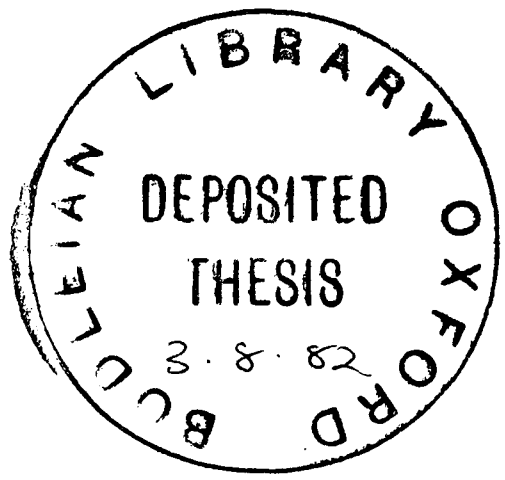
THE BUREAUCRATIZATION OF THE DENTAL HEALTH SERVICES IN BRITAIN

A study of the interaction between the government and the dental profession and the effect this has had on the provision of dental care under the National Health Service.



D.Phil. Thesis

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ABSTRACT

Despite an annual expenditure of the order of £400 million and administrative arrangements which in a number of respects are significantly different from the other arms of the National Health Service, the dental health services have attracted little scholarly attention. The recent Royal Commission on the National Health Service drew attention to this point (*Report*, para. 9.1) and in a sense the thesis represents an attempt to fill this particular lacuna.

The central question addressed is why the performance of the dental health services has neither realised the more general goals (such as equal treatment for all or the relating of access to treatment to need) which were behind the assumption of public responsibility for health care nor overcome the more particular problems associated with the provision of dental services. The thesis seeks to locate the answers in the particular approach adopted to public supply and to this end some considerable space has been given to both the origins and character of this approach.

An examination of the pressures that led to public involvement in the provision of dental care is followed, in the main part of the thesis, by an account of the implementation and subsequent operation of the services. Using material from the files of the Ministry of Health and the British Dental Association as well as the numerous public enquiries which have focussed on different aspects of the services, an attempt is made to relate the shortcomings in performance to the adopted approach to supply and more particularly to the inadequacies of the assumptions which underpinned it.

The central conclusion is that problems associated with both the power of those involved in the services and the values inherent in the

processes of public administration have been responsible for the untenability of these assumptions and that in consequence neither the administrative capacity nor the degree of political control on which policy achievement had been postulated have in fact been realised. The whole policy has become centred on the arrangements for paying individual practitioners in which wider community goals have generally been ignored and in which considerations other than equity or dental need have governed both the supply of, and access to, the available treatment.

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ABBREVIATIONS

The only abbreviation used throughout the text is NHS (National Health Service).

In the footnotes the following abbreviations have been used:

A/Rep.	-	Annual Report
BDA	-	British Dental Association
BDJ	-	*British Dental Journal*
DHSS	-	Department of Health and Social Security
DES	-	Department of Education - since 1962 the Department of Education and Science
DoH(S)	-	Department of Health for Scotland
MoH	-	Ministry of Health
NHS	-	National Health Service

PART ONE

INTRODUCTION

CHAPTER ONE

DENTISTRY AND THE NATIONAL HEALTH SERVICE

Dental health services were introduced under the auspices of the *National Health Service Act* (1946) on 5 July 1948 and since that date, despite their relatively small part in the NHS (in terms of employment and expenditure), they have had a stormy career. For example, no sooner had the Service got under way, than supplementary estimates had to be introduced as expenditure on the general dental services mushroomed past the estimate of £8.15m. to reach £18.1m.[1] in the first nine months and then £41,892,698[2] for the first full year of operation (1949-50). This figure in fact represented approximately 10% of the whole NHS expenditure for that year[3] and the beneficiaries were the dentists who, under an unanticipated level of demand, achieved incomes far in excess of the government's projected figures. There was indeed a sense of scandal about some of the earnings as the *Times* reported in December 1948 incomes of up to £1,000 per month[4] and later a total of over £25,000 paid to a Lanarkshire dentist in the first eleven months of the new service.[5]

The Government's response to the situation was fairly immediate and involved first, a reduction by half of all earnings in excess of £400 per month, then a cut in the level of fees and finally the imposition of a charge for dentures.[6] It was this move, along with a system of charges for spectacles, that as part of Gaitskell's

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1. House of Commons, *First Report of the Estimates Committee, Session 1962-63,* 'Dental Services' (London, HMSO), p. 11.
2. MoH, *A/Rep. 1949-50* (Cmnd. 8342, London, HMSO), p. 35.
3. Office of Health Economics, *The Dental Service* (London, OHE, 1969), p. 8.
4. The *Times*, 6 December 1948, p. 4.
5. The *Times*, 14 July 1949, p. 3.
6. Full details of these changes can be found in ch. 7 below.

budgetary strategy, led to the resignation of Aneurin Bevan, Harold Wilson and John Freeman.[1] After the change in government in October 1951 further charges were introduced whereby the patient was obliged to pay the first £1 towards the cost of treatment unless the total cost was less than the amount.[2] Since then these charges have been gradually increased until, in April 1981, a maximum fee of £58 could be levied.[3]

As a subject for public enquiry and report, the dental health services have also received their share of attention. In 1947-48 the Spens Committee[4] considered methods of paying general dental practitioners; in 1949 the Penman Working Party[5] reported on the timing of chairside operations; in 1950 and 1952 UK Dental Missions visited New Zealand and the United States to study the use of school dental nurses[6] and the success of adding fluoride to public water supplies;[7] in 1956 the McNair Committee reported on the problems of recruitment to the profession[8] and between 1957 and 1960 Lord Pilkington

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1. Though of course the dispute over dental charges was only a small part of a much wider argument. See ch. 10 below.

2. SI (1952), No. 1020.

3. *BDA News*. Supplement to *BDJ*, 150, 7 (7 April 1981).

4. MoH, DoH(S), *Report of the Inter-Departmental Committee on the Remuneration of General Dental Practitioners* (Cmnd. 7402, London, HMSO, 1948).

5. MoH, DoH(S), *Report of the Working Party on the Chairside Times taken in carrying out treatment by General Dental Practitioners in England, Wales and Scotland* (London, HMSO, 1949).

6. MoH, *New Zealand School Dental Nurses. Report of U.K. Dental Mission* (London, HMSO, 1950).

7. MoH, DoH(S), Ministry of Housing and Local Government, *The Fluoridation of domestic water supplies in North America as a means of controlling dental caries. Report of the United Kingdom Mission* (London, HMSO, 1953).

8. MoH, DoH(S), *Report of the Committee on Recruitment to the Dental Profession* (Cmnd. 9861, London, HMSO, 1956).

headed a Royal Commission on Doctors' and Dentists' Remuneration.[1] In 1968 and 1973 major surveys were carried out into the condition of the dental health of adults[2] and children[3] in England and Wales and a follow up to the adult survey was conducted in 1978.[4]

In addition dentists' remuneration has been the subject of report and recommendation by two Review Bodies: one issuing twelve reports between 1963 and 1970 when it resigned after the Wilson Government declined to implement its recommendations and the other which was constituted by the Heath Government and issued its first report in 1971. In a wider context the provision of dental health services has also been examined by the Guillebaud Committee which reported in 1956 on the cost of the National Health Service;[5] by various Parliamentary Committees;[6] by the Court Committee on Child Health Services;[7] by the Royal Commission on the National Health Service which reported in 1979[8] and in the plethora of documents which preceded the major health service re-organisation in 1974.

In a third area that demonstrates the administrative and

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1. Royal Commission on Doctors' and Dentists' Remuneration, *Report* (Cmnd. 939, London, HMSO, 1960).

2. P.G. Gray *et al.*, *Adult Dental Health in England and Wales in 1968* (London, HMSO, 1970). A similar survey was carried out in Scotland in 1972. See J.E. Todd, *Adult Dental Health in Scotland, 1972* (London, HMSO, 1974).

3. J.E. Todd, *Children's Dental Health in England and Wales, 1973* (London, HMSO, 1975).

4. J.E. Todd, and A.M. Walker, *Adult Dental Health. England and Wales 1968-1978* (London, HMSO, 1980).

5. Committee of Enquiry into the Cost of the National Health Service, *Report* (Cmnd. 9663, London, HMSO, 1956).

6. For example, *First Report of the Estimates Committee, Session 1962-63.*

7. 'Fit For The Future', *Report of the Committee on Child Health Services* (Cmnd. 6684, London, HMSO, 1976).

8. Royal Commission on the National Health Service, *Report* (Cmnd. 7615, London, HMSO, 1979).

political volatility of this aspect of health care provision the relative militancy of the dentists and the major dental organisation may be noted. The British Dental Association was the only professional body to recommend to its members that they should not join the NHS at its inception, and since then relations between the profession and the government have been generally uneasy. They reached an all-time low in 1977 when the Association declared that they could '... no longer discountenance the selective acceptance of patients for dental treatment under the National Health Service',[1] and in a later letter to Dr Ennals, the Secretary of State for Social Services, added that

> 'you should not be surprised that dentists have lost all confidence in the NHS under your administration, or that the GDSC [General Dental Services Council of the British Dental Association] has been compelled by your attitude to recognise that a selective attitude to the Health Service is the only way in which dentists can maintain their professional and living standards and safeguard their future.'[2]

A special meeting of the GDSC then recommended that 'general dental practitioners must, to preserve their professional and living standards, take every opportunity to reduce their financial dependence on the NHS.'[3]

Thus, all in all, the provision of dental health services has been nothing if not controversial and the problems and shortcomings of the services, which are the central concern of this thesis, have received widespread and regular attention from both within and outside the dental profession. By way of introduction to the particular nature of these controversies, a brief outline of the six major problem areas

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1. BDA, *Scales of Justice* (London, BDA, 1978).
2. *Ibid.*
3. *Ibid.*

is given in the pages that follow.

The first has been the general dental health of the nation: it was extremely poor in 1948 (the Minister of Health described it as a 'national reproach')[1] and although significant improvements had taken place by 1979, the Royal Commission nevertheless found that:

> 'by any standards the dental health of the nation is poor. This is vividly illustrated by the statistics. Total tooth loss is a good measure of the ultimate breakdown of dental health. In 1968, 37% of the population of England and Wales over the age of 16 had no natural teeth. In Scotland in 1972, 44% of the population over 15 had no natural teeth. The prevalence of caries (decaying teeth) and periodontal disease (diseases of the gums, bone and other supporting structures of the teeth) is also high. In 1973, in England and Wales, 31% of children by the age of five had five or more teeth affected by caries and, at the age of 14, five or more permanent teeth of 72% were affected. Of all the general anaesthetics given for dental purposes in the UK in 1975, 56% were given for the extraction of teeth in the 5-14 age-group. Periodontal disease was present in 73% of the 16-34 age-group and in 90% of those over 35 in 1968.'[2]

The second area of concern throughout the period of operation of the NHS has been the fact that only a minority of the population actually receives dental treatment. The utilisation of services has increased gradually since 1948, though as dental health statistics generally refer to courses of treatment and not persons treated, a high degree of accuracy is not possible. One author has estimated that utilisation has risen from 18% of the population in 1949 to 41% in 1968,[3] while a more recent survey suggested that by 1978 the figure had reached 46%.[4]

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1. 422 H.C. DEB. 5s. Col. 44.

2. Royal Commission on the NHS, *Report*, para. 9.7.

3. N.D. Richards in N.D. Richards and L.K. Cohen, *Social Sciences and Dentistry. A Critical Bibliography* (The Hague, Fédération Dentaire Internationale, 1971).

4. Todd and Walker, *Adult Dental Health. England and Wales 1968-1978*, Table 8.1.

The third major area of concern has been the regional and social differences in the conditions of oral health. Captain Baird M.P., himself a dentist, speaking on the third reading of the NHS Bill, declared that it

> 'is going to give the ordinary dentist a better chance than ever of treating the ordinary people in the country. In the past dentistry was a science that could only be bought by the middle and wealthy classes - that is preventive dentistry - and, for the first time, this Bill is going to place this service at the beck and call of the ordinary people.'[1]

Unfortunately as dental epidemiology was only in its infancy before the start of the NHS, most of the evidence relating to the dental health of the different sections of the community must be largely inferential, but nevertheless the conclusion that the poorer elements suffered from almost total neglect is borne out by several sources. These will be discussed in chapter three and reference here will be made only to the explanation offered by Eckstein[2] who has examined the comparative growth of medical and dental services. He argues that on the whole medical and hospital facilities were available to the poor prior to the NHS, but that this was not the case with dental and optical services:

> 'Both were "professionalised" at a relatively late date, considerably after the classic age of British philanthropy. Hence, private charity never made up for the inadequacies of public legislation in respect to these services. For both dentistry and opthamology, the poorer classes were almost dependent on their Approved Societies and on special services for mothers and young children supplied by some local authorities.'[3]

But the very low acceptance rates under these schemes suggests that

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1. 426 H.C. DEB. 5s. Cols 445-446.

