 1993; 13 (1): 19-26.
[109] Brockington CF, Lempert SM. The social needs of the over-80s. Manchester: Manchester University Press; 1966.
[110] Mackay JSB, Ruck SK. The care of the aged in the Manchester Regional Hospital Board area. Manchester: Manchester Regional Hospital Board; 1967.
[111] Freeman A, Sholl T. This is the DPB: the history of a quango 1948-1998. Eastbourne: Dental Practice; 2000.
[112] Samson E. The dentist and the state: a critical examination and interpretation of the General Dental Services Regulations as they affect the dentist in the surgery. London: Henry Kimpton; 1973.
[113] Taylor-Gooby P, Sylvester S, Calnan M, Manley G. Knights, knaves and gnashers: professional values and private dentistry. Journal of Social Policy. 2000. 29(3): 375-395.
[114] Robinson R, Patel D, Pennycate R. The economics of dental care. London: Office of Health Economics; 2004.
[115] Lambert M. How to make friends and influence people? Lancaster Medical Book Club and professional leadership in the early NHS. Morecambe Bay Medical Journal. 2023; 9(3): 71-75.
[116] Garnett GF. Geoffrey Wood. British Dental Journal. 2008; 205(7): 409.
[117] JE. Albert Trevor Salter. British Dental Journal. 1999; 187(4): 228.

[118] JRC. Derrick Worthington Torkington. British Dental Journal. 2000; 188(9): 520.
[119] Sandham J. Edgar Cowperthwaite. British Dental Journal. 2018; 225(1): 14.
[120] Williams M. Howard Wall. British Dental Journal. 2018; 224(9): 678.
[121] MH. Frank Parrott. British Dental Journal. 2002; 193(2): 120.
[122] Dyer PV. Hubs and spokes or clinical networks?. Morecambe Bay Medical Journal. 2002;4(1): 2-3.
[123] KW, HF. Eric Cooper. British Dental Journal. 2000;189(1): 56.
[124] Edwards JO, Merrill H. John Kenneth Bowker. British Dental Journal. 2013; 215(10): 539.
[125] Lancashire Archives. Blackburn and District Hospital Management Committee Minutes, 1963-70. HRBl 1/3.
[126] Fox B, Seward M. Dentistry. In: Silverstone R, Ward A, editors. Careers of professional women. London: Croom Helm; 1980, p. 83-98.
[127] Morton M, Garnett G, Codling P, Hawker E. Obituary: Mary Catherine Stark Codling (McFarlane). British Dental Journal. 2021; 231(11): 674.
[128] Chekar CK, Brewster L, Lambert M, Patel T. Gender, flexibility and workforce in the NHS: a qualitative study. International Journal of Health Planning and Management. 2024; 39(3): 740-756.
[129] GFG. Obituary: Pam Watson. British Dental Journal. 2006; 201(7): 475.
[130] GFG. Obituary: Ros Quinn (Birkett). British Dental Journal. 2001; 190(7): 398
[131] GFG. Obituary: Stewart Higham Jackson. British Dental Journal. 2001; 190(7): 398.
[132] Thomas, M. Francis Derek Thomas. British Dental Journal. 2008; 205(6): 345.
[133] Barrow Archives. Barrow-in-Furness Executive Council, minutes, 1965-68. BTCAHA/1/25.
[134] Lewis J. The politics of motherhood: child and maternal welfare in England, 1900-1939. London: Croom Helm; 1980.
[135] Marshall JD. Health, 1929-74. In: Marshall JD, McClintock ME, editors. The history of Lancashire County Council, 1889 to 1974. London: Martin Robertston; 1977, p. 292-305.
[136] The National Archives. Ministry of Health, Manchester County Borough Council, section 22: dental services general correspondence, 1948-1955. MH 52/656.
[137] Diack L, Smith DF. Professional strategies of Medical Officers of Health in the post-war period – 1: 'innovative traditionalism': the case of Dr Ian MacQueen, MOH for Aberdeen 1952-74, a 'bull-dog' with the 'hide of a rhinoceros'. Journal of Public Health Medicine. 2002; 24(2): 123-129.