2. H. Eckstein, *The English Health Service* (Cambridge, Harvard University Press, 1959).

3. *Ibid.*, p. 42.

the majority of working class mouths went unexamined.[1]

Although dental epidemiology has improved since 1948 the picture it presents of the nation's oral health is still sketchy. The results of various surveys and reports will be considered in later chapters, but here, in support of the argument that major differences in dental health can be accounted for by social and regional factors, the evidence presented by the Royal Commission (see Table 1.1 below), which they maintain is 'another illustration of poorer health amongst the less well-off', should also be noted.[2]

TABLE 1.1

PROPORTION OF PEOPLE WITH NO NATURAL TEETH BY SOCIAL CLASS, REGION AND COUNTRY: GREAT BRITAIN, 1978[3]

	I, II, IIIa non-manual %	IIIb manual %	IV, V %
North	24	35	38
Midlands and East Anglia	23	30	37
South West	22	22	40
South East	15	17	33
Scotland	32	38	45
Wales	29	38	40

Closely related to these regional differences appears to be the distribution of dental manpower: in 1950 using a measure of the number of persons per dentist, the ratio of the "best" to the "worst" served health areas was 1:1.46[4] (1 dentist to 3700 persons in London and the South-East, compared with 1 to 5400 in the North and Midlands). In

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1. Details in ch. 3 below.
2. Royal Commission on the NHS, *Report*, para. 9.15.
3. *Ibid.*, Table 9.5.
4. MoH, *A/Rep. 1954-55* (Cmnd. 9857), p. 217.

1970 this ratio was 1:1.93[1] among the planning regions (although 1:3.48 if the individual counties were considered) and on the figures supplied to the Royal Commission the ratio had grown to 1:2.18 in 1977[2] with the greatest discrepancy still being between part of London (N.W. Thames) and the Northern Region.

A fourth area of concern both in late 1940s and at the present time has been the supply of dental services. Two main questions are involved: the number of dentists required and whether or not the provision of treatment should be the sole province of the qualified practitioner. The questions are clearly related but in this brief introduction they will be dealt with separately. What constitutes an adequate number is always likely to be contentious, yet there can be little doubt that at the beginning of the NHS the government at least viewed the number of practitioners as wholly inadequate. A major term of reference of the Teviot Committee was to consider and report upon 'the measures to be taken to secure an adequate number of entrants to the dental profession',[3] while the perceived shortage was also responsible for what the 1944 White Paper termed 'temporary exceptions to "comprehensiveness"',[4] and the consequent need for some form of priority treatment. Reviewing the situation thirty years later the Royal Commission reported that '[o]n the basis of current estimates of need there is a considerable shortfall in dental manpower and a much smaller and locally variable shortfall on the basis of demand',[5] though

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1. DHSS, *A/Rep. 1970* (Cmnd. 4714), p. 183.
2. Royal Commission on the NHS, *Report*, Table 9.4.
3. MoH, DoH(S), *Final Report of the Inter-Departmental Committee on Dentistry* (Cmnd. 6727, London, HMSO, 1946), p. 4.
4. MoH, DoH(S), *A National Health Service* (Cmnd. 6502, London, HMSO, 1944), p. 9.
5. Royal Commission on the NHS, *Report*, para. 9.16.

'if the same access to care as in North West Thames RHA were to be enjoyed by the other English regions then the number of dentists would have to be increased by about 60%'.[1] In 1977 the dentist/population ratio for England as a whole was 1:3914; for Scotland 1:4293; for Wales 1:4794 and for Northern Ireland 1:4413. These figures can be compared with the data for other countries in Table 1.2.

TABLE 1.2

COUNTRIES WITH FAVOURABLE DENTIST-POPULATION RATIOS[2]

Monaco	1: 884
Sweden	1:1126
Norway	1:1280
Denmark	1:1354
Finland	1:1830
W. Germany	1:1955
Argentina	1:2000
U.S.A.	1:2043
Iceland	1:2052
Israel	1:2053
Switzerland	1:2089

The second part of this question, the extent to which dental services should be confined to the work of qualified dental practitioners, has reduced to an issue between the desire to expand resources (by the employment of ancillary personnel) at a relatively low cost, and the determination of the profession to maintain its monopoly over operations in the mouth of the patient. The Teviot Committee hedged its bets on the question, recommending a modest experiment with ancillary personnel,[3] while the Royal Commission in 1979 offered

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1. *Ibid.*, para. 9.56.

2. Information from Fédération Dentaire Internationale, *Basic Fact Sheet* cited in Richards and Cohen, *Social Sciences and Dentistry*, p. 121.

3. *Final Report of the Inter-Departmental Committee on Dentistry*, para. 190.

little further advice. 'Increased delegation', it argued, 'must be carefully monitored and evaluated to ensure that roles do not become inflexible and that patients do not suffer undue dilution of services'.[1]

The fifth area of concern derives from the initial need for 'temporary exceptions to "comprehensiveness"'.[2] The National Health Service White Paper in 1944 noted that:

> 'A full dental service for the whole population ... including regular conservative treatment, is unquestionably a proper aim in any whole health service, and must be so regarded. But there are not at present, and will not be for some years, enough dentists in the country to provide it. Until the supply can be increased, attention will have to be concentrated on priority needs. These must include the needs of children and young people and of expectant and nursing mothers.'[3]

The Teviot Committee, which fully supported this approach to priorities, believed that the claims of the particular groups 'need hardly be argued' and recommended that services for such groups 'must form as it were the sharpest point of attack of the dental force of the country upon dental disease.'[4] Thirty years later the Committee on Child Health Services reported that 'despite extensive and increasing treatment, there is still a daunting amount of untreated disease'[5] and further noted that they had received evidence

> 'to the effect that dental care in Britain had in the past, been largely directed towards adult treatment, and while this had been necessary, nonetheless many dental situations had only become inevitable because of neglect in childhood. We believe from the evidence that if we could get the first 12 years right, the picture would look very different. *The*

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1. Royal Commission on the NHS, *Report*, para. 9.37.
2. *A National Health Service*, p. 9.
3. *Ibid.*
4. MoH, DoH(S), *Interim Report of the Inter-Departmental Committee on Dentistry* (Cmnd. 6565, London, HMSO, 1944), para. 83.
5. *Report of the Committee on Child Health Services*, para. 13.2.

> *emphasis should move away from adult dentistry and repair, to children's dentistry and prevention.*'[1]

That this comment should be made represents something of an indictment of the success of the priority service under the NHS. The extent of the problem can be judged from the data in Table 1.3.

TABLE 1.3

CHILD DENTAL HEALTH: ENGLAND AND WALES, 1973[2]

Children with untreated dental disease 1973	Age in years 5 %	9 %	14 %
Caries	63	76	62
Periodontal disease	47	78	74
Malocclusion (irregularities of the teeth)	17	55	28
Needing some dental attention	79	96	90

Finally, a sixth area of interest may be identified in the balance between curative and preventive approaches to dental health. The Teviot Committee laid great stress on the importance of dental health education,[3] and since then a fuller understanding of the potential of fluoridation has considerably widened the horizons of preventive dentistry. It is interesting to note that under the general heading of "The Future" the Royal Commission channelled all its faith into preventive matters. In particular it stressed the need for the fluoridation of public water supplies, better financial recognition for preventive work by dentists, effective dental health education supported by relevant behavioural studies and increased support for biomedical

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1. *Ibid.*, para. 13.26.
2. Royal Commission on the NHS, *Report*, Table 9.3.
3. *Interim Report of the Inter-Departmental Committee on Dentistry*, paras. 99-106.

research directed towards prevention.[1]

Some considerable importance is attached to the similarities between the analyses made in 1946 and 1979 in so far as they suggest that the problems facing the dental health services have remained fundamentally the same and that the arrangements introduced on 5 July 1948, and subsequently revised, have enjoyed only limited success in achieving the goals that informed the original policy decision. The central purpose of this thesis is then an attempt to explain why the dental health services have been unable to resolve the shortcomings that have just been described and more particularly why they have generally failed to live up to expectations as part of a wider health service in which the primacy of medical need and the equal provision of treatment for all were to be the fundamental guiding principles.

Adherence to these principles required not only a substantial revision of the existing patterns of distribution and use of services but also, because of the shortage of dental practitioners, some form of rationing which would give priority in receiving treatment to particular sections of the community.[2] Thus in many ways the experience of the dental health services provides an excellent indication of the capacity of the particular approach to public organisation favoured in Britain to effect a pattern of service availability which was in marked contrast to the existing, essentially market, situation. That such a pattern of dental health care has not been achieved will be demonstrated in the chapters that follow where it will be shown that despite the assumption of public responsibility, factors other than dental need have continued to dominate both the distribution of the available

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1. Royal Commission on the NHS, *Report*, paras. 9.54-9.71.

2. *A National Health Service*, p. 9 and 422 H.C. DEB. 5s. Col. 45.

dental services and the receipt of dental treatment.

It is clear that any number of aspects of the services might be examined in order to explain these shortcomings, but in this thesis it is proposed to concentrate on the manner in which public responsibility has been undertaken, to argue that the employment of specific administrative methods, bureaucratic frameworks and organisational practices have been central to the problems of the dental health services and hence to suggest that the limitations on policy achievement can be directly attributed to the particular approach adopted to the public administration of the policy area. More specifically it will be shown that the four major assumptions on which the approach was predicated - the almost limitless capacity of administration, the ability to maintain political control, the irrelevance of considerations pertaining to the power of those involved in public organisations and the instrumental and neutral character of public administration - have been found to be untenable in practice. Consequently the organisation as a whole has been unable to yield the kind of performance, in respect of matters such as the coordination of services and the relating of treatment to need, which the assumption of public responsibility for supply presumed. However, further exegesis of this argument will be withheld until the general plan of the thesis has been outlined.

The three chapters in Part Two consider the arguments and events which preceded the adoption of public responsibility for the provision of dental health services. Chapter two examines the pressures for medical reform between the two world wars and seeks to demonstrate that while there was some measure of disagreement amongst the various interested parties there was a remarkably high level of consensus on both the nature of the problems with the existing services and the form of the necessary revisions. In short the present medical

facilities were diagnosed as being both inefficient and poorly distributed and the solution was seen to lie in the co-ordination and rationalisation which could be achieved by a major commitment to public planning and control. Chapter three seeks to compare and contrast the situation of medicine with that of dentistry. It will be argued that an analysis of the problems facing the dental services between the wars showed them to be significantly different from those of the medical and hospital services but because of the relatively low status of the dental profession, plans for changes to the dental services became almost wholly subordinated to those for other health areas. The dentists' pursuit of an improvement in their status was an important element in their behaviour during the implementation of the NHS and a brief history of dentistry as a profession has been included in this chapter to help understand their position on the issue. Finally chapter four examines the background to the particular administrative arrangements of the dental health services. As the thesis places such emphasis on the administrative arrangements as a factor explaining the limitations of policy achievement some importance is attached to considerations pertaining to methods of public organisation and more particularly to the way in which those associated with the Labour Party, which would eventually shoulder responsibility for the implementation of the services, approached the problems of public supply. These issues are discussed in chapter four which, although it has practically nothing to say about dentistry, is held to be of central importance to the thesis in so far as it seeks to demonstrate the kinds of values, considerations and assumptions that informed the administrative apparatus of the dental health services.

Part Three of the thesis concentrates on the implementation of the policy for the dental health services: chapter five details the

major arguments, meetings and negotiations which preceded the introduction of the NHS in July 1948 and chapter six gives a brief overview of the administrative arrangements of the dental health services which resulted from this process of implementation. The central argument of these chapters is that adherence to the particular approach to supply resulted in a pattern of implementation in which the well-documented shortcomings of the existing arrangements were largely ignored and where the specific problems of supplying dental health services (as opposed to say medical health services) were never really faced. There are two components to this argument about the shortcomings of the approach and both are dealt with in chapter five. The first is that the strength of the demands for overall administrative coherence left little room for deviation from the traditional bureaucratic norms (irrespective of the costs of achieving this compliance) and the second that even when dental matters reached the agenda their treatment was only partial and that the pattern of this partiality can be explained in terms of the particular approach adopted to administration.

The consequences of adhering to this approach are dealt with in Part Four. Chapter seven details the development of the three arms of the dental health services under the NHS and attempts to highlight the problems that have arisen and to demonstrate their consequences in terms of the dental health of the nation. Chapter eight takes a more thematic approach to the shortcomings of the services and looks in detail at the six major problem areas discussed in this chapter. Included in both chapters are references to a number of studies by other authors which suggest, *inter alia*, that the shortcomings which have been discussed are not necessarily insoluble but that their resolution may require strategies which are generally unavailable under the existing administrative arrangements. However, it is not the purpose

of this thesis to posit hypothetical solutions and reference to this kind of work is included only as support for the central argument of the thesis that the particular approach to public supply has brought its own limitations to policy achievement. Chapters nine and ten consider the administrative and financial arrangements of the dental health services and argue that while these may be sufficient for administering the provision of dental services by a large number of publicly paid practitioners it cannot be said that they are adequate for administering a policy aimed at the active promotion of dental health. It will be shown that in a number of crucial areas the institutional arrangements provide neither the Secretary of State nor any of the other involved authorities with the capacity to meet the shortcomings of the services and further that the existing arrangements have demonstrated little capacity to promote the values (discussed in Part Two) on which the initial assumption of public responsibility was premised.

Finally, in Part Five, chapter eleven attempts to explain the shortcomings of the services in terms of the untenability of the assumptions behind the particular approach adopted to public supply. Drawing on the evidence presented in previous chapters, it will be shown that in practice, the administrative capacity of the NHS organisation has been very much less than had been expected; that political control has proved very difficult to maintain; that the power of those involved to influence outcomes has been considerable and, that in attempting to administer a policy for dental health, considerations pertaining to *dental* matters have paled beside the concern with administrative questions. Thus it is argued that with each of its basic assumptions undermined it is not surprising that the organisation had failed to resolve the particular problems facing the supply of dental health

services and the improvement of oral health.

In more general terms it is suggested that the inadequacy of the approach stems from its overwhelmingly administrative character and its failure to confront and resolve what might be termed the major political problems involved. And if the provision of health services was seen in essentially administrative terms in the 1940s, the words of the Secretary of State showed that little had changed by 1972:

> 'I have come to recognise, as many others have, that whilst this good work [that is, the work done in the NHS since 1948] will continue, nothing like its full potential can be realised without changes in the administrative organisation of the service. Hence this White Paper. It is about administration, not about treatment and care ... But both the patient and those who provide treatment and care will gain, if the administration embodies both a clear duty to improve the service and facilities for doing so.'[1]

But the appointment, within two years of these reforms of a Royal Commission to look at the operation of the NHS, gives some indication that its problems remain, and from the experience of the dental health services it will be suggested that these problems have rather less to do with bureaucratic pathology than with the conflicts which the particular administrative arrangements have done little to resolve and to which in fact they have indirectly contributed. The most obvious tension has centred on the attempt to incorporate a professional group within a bureaucratic mould but much will also be made in the chapters that follow of the inadequacy of the public organisation, despite the huge commitment of public funds, to promote community rather than individual goals in respect of dental care.

The dental health services have undoubtedly been successful in increasing the availability of treatment for individuals, but their

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1. *National Health Service Reorganization: England* (Cmnd. 5055, London, HMSO, 1972), p. v.

achievement in relating the provision of such treatment to criteria such as dental need or equality has been much less certain. The central proposition of this thesis is that much of the responsibility for the shortcomings can be attributed to the particular administrative arrangements and organisational techniques which were used to assume public responsibility for the supply of dental health services.

PART TWO

THE ORIGINS OF THE DENTAL HEALTH SERVICES

CHAPTER TWO

PRESSURES FOR HEALTH CARE REFORM

An examination of the origins and the objectives of the National Health Service presents two fundamental problems to the student of politics. The first is that in looking for origins it is not easy to know where to call a halt to the pursuit of historical antecedents. The second consists in the difficulty of recognising what is to be taken as an authoritative statement of intent. On the first point one writer[1] has gone so far as to suggest that the inspiration can be found in the nineteenth century Poor Law medical service while others have argued that the origins need be traced no further back than the 1918 Labour Party Conference.[2] Clearly the NHS and its administrative structure can be fitted into a number of traditions which must be identified, but in doing this care must be taken not to be diverted into speculation upon some arbitrary point of departure. With regard to the second point the intentions of the Service are noticeably absent from the sponsoring legislation and hence it is necessary to look elsewhere to discover the general purpose of this considerable undertaking.

This chapter will look at the question of origin and objectives in the period up to the publication, by the National Government, of the White Paper on the National Health Service in February 1944. It will be suggested that moves for reform were motivated more by concern with the medical inadequacies of the existing arrangements than by broader

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1. R.G. Hodgkinson, *The Origin of the National Health Service: the medical service of the New Poor Law 1834-1871* (Berkeley, University of California Press, 1967).

2. For example see G.D.H. Cole, 'The Growth of Socialism' in M. Ginsberg (ed.) *Law and Opinion in England in the Twentieth Century* (London, Stevens, 1959), p. 86. The Labour Party issued a statement on the subject of health care, but it was not taken as "official" policy. The Labour Party, *The Organization of the Preventive and Curative Medical Services and Hospital and Laboratory Systems under a Ministry of Health* (London, 1918). See discussion of this document in B. Abel-Smith, *The Hospitals 1800-1948: a study in social administration in England and Wales* (London, Heinemann, 1964).

questions of say social justice, that the bulk of the ideas came on the whole from people and organisations closely identified with the provision of health care services, and that they were remarkably bereft of political and administrative considerations. The next two chapters will consider the dental and political contributions to the subject of reform during the same period.

In the medical context the premises for reform can in fact be reduced to just two:

(1) that the existing medical organisation was not very efficient, and

(2) that the distribution of the services that were available left a great deal to be desired.

These statements represent something of a summation of the views being pressed in favour of reform. They are not operationalizing statements: they indicate neither why action was precipitated at a particular point in time nor the direction it was to take. They delineate only what might be termed the highest common denominator - the limits of a consensus - which had been generated in the pursuit of reform and represent the point to which the various interested organisations were in rough agreement and the point beyond which there was a huge divergence of opinion.

In looking at these statements it can be seen that they, like any comparable utterances, involve both factual and value components. The period prior to the introduction of the NHS appears to be one in which societal norms in respect of health and related topics were in a state of some flux, but in which the existing health services, after the major changes brought about by the 1911 *National Insurance Act*, underwent little reform. The period was then characterised by an apparently ever-widening gap between theory and practice which it seems to have taken the war to close. However there is some evidence that

the foundations for subsequent bridging were being laid in the 1930s.

The most serious obstacle to the reform of the health services was undoubtedly the relatively low priority it was accorded by successive governments faced with the enormous economic problems of the period. Expenditure on the social services (education, health, labour insurance and pensions) increased only 14% between 1920 and 1939 and although the category of health and labour insurance was relatively generously treated (an increase from £73m. in 1920 to £167m. in 1939)[1] much of this was needed to meet the enormous social cost of such a prolonged period of high unemployment. The Royal Commission on National Health Insurance which reported in 1926[2] was perhaps indicative of the mood of the period when, after noting particular lucanae in the provision of health services, felt bound to recommend

> 'that no extension of benefit involving substantial additional expenditure should be contemplated now or in the immediate future, but that any immediate changes in the Scheme of National Health Insurance should be limited to such as are possible within its present financial resources.'[3]

The financial inability to act decisively and the degree of satisfaction that was felt with the scheme when comparing it with both what had gone before and what foreign governments provided,[4] combined to keep the topic of health services from the inter-party competition. The election manifestoes of the major parties contain no substantive reference to the subject between 1918 and 1935, and

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1. Figures from D. Butler and A. Sloman, *British Political Facts 1900-1979* (London, Macmillan, 1980), p. 356.

2. Royal Commission on National Health Insurance, *Report* (Cmnd. 2596, London, HMSO, 1926).

3. *Ibid.*, p. 276.

4. See comments made by the Royal Commission in *ibid.*, pp. 72-3.

although social reform was sometimes mentioned it was rarely out of a sentence which also exhorted the need for a responsible financial policy.[1]

Perhaps the only significant change within the party-political system during the period was the gradual assimilation by members of the Labour Party of the doctrines espoused by the Socialist Medical Association, and their incorporation in the Party platform. The latter was achieved in 1934, although the Party only became fully committed to its overall recommendations in 1942, highlighting what Eckstein calls the 'full triumph of the socialist doctors over the socialist anti-doctors; the doctors had pervaded the Fabian stronghold'.[2] It represented a significant shift in the position of the party to whom illness had formerly been seen as a product of social conditions and the provision of free medical services as rather missing the point.[3] Disease was to be abolished not catered for and the writings of the early Fabians such as Shaw[4] and the Webbs[5] showed little sympathy either for the doctor or the National Health Insurance Scheme. Hence the socialists were well behind many other groups in suggesting the importance of medical reforms and their significance rests solely on the way in which they were able, eventually, to bring the topic within the party-political arena.

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1. For details of the manifestoes see F.W.S. Craig, *British General Election Manifestoes 1918-1966* (Chichester, Political Reference Publications, 1970) and particularly "National Manifesto" of 1935 at p. 80.

2. H. Eckstein, *The English Health Service* (Cambridge, Harvard University Press, 1959), p. 109.

3. *Ibid.*, pp. 102-105.

4. 'Preface on Doctors' in G.B. Shaw, *The Doctor's Dilemma* in *The Bodley Head Bernard Shaw* (London, Bodley Head, 1971).

5. S. and B. Webb, *The State and the Doctor* (London, Longmans, 1910).

The nucleus of the medical health services in the period prior to the introduction of the NHS was the National Health Insurance Scheme whose principles of operation and administration in 1939 were very similar to those which had been introduced at its inception in 1912. It consisted essentially of an insurance scheme run on actuarial principles by Friendly and other Societies under the permissive legislation passed by Parliament in 1911.[1] Membership was compulsory for those aged between sixteen and seventy who were employed under a contract of service in manual labour, or in non-manual employment where the rate of remuneration was less than that of a periodically revised figure. Contributions consisting of payments by both employee and employer were made weekly and in return all Societies were required to provide a number of statutory benefits (payment for the services of a medical practitioner, and cash payments for sickness, disablement and maternity)[2] while some, depending upon their financial viability, were also able to administer "additional benefits"[3] of which the most popular were dental and opthalmic treatment. Under the auspices of this scheme something less than half of the population was covered with the most obvious omissions being the wives and children of employed men.

In 1926 there were more than a thousand Approved Societies involved with memberships ranging from under fifty to over two million people with, in 1924, a total income from contributions (at that time 5d a week from both employee and employer) of more than £27m. A further £4m. was derived from interest on accumulated funds while some £26m. was spent on the payment of benefits and almost £4m. on administration.

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1. *National Insurance Act, 1911.* Part I, National Health Insurance.
2. *Ibid.*, s.8.
3. *Ibid.*, s.37.

The total cost to the Exchequer was a little over £7m.[1]

The introduction of the Scheme had engendered opposition from sources[2] as diverse as those who viewed it as an intolerable intrusion by the State into the life of the individual and a future Labour Chancellor of the Exchequer who believed it 'would be a tax on the starvation of the people, a pettifogging, meagre, meddlesome, inadequate and ineffective way of dealing with conditions which were a grave menace to the community'.[3] But the major objections were raised not so much by those who opposed the principle of the scheme but, as one might expect, from those who would have to be involved with its details. Most prominent in this regard were the insurance companies who feared the entry of the State into this important area of business and the doctors who were at once keen to maintain a high level of private practice yet at the same time escape the increasing domination of the insurance companies. The *National Insurance Act* and its administrative arrangements displayed the considerable concessions that these groups were able to elicit. Most obviously the commercially lucrative business of burial benefits was omitted from the Scheme;[4] the companies became the collecting agents for the fifteen million or so weekly contributions; benefits were administered at the behest of the doctors by an insurance committee rather than the Societies and professional representation was gained on the Scheme's executive committees.[5]

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1. Royal Commission on National Health Insurance, *Report*, pp. 5-11.

2. H. Levy, *National Health Insurance* (Cambridge, Cambridge University Press, 1944), ch. 1.

3. P. Snowden, 'Address to the Fabian Society', July 1911, cited in *ibid.*, p. 6.

4. *Ibid.*, chs. 1 and 2.

5. See *National Insurance Act*, ss. 58-9.

But at the same time while much of the Scheme was in private hands, the government came to be much more closely associated with the provision of medical services than it had been before. It provided a considerable injection of finance through representation on various committees, was involved in fee-setting, central and local administration and the discipline of participants. Statutory auditing requirements enabled it to closely scrutinise each individual Society's accounts. But perhaps most important was the way in which the government came to be politically identified with the operation of the Scheme, and although it took a long time for the matter to become a topic of inter-party rivalry, the British Government, in the period immediately before the First World War, became irrevocably committed to this expansive area of social policy.