[138] McLaurin S, Smith DF. Professional strategies of Medical Officers of Health in the post-war period – 2: 'progressive realism': the case of Dr R J Donaldson, MOH for Teesside, 1968-1974. Journal of Public Health Medicine. 2002; 24(2): 130-135.
[139] Ministry of Health. Report of the Ministry of Health for the year 1961. Part II: On the state of the public health. London: Ministry of Health; 1962.
[140] Harris B. The health of the schoolchild: a history of the school medical service in England and Wales. Buckingham: Open University Press; 1995.
[141] Warde A. Conditions of dependence: working-class quiescence in Lancaster in the twentieth-century. International Review of Social History. 1990;35(1):71-105.
[142] Walton JK. Blackpool. Edinburgh: Edinburgh University Press; 1998.
[143] The National Archives. Correspondence regarding shortage of school dentists; question of dental officers from the armed services practising within the local education authorities' control, 1957-58. ED 50/702
[144] The National Archives. Correspondence regarding shortage of school dentists; question of dental officers from the armed services practising within the local education authorities' control, 1955-59. ED 50/703
[145] Hill J. Nelson: politics, economy, community. Edinburgh: Keele University Press; 1997.
[146] Department of Health and Social Security Operational Research Services. Strategies for the provision of health care in Liverpool: main report. London: Department of Health and Social Security; 1978.
[147] Welshman J. Dental health as a neglected issue in medical history: the School Dental Service in England and Wales, 1900-40. Medical History. 1998; 42(3): 306-327.
[148] Gelbier S. The rise and fall of area dental officers: specialists in public health dentistry?. Dental Historian. 2009; 50: 64-80.
[149] Baker FA. Keith Woods. British Dental Journal. 2006; 199(10): 691.
[150] Gelbier S. The Court Report and child dental health. Dental Historian. 2009; 49: 48-61.
[151] The National Archives. Dental care: methods and priority service, 1956-60. MH 134/83.
[152] Lancashire County Council. Report of the medical officer of health for the year 1957. Preston: Lancashire County Council; 1958.
[153] County Borough of Burnley. Report of the medical officer of health on the public health and sanitary administration for the year 1957. Burnley; County Borough of Burnley; 1958.
[154] County Borough of Blackburn. Annual report of the medical officer of health for the year 1957. Blackburn. County Borough of Blackburn; 1958.
[155] County Borough of Preston. Annual report of the medical officer of health for the year 1957. Preston: County Borough of Preston; 1958.
[156] County Borough of Blackpool. Annual report of the medical officer of health for the year 1957. Blackpool. County Borough of Blackpool; 1958.

[157] Ministry of Health. Report of the Ministry of Health for the year 1957. Part II: On the state of the public health. London: Ministry of Health; 1958.
[158] Cohen EW. Autonomy and delegation in county government: a study of delegation in education and local health administration. London: Royal Institute of Public Administration; 1952.
[159] Marshall JD, Regan P. Education, 1929-74. In: Marshall JD, McClintock ME, editors. The history of Lancashire County Council, 1889 to 1974. London: Martin Robertston; 1977, p. 245-291.
[160] Berman DS. Family Practitioner Services and management towards an integrated child health service: (a) dental health in childhood. Royal Society of Health Journal. 1974;94(4):199-202.
[161] Gelbier S. Dentistry and the management of the National Health Service, 1974-1982. Public Administration. 1982; 60(2): 163-176.
[162] Read J. Transformation and regulation: a century of continuity in nursery school and welfare policy rhetoric. Journal of Education Policy. 2015. 30(1): 39-61.
[163] Todd JE. Child dental health in England and Wales, 1973. London: HMSO; 1975.
[164] Hennessy P. Never again: Britain, 1945-51. London: Penguin; 2006.
[165] The National Archives. Working party on dental services: reports, papers and minutes of meetings, 1973-75. MH 148/868.
[166] The National Archives. Joint working party on the future of NHS dental services: minutes of meetings and working papers, 1972. MH 149/1563.