Some historians, most notably Arthur Marwick, see no reason to connect the Liberal reforms of 1905-1912 with the subsequent concept of the welfare state: 'to talk of this as "laying the foundations" ... is to sacrifice historical perspective and analysis to facile metaphor and terminological anachronism'.[1] But to sustain this view it is necessary to adhere strictly to Marwick's definition of the welfare state as community responsibility (on an universal basis) for particular social needs, and to ignore a number of significant changes which the NHI Scheme incorporated. Benefits under this Scheme were undoubtedly selective and to a degree based on the level of contributions but to concentrate solely on this point is to miss the advances towards the collective provision of services to the individual which were features of the Scheme.

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1. A. Marwick, *Britain in the Century of Total War* (London, Bodley Head, 1968), p. 33.

For the purpose of this thesis the particular significance of the development lies with the various principles of administration which were established and which having attained this status became virtually immutable. The doctors had reluctantly come to prefer the authority of the State to the power of the insurance companies, but in so doing they had established the right to representation on professional advisory committees[1] and to have their financial dealings with a body independent of the Friendly Societies.[2] On top of this the Insurance Committees,[3] of which there was one for every county and county borough, were themselves subject to central direction on matters such as fees and conditions. Therefore in so far as the relationship between the doctor and the State was concerned a pattern of administration was established which was largely carried over into the NHS under the guise of the only satisfactory way in which the requirements of clinical freedom could be reconciled with the collective supply of services. Finally it should also be noted that the introduction of the Scheme gave expression to the changing attitude towards the recipients of government-controlled social welfare services. For although the Scheme was run as an insurance programme and remnants of the Poor Law philosophy were to linger long past 1912, National Health Insurance played a crucial role in removing the stigma of pauperism associated with those who were not always able to provide for themselves and opened the door for the government to provide a radical redefinition of the concept of need in relation to health services and thus chart a legitimate area for government intervention.

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1. *National Insurance Act*, s.62.
2. Through the Insurance Commissioners and the regional Insurance Committees.
3. *National Insurance Act*, ss. 59-60.

But if the NHI Scheme represented the core of the health services in this period, something must also be said about the periphery on which there were two major landmarks. The first was the system of hospitals and the second the services provided by the local authorities, usually the counties and the county boroughs. The hospitals were of two kinds, the voluntary ones which had largely been provided by charitable benefaction and the public hospitals which had frequently begun life as poor law or infections diseases hospitals in the nineteenth century.[1] Considerable status was attached to service for the first either through involvement in its government or else as an honorary consultant, and the autonomy of each individual hospital was closely guarded. The public hospitals were run by the local authorities and although much of their work tended to be specialised (tuberculosis, infectious diseases and maternity work) they were required to take any patient who wished to be admitted.

By the period in question both types of hospitals were faced with a similar financial problem. The increase in the number of diseases that could be treated and the increased costs of so doing coupled with the decline in philanthropy and the inability of the local authorities to further increase their rates meant that many hospitals were in a precarious financial position. Not only this but the rather arbitrary nature of their individual siting meant that the two types of hospital might well be adjacent or conversely that neither was to be found in a particular area.[2]

The local authority clinical and other services were generally aimed at a specific group of the population such as mothers and

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1. See, for example, Abel-Smith, *The Hospitals 1800-1948*.

2. *Ibid.*, particularly ch. 25.

children, the tubercular or those with infectious diseases. They acted under national legislation but in most cases this only gave them the authority to provide a particular service and did not compel them to do so. Hence there were considerable discrepancies in the standard and range of services between authorities depending on their relative size and affluence and the attitude of councillors.

As a general account of the situation in the health services prior to the introduction of the NHS this is clearly inadequate, but for the purpose of tracing the origins of the Service it is perhaps sufficient. For the facilities which existed in this period must loom large in any account of the NHS partly because their inadequacies were a major stimulus for reform, but also because their very existence represented a major stumbling block to such change. The general conservative nature of the inter-war governments, the difficult economic environment in which they had to operate and the particular interests which had grown up in support of the various services were sufficient in combination to ensure that changes were only of the smallest detail and that radical reform was wholly out of the question. In attempting to characterise the situation the Report prepared by the British Medical Association is an important source. It noted that although the services were generally superior to those found abroad they

> 'have grown up or been established in a piecemeal, independent, more or less haphazard fashion, and in consequence there is much overlapping and unnecessary complication and confusion, while there are yet large gaps in the provision needed in a reasonably complete service.'[1]

But if the organisation of the health services remained largely

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1. British Medical Association, *A General Medical Service for the Nation* (London, BMA, 1938), p. 3.

unchanged between the inception of the NHI Scheme and the outbreak of war in 1939, such inactivity cannot be attributed to any lack of interest in the subject. The matter may not have attracted the attention of the party politicians but for some voluntary and charitable groups, the professional associations and others with an interest in health matters this was a period of considerable ferment. Analytically the work of each of these interested groups can be divided into three parts: the perception of the problem to be met, the principles governing its possible solution and the particular suggestions for reform. There was a great deal of agreement among this diverse range of spokesmen on the nature of the shortcomings of the existing facilities and to a lesser degree on the principles to be followed. But in so far as recommendations were made they covered a wide spectrum of ideas, although each seems to have been both heavily informed by the structure of the existing services and largely unaware of the political and administrative complications of their intended reforms. However, before dealing with these brief note should be taken of the appointment, in 1924, of a Royal Commission, under the Chairmanship of Lord Lawrence, to

> 'enquire into the scheme of National Health Insurance ... and to report what, if any, alterations, extensions and developments should be made in regard to the scope of that scheme and the administrative, financial medical arrangements set up under it.'[1]

However, despite two years' work and the identification of a number of problem areas the Commission felt itself unable, as has been shown, to recommend any changes which would place additional strain on the Exchequer.

But if the Royal Commission's conclusions were conservative in

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1. Royal Commission on National Health Insurance, *Report*, preamble.

the extreme, the same cannot be said for the other reports of the inter-war years. The first was that of the Consultative Council on Medical and Allied Services[1] under the chairmanship of Lord Dawson which was published in interim form in 1920, and this was followed by the British Medical Association's *A General Medical Service For The Nation*,[2] (1930 and 1938), and the *Draft Report of the Medical Planning Commission* published in 1942.[3]

As the interest in these reports is partial rather than comprehensive in the sense that the concern is with their contribution to a particular aspect of the health reform debate, they are probably best approached thematically. In relation to the question of the identification of the shortcomings of the existing services, the view that the medical organisation was not really efficient, can be broken up to include:-

(1) a lack of co-ordination among hospitals
(2) a maldistribution of specialists among the hospitals
(3) a maldistribution among the types of specialists
(4) a lack of support facilities for doctors
(5) the view that medical organisation was not in step with scientific advances
(6) the fact that new medical knowledge was not available to all practitioners
(7) that with the rising costs of medical technology many doctors could not afford to give the kinds of treatment they thought to be necessary.

The view that the distribution of medical services left a lot to be desired may be similarly divided:-

(8) that medical services were not available to the whole community

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1. Consultative Council on Medical and Allied Services, *Interim Report on the Future Provision of Medical and Allied Services* (Cmnd. 693, London, HMSO, 1920).

2. British Medical Association, *A General Medical Service for the Nation.*

3. Medical Planning Commission, *Draft Interim Report* in *British Medical Journal*, 1 (20 June 1942) pp. 743-53.

(9) that amongst those qualified to receive them the same services were by no means equally available.

These nine propositions, which are by no means exhaustive, nevertheless represent the basis of an indictment of the existing services on which all the major reports were agreed, and they formed something of a framework for the advocated measures of reform. Each is considered in turn below:

(1) The point has already been made that there were two types of hospital and that their geographical location rarely bore any relationship to the needs of the area. Communication was poor and the exchange of facilities was not widely practised while the rather arbitrary local authority boundaries often made for unnecessary duplication. Also the catchment area of each authority was usually too small to permit much specialisation among the hospitals.

(2) The distribution of specialists among hospitals was generally based on considerations which again had little relevance to the requirements of the particular hospital. Specialists were unpaid for their hospital work, but needed such positions as a base from which to engage in the lucrative business of teaching pupils and attracting a large number of private, fee-paying patients. Hence the Voluntary hospitals, often accorded high status were relatively overstaffed in comparison with the public hospitals while the cities, with their large catchment areas, were favoured at the expense of the country.

(3) The maldistribution among the specialists was the result of the relative earning potential of the different types. The capacity and willingness of the private patient to pay was an important consideration and hence there was a plethora of gynaecologists and obstetricians and an acute shortage of ear, nose and throat specialists and general surgeons.

(4) As medical technology provided possible solutions to an ever increasing number of complaints the resources of the individual practitioner in his own surgery became inadequate. Access was required to facilities such as pathology laboratories and a range of para-medical skills if the patient was to have the best possible chance of recovery. Frequently these were unavailable either because the doctor himself had no access to them or the patient could not afford what was usually a non-insurable item.

(5) The discovery of new drugs and techniques in this period had led to the acceptance by the medical profession of a number of optimum ways of dealing with certain problems. These often rested on such factors as the place of treatment, the size of the hospital, its specialisation and the duration of stay. For largely administrative reasons based on

significant differences between the providers of the various services, the existing system was unable to adopt these procedures and consequently the practice of medicine often lagged significantly behind the fruits of research.

(6) The strong British tradition of individual professional practice meant that often a doctor would rarely meet his colleagues except on a social basis and could easily remain unaware of significant advances in treatment techniques. Contact with a teaching hospital was usually minimal, especially as the doctor with so much pressure on his services felt unable to give up part of the working day to improve his performance.

(7) The rising costs of technology meant that many medical techniques could no longer be performed in the surgery and that the patient would often have to obtain them in a hospital or elsewhere - which again put them out of reach of the uninsured. In addition even some of the more rudimentary devices went beyond the purse of the individual doctor and thus reduced further the range of treatments he could offer his patients.

(8) The limits of the National Health Insurance Scheme, the pressure on the charitable schemes and the inability of many people to meet their own medical costs combined to put medical treatment beyond the reach of a significant part of the community.

(9) The arbitrary placement of the hospitals, the permissive character of much of the legislation covering the local authority services and the particular rules of the Approved Societies, especially in regard to Additional Benefits meant that the range of services available to the individual varied a great deal.

If these then represent the shortcomings of the existing services as identified by the various reports, the general principles governing their suggested solutions must also be considered. In short these can be listed as the need for any new systems to be uniform, equal and complete. The BMA Report of 1938 gave the most complete expression of this when it stated *inter alia*:

> '(II) That there should be provided for every individual the services of a general practitioner or a family doctor of his own choice
>
> (III) That consultants and specialists, laboratory services and all necessary auxilliary services ... should be available for the individual patient
>
> (IV) That the several parts of the complete medical service

> should be closely co-ordinated and developed by the application of a planned national health policy.'[1]

This presumed the view which the Dawson Committee[2] had accepted as far back as 1920, and which the other reports were to echo, that each individual had a fundamental right to a healthy existence and consequently that medical and related services should be available to him if and when he should require them.

In pursuit of this aim each of the reports supposed that some degree of co-ordination, planning and an appropriate amount of authority would be required although none of them appears to have questioned either the efficacy or the consequences of the application of these concepts. But perhaps this is unsurprising in a period when increasingly more and more faith was being placed in these techniques in many areas of economic and public life. For example many major industrial amalgamations took place,[3] there was increasing pressure for the use of more complex planning techniques[4] and, as it will be shown in chapter four there was a widespread belief that there were many areas where only the intervention of the State could resolve the intrinsic difficulties. Nevertheless, these techniques were adopted by the advocates of health care reform with little consideration either of their appropriateness for the particular subject matter or of the consequences of their use. They were considered as a neutral

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1. *A General Medical Service For The Nation*, p.8.

2. *Interim Report on the Future Provision of Medical and Allied Services*, p. 5.

3. K. Middlemas, *Politics in Industrial Society* (London, Andre Deutsch, 1979), ch. 7.

4. By people from a wide range of political positions. For example see H. Macmillan, *The Middle Way* (London, Macmillan, 1938) and L. Abercrombie *et al.*, *The Next Five Years* (London, Macmillan, 1935).

technique whose applicability was presumed to be universal.

The Dawson Committee was particularly critical of the wide range of sources of medical care and recommmended that any new system should be based on a new Health Authority, covering a particular geographical area, which will 'bring about unity of local control for all health services, curative and preventive'.[1] It ducked the question of whether the new Authorities should be entirely new constructs or else offshoots of the existing local government arrangements,[2] but a high professional representation on the executive (40%) was advocated.[3] In addition each area would also have a Local Medical Advisory Council which would appoint sub-committees to investigate and report in specialised areas.[4]

The physical delivery of health care under the system was to be based on what were to be called "Primary Health Care Centres":

> 'Institution(s) equipped for services of curative and preventive medicine to be conducted by the general practitioners of that district, in conjunction with an efficient nursing service and with the aid of visiting consultants and specialists.'[5]

A number of these primary centres were to be grouped around a "Secondary Health Centre" in which more specialised care would be available. Supplementary services, laboratories, ambulance facilities and research would be attached to one or other level of health centre. However such arrangements were not to prejudice the existing,

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1. *Interim Report on the Future Provision of Medical and Allied Services*, para. 93.
2. *Ibid.*, para. 94.
3. *Ibid.*, para. 98.
4. *Ibid.*, paras. 99-100.
5. *Ibid.*, para. 10.

individual general practices though encouragement was to be given to the formation of group practices where this was practicable.

Hence in this way the health services of a particular area were to be planned and co-ordinated with a view to providing a service that was at once uniform, equal and complete. However despite the fact that the recommendations were both wide-ranging and radical, conspicuously absent from them was any discussion of three issues that would be crucial to the administration of any such system. The first was the question of finance: the report stressed the need for services to be available to all, but qualified this by noting that in 'using the word "available" we do not mean that the services are to be free; we exclude for the moment the question how they are to be paid for.'[1] Second, there was no discussion of the authority to be given to the new Health Authorities: no mention of their capacity to bring hospitals and other services within the new unified system of provision. Finally there was no reference to the powers of central government: the Report confined itself to discussion of the system within a specific area and avoided the question of how uniformity was to be ensured between districts and what authority the central government was to have over the Area Health Authorities. The lucanae can be explained to an extent by the fact that the Report was an interim one (though no final one was ever issued), but they suggest more obviously that the conclusions were based primarily on medical criteria and that little attention was paid to the detailed requirements of administration.

The BMA Report on the other hand paid a little more attention to administrative detail, though this is perhaps unsurprising since

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1. *Ibid.*, para. 7.

its major recommendations countenanced no more than minor adjustments to the existing structure. The general principles of a comprehensive medical service, which have already been alluded to could, the Report believed, be obtained by piecemeal reform and that indeed this, in view of the strength of the existing traditions in British administration, was perhaps the most likely way of ensuring its success. As the Report noted,

> 'In formulating, then, a scheme for the nation it is not attempted to set out one which is ideal in the abstract or even perfectly logical, either in its administrative or in its clinical aspect. We seek, rather, while recognizing existing conditions and circumstances so to adjust, modify, and extend present services and administrative arrangements as to produce a co-ordinated and, as far as possible, unified system, effective and reasonably complete.'[1]

The basis of the recommended system was that the NHI Scheme was to be reformed to bring in dependents and those presently served by public assistance,[2] and extended so that dental and opthalmic services were included as statutory benefits.[3] Co-ordination amongst the institutional services was to be provided by a reduction in the number of levels of local authority involved in their administration and the rationalisation of those remaining on the basis of population and financial capacity.[4] In line with its general pragmatic approach the Report decided against wholly new bodies responsible for the co-ordination of health care and instead sought only to modify the existing local government arrangements.[5]

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1. British Medical Association, *A General Medical Service For The Nation*, Introduction (iii).
2. *Ibid.*, paras. 27-8.
3. *Ibid.*, paras. 33-4.
4. *Ibid.*, paras. 93-9.
5. *Ibid.*, para. 96.

Like the Dawson Report the BMA had a great deal to say about the facilities to be provided under this new system of health care, but it was ominously quiet on important aspects of the administration. Much was said about who would do the various tasks, but little was added about how or why they would be done. The co-ordinating authority was identified but nothing was said about how it was to function or why for example the doctors were exempted from it. Central organisation was brought into the relationship between the State and the doctors, yet nothing was said about the basis of the relationship or about how this "vertical" relationship was to be married to the essentially "horizontal" structure at the health authority level. These shortcomings may perhaps be explained by assuming that while the Report ranged wide over the problems of health care delivery its primary purpose was undoubtedly to protect and enhance the lot of the members of the organisation which compiled it. But it may also be seen as a manifestation of the lack of thought given to questions of administration while so much was expended on both general questions of social organisation and the minutae of the provision of the service to the individual.

Of the three reports the Medical Planning Commission demonstrated the greatest concern with administrative matters. This is understandable in terms both of its date of appointment (August 1940) and its specific remit to 'study wartime developments and their effects on the country's medical services both present and future'.[1] Problems of administration, through the experiences of the Emergency Medical Services, were rather more to the fore at this time and to an extent some of the proposed administrative techniques were already being

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1. Medical Planning Commission, *Draft Interim Report*, para. 1.

tried. The Commission envisaged the establishment of a central authority which might be either 'a Government Department ... or ... a corporate body formed under Government auspices and responsible through a Minister to Parliament',[1] and which with a medical practitioner as its chief officer would be concerned with civilian health services. At the local level it suggested the creation of new elected authorities (termed Regional Authorities) which would be larger than most of the existing local authorities and become responsible for the efficiency and co-ordination of the hospital and medical services. At each level provision was made for the establishment of professional advisory committees.

Taken together the major reports of the period, of which these were probably the most significant, exhibit a high degree of agreement about both the objectives of a health care system and the shortcomings of the existing arrangements, but much less of a consensus about the necessary substantive changes. But even where their level of disagreement remains high they share the characteristic when considering administrative matters, of drawing a simple chain of causality between the provision of arrangements designed to promote planning, co-ordination and the exercise of governmental authority and the manifestation of the required characteristics of uniformity, equality and comprehensiveness. In other words it was assumed that the provision of particular means would produce the desired ends and little thought was given to the problems in this progression.

But if the lack of proven practicability of some of the recommended solutions is left aside for the moment it can be seen that by the early years of the second world war a considerable gap had

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1. *Ibid.*, para. 51.

emerged between the ideas about health care delivery and its actual provision. The war years were to radically alter that position: by 1944 the National Government had issued an important White Paper on the subject; by 1945 the electoral manifestoes of both parties were detailing the commitment to a comprehensive health service;[1] by 1946 the necessary legislation was on the Statute Book and by 1948 the Service was in operation. Clearly the war had made an obvious impact on this area of social policy, though the historians are divided as to its overall significance.

Professor Gilbert,[2] for example, maintains that a consensus about the problem and its practical solution had been reached in political circles by 1939 and he cites the depression and the evolution of socialism as the major catalysts. Paul Addison[3] on the other hand argues that it was in fact the war that brought the necessary political stimulus for reform and that this had been generated by the exposure of the middle classes to the problems of the working classes, the general equalising effects of hardship and suffering, and the way in which the war had so mercilessly exposed the inadequacies of the existing health services, especially when the survival of the nation could to an extent be directly related to the general health and well-being of the population.

But whichever view is taken about the generation of political support for the reform of the health services, it is difficult to ignore the significance of the war as both a harbinger of concrete reform and

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1. Craig, *Election Manifestoes*, pp. 103-4 and p. 92.

2. B.B. Gilbert, *British Social Policy 1914-1939* (London, B.T. Batsford, 1970), *passim*.

3. P. Addison, *The Road to 1945* (London, Jonathon Cape, 1975), *passim*.

as an important influence on the form that such change was to take. The war experience showed, first of all, that it was feasible to provide increased social services without the apparent economic debilitation which so many pre-war theorists had predicted. For example, Margaret Cole wrote in *The Story of Fabian Socialism* that

> 'people could see with their own eyes that in a war which was making greater and greater demands on material resources, it was possible, for example, to provide quickly help, food, milk for those who needed it, to raise remarkably the standard of health and nutrition of British children.'[1]

Pre-war resistance to health service reform had centred on the question of increased expenditure which was anathema to the Treasury whose orthodoxy in matters economic demanded balanced budgets and rigid constraints on public spending. But the experiences of wartime effectively lowered these barriers: government spending burgeoned, supported by higher taxation and the use of deficit budgeting advocated by the Keynesian school of economists, while the government involved itself in many aspects of social and political life to which it had previously been a stranger.

And if it was shown to be materially feasible to enjoy such social benefits, various groups made much of this possibility. For example members of the Labour Party, which had been brought into the Government and whose resources were concentrated in domestic affairs, made no bones about the price they felt it right to extract for the co-operation of themselves and the trade unions. The *New Statesman* in June 1940 felt itself able to report that 'we cannot actually achieve socialism during the war, but we can institute a whole series of government controls which after the war may be used for socialist

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1. M. Cole, *The Story of Fabian Socialism* (London, Heinemann, 1961), p. 275.

ends.'[1] But likewise the Government which was conscious of the need to maintain a high level of morale, especially among the civilian population who were subject to a much greater degree of danger and deprivation than during any previous hostilities, and which was only too well aware of the debacle which followed the first world war, made considerable effort at a relatively early stage in the war to show that the lessons of 1919 had been well learnt. Considerable resources were channeled towards the problem of reconstruction under the general supervision of a War Aims Committee. Among its term of reference was the requirement

> 'to consider means of perpetuating the national unity achieved in this country during the war through a social and economic structure designed to secure equality of opportunity and service among all classes of the community.'[2]

The most prominent outcome of this work towards reconstruction was undoubtedly the Report of the Committee on Social Insurance and Allied Services[3] which had been set up under the chairmanship of W.H. Beveridge in June 1941.[4]

Thus, regardless of preferences about the time that a consensus was obtained in regard to the need for change, there is no denying the importance of the war years for both showing that health reform was within the capacity of the economy and for generating a positive commitment to change in addition to agreement about what it might

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1. Cited in Addison, *The Road to 1945*, pp. 115-116.

2. *Ibid.*, p. 122.

3. Sir William Beveridge, *Social Insurance and Allied Services* (Cmnd. 6404, London, HMSO, 1942).

4. For a discussion of the Committee's appointment and operation see J. Harris, *William Beveridge* (Oxford, Clarendon Press, 1977), chs. 16-17.

involve. But of greater significance for this thesis was the degree to which the experiences of the wartime health administration affected and moulded the suggestions for post-war reform.

The first point of interest is the speed with which the various recommendations were made. This suggests both that there was widespread understanding of the possible alternatives and that a good degree of consensus existed, at least among those responsible for drafting the particular documents. For instance as early as 1941 the Deputy Permanent Secretary at the Ministry of Health had minuted the main objectives of health policy on which he believed there to be general agreement on the Ministry's Office Committee on post-war Hospital Policy.[1] This included the need for a comprehensive health service including all types of medical service, based on treatment in hospitals or clinics which would form part of a planned system for a particular region. But in addition to this the experiences of the war-time medical arrangements served to support many of the provisions of the pre-war reports. To quote Margaret Cole again, the beneficial effects which have already been referred to were obtained 'by what was in effect partial nationalisation, centralised control administered by non-profit making servants of the community ... Britain was operating a society of Planned Production for Communal Ends.'[2] Even allowing for the excesses of Fabian rhetoric there is no escaping the fact that governmental policy in maintaining the war economy relied heavily on a high degree of central planning, co-ordination and the exercise of governmental authority. It is unsurprising then to find that the 1944 White Paper on the National Health Service represents something of a marriage

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1. Cited in Addison, *The Road to 1945*, pp. 179-180.

2. Cole, *The Story of Fabian Socialism*, p. 275.

between the war-time administrative experiences and those ideas of the pre-war reports which were in accord with this particular model of administration.

What then were the characteristics of the National Health Service that was proposed? Perhaps the most significant feature was the way in which it was almost totally sympathetic to the existing administrative structures. The proposals for reform might be radical and the techniques advocated to attain them largely untried, but the machinery of government onto which they were to be drafted was strictly orthodox. The Paper is an outstanding example of the spirit of gradualism which has pervaded administrative reform in Britain and indeed the authors went out of their way to assure the reader that the structures which were to be introduced did not depart significantly from those which were already familiar. The method of approach, stressed the Report, was to 'use and absorb the experience of past and present, building it into a modern service.'[1] And in preferring this approach to something more radical it felt justified in observing that it was 'more in accord with native preference in this country.'[2]

But surely the natives were to an extent being deceived, for the recommendations of the White Paper represent something of a wolf hiding within the sheep's clothing. The institutions of administration may have been familiar, and consequently uncontroversial, but the subject matter of administration was almost wholly untried. The consequences for public administration were the subject of little scrutiny: it seems just to have been assumed that the subordination of the policy to a traditional administrative structure informed by the long-standing

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1. *A National Health Service*, p. 8.

2. *Ibid.*

conventions of British government would be sufficient to overcome any problems.

The most important of these conventions, the principle of responsibility, is indelibly stamped upon the White Paper. The NHS would be a responsible organisation: responsible to the Parliament and the people, and responsible in the more positive sense of making sure that all those eligible receive the services to which they are entitled.

> 'If people are to have a right to look to a public service for all their medical needs, it must be somebody's duty to see that they do not look in vain. The right to service involves the corresponding duty to see that the service is provided. Some organisation has to carry that duty, and as the service is to be publicly provided this involves responsible public authority in some form.'[1]

Indeed such was the dominance of the concept of responsibility that it was also used to dismiss the idea of a statutory corporation as the most appropriate organisational form on the grounds that it would be too difficult to define its relationship with the Minister and that a local (elected) body should not reasonably submit to being over-ruled by a body itself not directly responsible to Parliament.[2]

Responsibility was also carried over into the principle of local organisation where, despite the central provision of funds and the control of certain parts of the service, the counties and the county boroughs were to be used as the basis for the provision of clinical and similar services while combinations of such authorities were to form the Joint Authorities for the co-ordination of hospitals and the promulgation of the regional plan.[3] And while professional and technical advice was to be heeded where appropriate the authorities were to be

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1. *Ibid.*, p. 12.
2. *Ibid.*, p. 13.
3. *Ibid.*, pp. 15-19.

elective and without the mandatory professional representation which a number of the pre-war reports had advocated.[1]

Structurally the White Paper proposed that the Service be divided between three separate arms. The provision of the general practitioner services was to be centrally directed; welfare and clinic services were to come under the jurisdiction of the existing local authorities while hospitals were to be organised on an area basis by the new Joint Authorities.

The Paper saw the general practitioner services as the most crucial for a number of reasons: that they were to be the most important part of the service in so far as they acted as gate-keepers to the whole system; that if the Service was to live up to its expectations it was essential that this stage be wholly comprehensive; and that this part of the Service involved the Government in a relationship with most of the country's medical practitioners, which had not been tried before.[2] Administratively then the problems were of three sorts: the mobilisation and organisation of the necessary resources; the mobilisation and organisation of the potential consumers and the negotiation of a satisfactory contractural arrangement between doctors, patients and the Government.

On the hospital side two main problems were expected. 'First the need to bring together within suitable areas the activities of the various separate and independent hospitals,'[3] and second the need to accommodate the two different hospital systems within a single service. Such measures involved the use of authority to bring the individual

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1. *Ibid.*, p. 20.
2. *Ibid.*, p. 26.
3. *Ibid.*, pp. 20-1.

institutions within the plan for the area and the use of co-ordination to reduce overlap and inefficiencies.

Finally the White Paper saw the local authority services as needing the least reform. To a greater extent than the other two branches this one was already in existence and administratively the major problem was one of co-ordination with the other areas of health care and ensuring that the particular needs of the area were met.[1]

Essentially the problems were to be met by the three administrative techniques which have already been noted: the use of governmental authority, planning, and arrangements to facilitate co-ordination. For instance the mobilisation of resources was to become the concern of central government and through the exercise of its authority the latter was determined to see that every man, woman and child

> 'can rely on getting all the advice and treatment and care which they may need in matters of personal health; that their getting these shall not depend on whether they can pay for them, or on other factors irrelevant to the real need - the real need being to bring the country's full resources to bear upon reducing ill-health and promoting good health in all its citizens.'[2]

Under this authority area plans were to be developed to ensure that all the necessary medical resources were provided and that there was little chance of an individual patient being disadvantaged. Co-ordinating machinery was to be developed to move the patient from one area of the health care delivery system to another and to ensure that such movement was possible.[3]

But like the recommendations of the reports from which it draws,

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1. *Ibid.*, pp. 38-9.
2. *Ibid.*, p. 5.
3. *Ibid.*, p. 19 and p. 22.

the White Paper is noticeably quiet on the subject of these administrative procedures. Only on the question of the relationship between the doctor and the State it is less reticent. The assumption is that the means are appropriate to the ends; that the provision of say the resources and authority of central government will be sufficient to ensure that every citizen receives medical attention when he needs it. But on what grounds is this assumption made? Basically they seem to be threefold; the experiences of the war when the government had utilised these particular administrative tools; the general high level of trust in the efficacy of governmental action; and the susceptibility of political problems to solution by the results of a process of rational thought. Furthermore the whole situation was complicated by the need to administer the programme through a number of agencies, organisations and individuals who could not necessarily be relied upon to share either the enthusiasm for the project or the belief that they should commit their resources to such a goal.

The particular responses of the White Paper to the individual problems of the pre-war service can be readily identified. Lack of co-ordination between the hospitals was to be reduced by the appointment of the Joint Authorities who in turn could act to reduce the maldistribution of specialists through their capacity either to create specialist hospitals or move consultants from one hospital to another. The introduction of a system of payments and the ability to provide particular specialist equipment could be used to solve the problem of the maldistribution of specialists, while the Joint Authority through its planning could ensure that all the necessary support facilities were available. The problems of the dissemination of medical knowledge, of better organisation to cope with scientific advances and the rising costs of medical technology were to be met in a number of specific ways.

Encouragement (including financial incentives) was to be given to group practice, doctors would be invited to take a greater interest in the work of hospitals, the new administrative apparatus could be used to see that the results of new research were quickly disseminated while equipment too expensive for the individual practitioner's clinic could be provided on a collective basis at either a health centre or a hospital. Finally the problems of the distribution of services were to be met by resource mobilisation as a result of governmental financial initiatives and local planning operations.

At whatever level the Paper is examined, its methodology is consistent. The 'problem' or 'problems' (say the inadequacies of the distributive system or a more specific proposition such as the mal-distribution between types of specialists) are identified, the generally desired situation is spelt out (to ensure that everybody in the country - irrespective of means, age, sex of occupation - shall have equal opportunity to benefit from the best and most up-to-date medical and allied services available)[1] and a basket of techniques is introduced with which to bridge the gap.

The model was the classical bureaucratic one and presumed instrumentally rational behaviour from those who were to be involved in the system's administration. Little or no regard was paid either to the problems of attempting to impose the behavioural norms of bureaucracy on a number of non-bureaucratic occupational groups or indeed of the consequences of so trying to do. In other words in the manner in which the other reports had looked at questions such as co-ordination, the use of resources and authority, the White Paper took as a "given" the whole process of implementation and subsequent

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1. *Ibid.*, p. 47.

operation. Once the necessary techniques, resources and authority were available, the improved well-being of the populus seems to have been assumed. Certain opposition was expected, particularly from the medical profession, but with minor concessions this was to be overcome by the authority of the Minister backed by Parliament and a recent election.

Thus far in this chapter the subject of dentistry has not been mentioned and it remains to consider the significance of the omission. To a degree it has been deliberate: the reports did occasionally refer to dental matters but never in more than perfunctory fashion, and matters of dental health made little contribution to the formulation of the reports' recommendations. Thus the omission of dentistry from the chapter can be justified historically and the point emphasised that in so far as the White Paper "took over" many of the recommendations of the reports it pursued strategies which were devoid of a dental input and whose objectives were focussed almost entirely on matters on hospital and medical organisation. Some changes were made to the administrative arrangements of the NHS between the publication of the White Paper and the proclamation of the legislation in 1946,[1] but by and large the principles contained in the Paper were those that were carried into practice on 5 July 1948.

The point is laboured because of its importance, in a number of ways, to the argument of this thesis. A central conclusion of the thesis is that solutions to many of the problems facing the dental health services have not been found because the problems themselves played no part in determining the original organisational structures.

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1. Especially the nationalization of the hospitals. See A.J. Willcocks, *The Creation of the National Health Service* (London, Routledge and Kegan Paul, 1967), ch. 2.

Under the particular approach adopted to the public supply of health services, little opportunity was afforded for discrimination between the problems presented by different types of health care both because the universality of the proposed administrative techniques was merely assumed and because, in political terms, the relatively minor provisions, such as dental care, paled beside the importance of the hospital and medical considerations.

But considerable space has also been given to the pressures for medical reform in order to demonstrate the kinds of values and aspirations that lay behind the introduction of the NHS. Throughout the chapter a concern with matters such as access to health care irrespective of the capacity to pay and the universal availability of all necessary forms of treatment has been apparent, and the issues have been stressed in order to give some indication of the kind of expectations that accompanied the moves to the public provision of health care. These matters were not canvassed so openly in relation to the dental health services and hence it is important to remember that as part of the wider health services, it was believed that significant changes would result from the assumption of public responsibility for the supply of dental treatment. The dental arrangements prior to the advent of the NHS are considered in the next chapter.

CHAPTER THREE

DENTISTRY AND DENTAL SERVICES BEFORE THE NATIONAL HEALTH SERVICE

Although this chapter is concerned primarily with the problem facing the supply of dental health services in the period immediately before the introduction of the NHS, a brief history of the dental profession in Britain has been included to provide a background to some of the issues that are of significance to this thesis. Of these the contrast with the medical profession is perhaps the most important but a number of other questions, such as the profession's hostility to the use of para-dental personnel, can be more readily understood with the benefit of an historical perspective.

Three major themes are pursued: the organisation of the profession, public involvement (through Parliament and by the government) in dental affairs and the public provision of dental services. The items mentioned assume an importance in the order that they have been listed with a general tendency for one issue to spill over into the next. Thus as moves were made to organise the profession, pressure came for legislative support for a professional monopoly which brought the subject within the public gaze and led to calls for the public supply of services as the system of private provision was deemed to be inadequate. However care must be taken not to put this progression within too deterministic a framework, for it will be shown throughout the thesis that dentistry cannot be considered in isolation either from the developments in medicine and the supply of medical services or the rather wider political debate about the role of governments in the provision of welfare generally.

The question of the organisation of dentistry is practically synonymous with that of the status of the activity. Pressure for stronger organisation meant unequivocally pressure to improve the status of the dentist and his work, and it is a theme which can still be identified in the controversies surrounding the profession today.

Status for dentistry had two components. First the question of status within the subject area, in which the battle lines were drawn initially between those with some form of qualifications and those without, and later between those who were registered and those who were not. And second, status outside the subject area, particularly in relation to the medical fraternity.

Organisationally these issues began to become of substance in the 1840s, with the publication by George Waite, of a pamphlet entitled *An Appeal to Parliament, the Medical Profession and the Public on the Present State of Dental Surgery* in which he bemoaned the fact that dentistry was so open to abuse and suggested that the capacity to practise the subject should depend on the successful completion of an examination supervised by the Royal College of Surgeons.[1] Waite's efforts, however, yielded little reward, a fact that can perhaps be explained in the laconic phrases of a contemporary observer. 'From imposters and swindlers, men without honour and moral obligation, we can expect no reform. They will be imposters and swindlers still'.[2]

Further moves were made in 1843 with an attempt to tack some dental provisions on to a medical reform bill before the House of Commons, but to no avail, and although two journals were also started at this time, they too soon expired. A quotation from one of them ably portrays the frustration felt by those who sought to improve the standards of dental practice:

> 'There is no other profession so totally destitute of combination and consequently of influence. The Surgeons have their College, the Apothocaries their Hall, the

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1. A.M. Carr Saunders and P.A. Wilson, *The Professions* (Oxford, Clarendon Press, 1933), pp. 108-9.

2. *Am. J. Dent. Sci.*, 3 (1842) cited in J. Menzies-Campbell, *From a Trade to a Profession* (Published privately, 1958), p. 89.

> Chemists their Pharmaceutical Society, the Artists their Royal Academy, and even the Veterinary Surgeons their College, but the Dentists seem to have no feelings in common - each practitioner stands isolated ...'[1]

Richards[2] has suggested that this incapacity to get organised was a consequence of a number of factors including the small numbers involved, the geographical separation and isolation, the problems of communication, the differing social origins of the practitioners, the absence of a substantially agreed body of knowledge (few textbooks and a great number of secrets), the absence of any national leadership, the fact that dentistry was not practised as a speciality in the major hospitals and the few facilities available for formal instruction. Dentistry was at this time, he suggests, 'foundling', and a contemporary address by the former editor of the *British Quarterly Journal of Dental Surgery* highlights the pessimism felt: 'the adage that any fool will do for a parson may be applied with still greater force and truth to the profession of a dentist'.[3]

A further ten years were to pass before any significant advance was made. This took the form of the foundation, in 1856, of two separate organisations, the Odontological Society of London and the College of Dentists. Each aspired to raise the status of dentistry, although they disagreed about the appropriate approach and for a number of years they advanced along separate but parallel paths with a journal, a hospital and a dental school becoming associated with

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1. *Forceps* (10 May 1844), p. 81 cited in N.D. Richards, 'Dentistry in England in the 1840s - the First Indication of a Movement Towards Professionalization', *Medical History*, 12 (1968), p. 148.

2. Richards, 'Dentistry in England'.

3. *Am. J. Dent. Sci.*, 10 (1850), p. 227 cited in Menzies Campbell, *From a Trade to a Profession*, p. 91.

each.[1] It was only in 1863 that the internecine feuding was resolved and the two parent associations were combined as the Odontological Society of Great Britain.[2]

However, prior to the reconciliation, and under pressure from the Odontological Society, an amending clause had been added to the *Medical Act* of 1858 which authorised the Royal College of Surgeons to initiate examinations and grant certificates of fitness to practise dentistry. But at the same time the College of Dentists, which saw itself as a possible future equivalent of the Royal College in the dental field, continued to issue licences of its own. It soon became obvious, though, that both schemes had their shortcomings. Most significant was the refusal of the General Medical Council to append the names of qualified dentists to the Medical Register. There was thus little reward for recognised qualifications and hence only a small demand for the appropriate courses and examinations. In retrospect it seems fair to say that it was this failure to achieve registration that led to the next wave of pressure which culminated in the passing of the *Dentists Act* of 1878. But before this legislation is considered a brief comment will be made on the state of dental practice at the end of the 1860's. Essentially it was characterised by great divide between those with formal qualifications who exhibited many of the traits of what is now termed professionalism,

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1. The Odontological Society was associated with the British Journal of Dental Science, the Dental Hospital of London and the London School of Dental Surgery. The College of Dentists was associated with the Quarterly Journal of Dental Science, the National Dental Hospital and the Metropolitan School of Dental Science.

2. For details of these disputes see Menzies Campbell, *From a Trade to a Profession*, pp. 89-94; Carr Saunders, *The Professions*, pp. 107-109 and Sir W. Fish, 'A Profession in the Making', *BDJ*, 107, 1 and 2 (7 and 21 July 1959), pp. 19-30.

with the production of journals, the instigation of formal teaching courses and the spread of dental hospitals in both London and the provinces,[1] and those whose methods had changed little over the years and whose formal training may well have been as a blacksmith or a farrier. One report suggests that such characters did not make false teeth but rather used natural ones collected from the battlefields of the American Civil War by a horde of tooth drawers who promptly boxed them and sent them to London.[2]

The introduction of the *Dentists Act* (1878) was largely a result of pressure brought to bear by the Dental Reform Committee which had been set up in 1876 by the Odontological Society to deal with dento-political affairs.[3] Brought into Parliament as a private members' bill, the legislation was modelled on the 1858 *Medical Act* and was intended to give qualified practitioners certain statutory privileges, and to make arrangements for the administration of the Act. In particular the Act made provision for the formation of a Register of persons qualified to practice dentistry and entrusted its keeping to the General Council of Medical Education and Registration in the United Kingdom.

But although a Register was introduced and competent authorities sanctioned to examine prospective practitioners it soon became clear that the Act had failed in its main stated aim of attempting to prohibit practice by those without formal qualifications. In consequence the dental history of the next forty years was

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1. See N.D. Richards, 'The Dental Profession', in F.N.L. Paynter (ed.), *Medicine and Science in the 1860s* (London, Wellcome, 1969), *passim.* for details.

2. See Menzies Campbell, *From a Trade to a Profession*, p. 83.

3. Carr Saunders, *The Professions*, pp. 109-110.

characterised by the large number of legal actions taken by qualified practitioners in an attempt to protect their professional status.

However the more immediate, and perhaps more significant result of the legislation was that of those admitted to the first Register an overwhelming proportion[1] (probably as high as 90%)[2] were persons without qualifications who had, under Section 6 of the Act, only to furnish the following declaration in order to apply for Registration.

> 'I, ..., residing at .... hereby declare that I was bona fide engaged in the practice of dentistry at the date of the passing of the Dentists Act, 1878.
> (Signed) ....
> (Witness) ....
> Dated this .... day of ...., 18..'[3]

Few applicants appear to have been investigated for the authenticity of their declaration, and some suggestion of the abuses that occurred can be gleaned from the comments of a later President of the General Medical Council to the Committee investigating the operation of the 1878 Act:

> 'Now and then we have a person brought before us who was registered in 1878 who, when we look at him, must have been registered when he was 10 or 11 years of age, if his statements are correct.'[4]

Such was the concern of the qualified practitioners at the immediate consequences of the legislation that in 1879 the Dental Reform Committee (DRC) called a national meeting which led, in 1880 to the formation and later, incorporation of the British Dental Association. Its founding motion was both simple and wideranging:

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1. Lord President of the Council, *Report of the Departmental Committee on the Dentists' Act, 1878* (Cmnd. 33, London, HMSO, 1919), para. 11.

2. N.G. Bennett, 'The British Dental Association: Its Origin, Growth and Advance', *BDJ*, 51, 11 (2 June 1930), p. 567.

3. *Report of the Departmental Committee on the Dentists' Act*, para. 9.

4. *Ibid.*, para. 10.

> 'That a society be now established under the title of the British Dental Association, whose object shall be to watch over the interests of the profession with special reference to the proper carrying out of the provisions of the Dentists Act of 1878, and with full authority to organise Special Committees, to the establishment of a Dental Benevolent Fund for the assistance of infirm and disabled members of the profession, to be supported by members' special subscriptions, and for any other object that may appear desirable.'[1]

The Executive Committee of the DRC was elected as the first Representative Board of the Association and membership was confined to qualified practitioners.[2] But although the British Dental Association had been formed largely to protect the interests of the qualified against those without formal training, the implementation of the 1878 legislation changed the nature of the struggle for raising the status of the profession. The proportion of unqualified practitioners on the Register declined steadily until in 1918 they constituted only 25% of the total,[3] but at the same time unregistered practice which the legislation had unwittingly sanctioned, expanded enormously. The Report of the 1917 Departmental Committee was unable to provide any data about the overall extent of such practice, but figures for certain local authority districts were included[4] and the Committee's general conclusion was that, 'the evidence submitted to us is conclusive that it is the least reputable section of unregistered dental practitioners that has increased most, and tends to increase'.[5] The Association had in fact sent the General Medical Council a long

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1. Cited in Bennett, 'The British Dental Association', p. 566.
2. N.D. Richards, 'Dentistry a Hundred Years Ago. Charles James Fox - The Forgotten Man', *BDJ*, 132,6 (21 March 1972), pp. 61-64.
3. *Report of the Departmental Committee on the Dentists' Act*, para. 12. Also see table on p. 24 giving comparison with doctors.
4. *Ibid.*, para. 88.
5. *Ibid.*, para. 15.

list of names of persons it believed should be deleted from the Register, but the Council had decided on a legal pretext that it could do nothing.[1]

The main problem with the Act lay in its obsessive concern with specific titles to be reserved for the use of registered practitioners which left a whole host of related designations open to abuse. The unscrupulous were not slow to seize the opportunity. Advertisements and placards referred to "Dental Specialist", "Experts in the Science of Teeth Treatment", "One of the Greatest Experts in Crown, Bridge and Bar Work", "Dental Specialist of Anglo-American Reputation", amongst others.[2] The British Dental Association undertook considerable litigation in an effort to reduce the scope of unregistered practice and in one important decision in *Brown v Barnes*, the Court of Appeal found in their favour. However the apparent victory was short-lived by the judgement of the House of Lords in *Bellerby v Beyworth* which effectively reversed the Court of Appeal's decision. The substance of their opinion was that,

> 'The words "specially qualified to practise dentistry" in Section 3 of the Dentists Act, 1878, import a professional qualification entitling the holder to registration under the Act, and not merely professional skill or competence. There is nothing in the Act which prevents any man from doing dentists work and informing the public that he does such work without being registered under the Act'.[3]

More than anything else it was probably this decision that led to the appointment of the Departmental Committee in 1917 which, in its Report described the judgement as

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1. Bennett, 'The British Dental Association', p. 568.

2. From evidence of British Dental Association to the Departmental Committee. *Report*, p. 12.

3. Harper, *Legal Decisions Upon the Medical and Dental Acts*, cited in *ibid.*, p. 6.

> 'the Charter of the unregistered dental practitioner; in effect it seems to bring within the lawful occupation of any man the practice of dentistry provided he does not use the description of "dentist" or "dental practitioner" or any name, title, etc., implying that he is registered under the Dentists Act.'[1]

The cause of the unregistered practitioners had been promoted by the Society of Extractors and Adaptors of Teeth which had been founded in 1893 and which, following the judgement in *Bellerby v Heyworth*, changed its name to the Incorporated Dental Society in 1911. The members of this Society, who were required to pass an exam to be eligible for membership, probably represented the more skilled and conscientious of the ranks of the unregistered which also included, according to the Departmental Committee, 'the insurance or sewing machine canvassers, the butcher and the blacksmith'.[2] But most prominent in this area of practice were the vast numbers of dental companies, frequently operating under the title of 'Hygienic Institutes', who employed untrained men to canvass for business from house to house and who charged fees as high if not higher than the qualified dentists. The Departmental Committee was under few illusions about this type of practice and reported that they were 'of the opinion that gross abuses have been associated with the practice of dentistry in Incorporated Companies; that these abuses are of the nature of both malpraxis and of fraud and that an alteration of the law is needed to remedy them.'[3] Numerous instances of litigation involving such companies were included in the Committee's Report and one example is given to provide some indication of the extent of the abuses involved.

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1. *Ibid.*
2. *Ibid.*, para. 15
3. *Ibid.*, para. 21.

> '*Case No. 2* "Durham County Court. £56 damages with costs awarded to Mrs Knaggs against Bishop Auckland Hygienic Institute. The doctor's evidence stated that part of the jaw was literally torn away; the woman seemed to be suffering from cocaine poisoning and from slight lockjaw; bleeding continued for five or six days. 'He had never seen a mouth in such a condition in his life; it was torn to pieces. There was a compound fracture of the jaw'".'[1]

It was against this kind of background that the Inter Departmental Committee, under Mr (later Sir) Francis Acland, was appointed. On the face of it the Committee seemed an unlikely forum for a reasonably wide presentation of the problems of dental practice but, in choosing to interpret its references quite broadly, the Committee was drawn into a more comprehensive analysis than perhaps its appointers had intended.

This was largely a product of the fact that as the Committee pursued the purposes central to its reference, it felt bound to consider the consequences of any recommendations it might make and in seeking to mitigate the present position in which 'owing to the shortage of dentists registered dentists practise in localities which are determined more by the social status of the inhabitants and the fees which it is possible to earn than by the need of the people for dental treatment',[2] the Committee found itself in something of a dilemma. They believed that without reform this situation would only be exacerbated and that the

> 'number of dentists entering the profession is only likely to suffice for the services of the rich and the comparatively well to-do. The working classes will have to rely on the unregistered practitioner, and will continue to suffer all the evils associated with his class of practice.'[3]

But on the other hand if the unregistered practitioners were debarred,

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1. *Ibid.*, para. 17.
2. *Ibid.*, para 89.
3. *Ibid.*, para. 94.

few services if any would be available to the poor. The Committee believed that it was necessary to bring the services of the qualified practitioner within reach of the whole population and hence it advocated both measures designed to increase the number of practitioners (by way of shortening the length of the curriculum, reducing fees at dental schools and increasing the number of available scholarships)[1] and to increase the public provision of services:

> '[S]imultaneously with the enforcement of prohibition of unqualified practice, the nucleus of a public dental service should be set up in populous areas for the treatment of dental disease, and that dental treatment by such a service should be available to persons needing it free of charge.'[2]

So what in fact began as an enquiry into "the extent and gravity of the evils of dental practice by persons not qualified under the Dentists Act" concluded by recommending that:

> 'in our opinion, the State cannot afford to allow the health of the workers of the nation to be continuously undermined by dental neglect. Steps should be taken without delay to recognise dentistry as one of the chief, if not the chief means for preventing ill-health, and every possible means should be employed for enlightening the public as to the need for conservative treatment of diseased teeth. The dental profession should be regarded as one of the out-posts of preventive medicine, and as such encouraged and assisted by the State. Treatment should be rendered available for all needing it. The present anomalous position in which an uneducated, untrained person can practise as a dentist, performing surgical operations on the teeth and jaws, doing untold damage and casting undeserved odium and dishonour on a scientific profession is intolerable, and should be dealt with immediately'.[3]

The Committee perceived State action to be the only possible solution to the problems it had identified and as such was the fore-runner of many of the inter-war reports on related subjects. Problems

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1. *Ibid.*, paras. 156, 216-220, 225.

2. *Ibid.*, para. 142.

3. *Ibid.*, 'Conclusion', p. 56.

of inequality of access were seen to be amenable to instrumental solution while the moral obligation to act, in face of the evidence presented, was taken as axiomatic. In the event, with a weather eye to the economy and with less conviction about the social necessity, the government took little heed of the recommendations about public supply, so that the *Dentists Act* of 1921 was almost wholly concerned with the government of the profession. A Dental Board was set up under the aegis of the General Medical Council and for the first time the dentists were given a substantial voice in the running of their profession. But the move was not overwhelmingly supported by the dentists of whom many agreed with the desire to stop unregistered practice but opposed the arrangements to admit certain unqualified men to the Register. These last practitioners became known as the "Dentists 1921" and it was to be almost thirty years (by which time due to natural wastage their number as a proportion of the registered dentists had greatly diminished) before significant assimilation with the remainder of the profession took place.

But if the legislative outcome of the Committee's report concentrated on the government of the profession, its deliberations and the subsequent Parliamentary debate provide an excellent window on the issues facing dentistry at the time. The 1921 Act which sanctioned the Dental Board gave the dental profession a coherence that it would otherwise not have been able to effect at this time. The legislation, which received strong support from within the recently formed Ministry of Health,[1] bestowed upon the profession a status that neither its overall reputation nor its internal organisation really merited. Ultimate control still lay with the General Medical Council, but greater

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1. See Bennett, 'The British Dental Association', p. 576.

independence than this had been sought by none of the major witnesses to the Committee. The submission by the BDA is instructive in this regard. It supported the recommended solution on grounds of both merit and expediency: that close affiliation with the medical profession would be beneficial to the dental profession and that it was thought unlikely that a nascent Dental Council would be granted powers on a scale comparable with those of the GMC.[1] Only one witness, Sydney Webb, challenged the desirability of the move to give the profession both a legal monopoly over the right to practise and self government, but other than recording his comments in their report there is no evidence that the Committee took cognisance of them. In his memorandum to the Committee Webb had argued that:

> '... if it is proposed actually to give a legal monopoly to the registered practitioners, it is plain that these practitioners cannot possibly be entrusted with the fixing of the conditions of entry into their own monopoly - cannot therefore be allowed to dictate the educational requirements or the length and expense of the professional training - cannot even be permitted to decide what is or is not within the etiquette of the profession, still less what unprofessional conduct shall condemn one of their number to be removed from the register.'[2]

Instead he recommended control of the dental profession by a Minister responsible to Parliament and assisted by advisory councils including representatives of public interests as well as members of the profession.[3]

But although the profession's "external" status had been immediately enhanced in this way, the same cannot be said for its internal strife. For while the legislation excluded unregistered

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1. *Report of the Departmental Committee on the Dentists Act*, para. 174.

2. *Ibid.*, para. 178.

3. *Ibid.*, para. 178.

practice and created a legal monopoly, there was still considerable disagreement over the extent to which those without formal qualifications, but already practising, should be admitted to the Register. In the end the legislation included specific regulations on the subject but even these could not bridge the gap that had come to exist between the "dentists 1921" and the qualified men. The dental organisations came to reflect these divisions. The British Dental Association, after some internal disputation,[1] decided to exclude the "dentists 1921" and confine membership to those with a university or medical corporation qualification. The Incorporated Dental Society which had grown to champion the cause of the unqualified took its membership from this strata while the Public Dental Service Association, which was the largest of the three, represented the "panel" dentists operating under the National Health Insurance scheme, and consisted of both those with and without qualifications. It was not until 1949 that the three associations were combined.

A further measure of the depth of disagreement inherent in the profession can be gauged from a speech made almost ten years after the passage of the Act by Sir Norman Bennett who, as a witness to the Departmental Committee, appears to have been instrumental in persuading it to recommend the registration of the unqualified. In his Presidential Address in 1930 he nevertheless noted that:

> 'professional education is expensive, and for this and other social reasons it is right and natural that the professionally qualified dental surgeon should expect to enjoy a higher scale of living than those who have not equipped themselves so thoroughly. *Ceteris paribus*, he should be the better man'.[2]

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1. See Carr Saunders, *The Professions*, p. 116.

2. Bennett, 'The British Dental Association', p. 581.

But while it is not possible to say that the Act removed the internal strife of the profession it is perhaps reasonable to argue that it prejudiced its eventual outcome. For although the proposed legislation brought opposition from within the ranks of the British Dental Association, it is fair to say that in the main it represented the measures sought by the leaders of that body. The requirement for all future dentists to be qualified along with the Association's stress on qualifications as a prerequisite for membership clearly meant that over time its position would be strengthened, but more immediately the negotiations between the government and the interested parties greatly enhanced the position of the British Dental Association. Both the Association and the government were advocating a very similar position and the Bill came to be defended in the House in terms of the compromises the profession was having to make. 'The Bill has been supported by the British Dental Association in a most self-sacrificing and generous way',[1] declared Major Molson, who went on to note how the 'Association most generously, as I consider, gave way and did not oppose the Amendments of the Labour Party ...'[2] Sir Norman Bennett in the speech already referred to, spoke of how 'recognition of the Association as an authoritative body had matured',[3] and earlier the *British Dental Journal* had claimed that

> 'the Association occupies to-day in the eyes of government departments and officials a position as the body representing professional interests and as the body to appeal to for assistance or advice on dental matters in the interests of the public that it did not approach ten years ago.'[4]

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1. 141 H.C. DEB. 5s., Col. 178.
2. *Ibid.*, col. 179.
3. Bennett, 'The British Dental Association', p. 576.
4. 'Editorial', *British Dental Journal*, 46 (1925), p. 929 cited in Carr Saunders, *The Professions*, p. 117.

The editor of the *Journal* had expressed both gratitude and surprise at the ease with which the Bill had been passed through Parliament: 'a measure which ... [if introduced] only a few years before ... would have been generally resented and probably violently resisted, as a gross violation of the liberty of the subject'.[1] A number of hypotheses could be advanced in an effort to explain this change in attitude, but here it should just be noted how by public legislative fiat the condition of dentistry was considerably altered. The profession gained both a status and a legitimacy before denied it and the British Dental Association moved towards centre stage as the major spokesman for a profession now granted a monopoly over the supply of services.

The other area of interest concerns the efficacy of using the public supply of services as a means of improving the dental health of the nation. The matter was raised in the Parliamentary debate on the Bill although the latter made no provision for such a service. Replying to Colonel Wedgwood who had pointed out the discrepancy between the Departmental Committee's report and the intended legislation,[2] the Minister of Health (Sir Alfred Mond) declared himself 'not altogether opposed to that view', [of the utility of public provision] but found that 'the times are not propitious for carrying it out'.[3]

The Committee had supported the provision of a public dental service on at least two grounds: first as a means of making the services of qualified practitioners available to the whole population and second because it was felt that there was a close connection between

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1. 'Editorial', *British Dental Journal*, 48, 5 (1927), p. 275.
2. 141 H.C. DEB. 5s., Col. 166.
3. 141 H.C. DEB. 5s., Col. 177.

dental disease and the incidence of other and more serious illnesses. Thus advocacy of such a scheme presumed connections of both a distributive and a medical nature.

The Committee's recommendation of a public supply of services was perhaps motivated as much by a desire to solve the thorny problem of unregulated practice as it was to make a positive contribution to the state of the public health, and this emphasis is reflected in their commentary. For although questions of distribution and unequal access informed their advocacy of an end to unregulated practice, such considerations were absent when the argument moved to the logical consequences of this (the public supply of services) where the adult population was treated as an undifferentiated whole. In other words while the condition of the teeth of the poorer classes was a stimulus for the recommended reforms, the measures advocated assumed both the willingness of all sections of the population to utilise a public service and their capacity to derive long-term benefits from it. There seems to have been a general, though unstated, belief that the financial barrier was the main disincentive to attendance for treatment. Break this nexus and problems such as the maldistribution of practitioners would be solved by a more even demand for service across the country.

But an even greater assumption was made in respect of the motivation for concentrating attention on the young as a form of social investment. The Report noted how the professional witnesses had

> 'in the main agreed that although an adequate school dental service would require in the present an increased supply of dentists, nevertheless, owing to the improved condition of the teeth of the people which would result, the necessity for dental treatment in later years would be diminished.'[1]

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1. *Report of the Departmental Committee on the Dentists' Act*, para. 139.

Only two people seem to have dissented from this view: Dr Jenkins the Medical Officer of Health for Rhondda who argued that children fitted with artificial teeth require much less attention in later life than those whose natural teeth have been preserved through childhood,[1] and Sydney Webb who doubted whether an emphasis on treating the young would produce any overall saving. In his evidence he stated that:

> 'I do not think that you can regard as a net saving of dentistry the lessened need that you may possibly make by conservative dentistry up to 18, because, against that you have to put the higher standard that will be required, and you will want a great many more dentists.'[2]

But again Webb's contribution made little impact and the Report's implicit conclusion was that if the resources (particularly more dentists and a greater public financial commitment) were forthcoming then the dental health of the nation as a whole would be significantly improved. In the face of such an attractive prospect Webb's argument received little support, especially when a more positive role for the state was coming to be seen as the norm.

Assumptions about the capacity for distribution and utilization of dental health services received support from the relationship that was seen between dental well-being and overall general health. A succession of witnesses gave evidence to the Committee on the connection between dental disease and, for example, anaemia, gastric problems, tonsilitis and rheumatism.[3] The Representative of the London Insurance Committee reported that 'I am directed to state that there is a definite relation between "un-cared for" mouths and pulmonary

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1. *Ibid.*, para. 139.
2. *Ibid.*
3. *Ibid.*, paras. 53-67.

tuberculosis',[1] while Mr W.C. Anderson, MP suggested that dental disease led to malnutrition (through the inability to eat certain kinds of food) and a general loss of health which was of considerable import to the nation's economy.[2] The Committee largely accepted the evidence brought before it and concluded that:

> '[h]aving regard to the large amount of preventable sickness and chronic invalidity terminating, in many instances, in premature death which results from the effect or oral sepsis and decayed teeth, the Committee view the facts which have been brought to their notice with the gravest concern. They are of the opinion that the state of affairs revealed should receive early attention with a view to the improvement of the health of the nation and an increase in its industrial efficiency'.[3]

Thus the case for instrumental and public action to combat the prevalence of dental disease came to be supported by evidence and argument from a number of sources: as a necessary follow-up to the cessation of unregistered practice; as a way of improving the general health and well-being of the individual; as a measure to promote equality of health care; as a form of investment whereby a relatively small expenditure at the present avoided a much greater bill later on, and as a way of promoting industrial efficiency. But although all these justifications for a public supply of services were offered, none questioned the appropriateness of the action and each assumed that the desired results would be achieved by the measures proposed. In this way the style of the Report was very similar to those on the medical and hospital services discussed in the last chapter.

There are a number of justifications for looking at the work of the Inter-Departmental Committee in such detail and these will be considered before moving to examine the dental arrangements of the

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1. *Ibid.*, para. 59.
2. *Ibid.*, para. 66.
3. *Ibid.*, para. 76.

immediately pre-NHS period. The Report of the Committee was the only official publication, prior to the release of the National Health Service White Paper, to deal exclusively with the question of dentistry and as such it is an important source of information on the arguments, issues and arrangements of the time.

For this thesis, perhaps the most important point relates to the condition of the profession and here a contrast with medicine is instructive. Whereas some of the Royal Colleges had been in existence for centuries and the British Medical Association had represented doctors' interests since 1832, the dental profession was still a divided force in the inter-war years. Some measure of independence had been achieved with the introduction of the Dental Board but nevertheless ultimate control still lay with the medical profession which had itself enjoyed self-government since 1858. The point is stressed for two reasons. Firstly because it will be argued that the incorporation of dentistry within the NHS stimulated a level of professional solidarity and organisation which contrasted markedly with the experience in the period under discussion and which has subsequently inhibited the government's dental health policies. Secondly the close affiliation with medicine, which was emphasised both by the British Dental Association and those presenting evidence on the connections between dental and medical diseases, did little to promote consideration of the specific problems which might face the public provision of dental health services. The Committee showed considerable interest in such a provision, but it appears to have merely assumed that the assumption of public responsibility would overcome the particular barriers to better dental health which it had identified. Dentistry, in the Report of the Committee, was treated as an adjunct of medicine and the problems of the one were assumed to be those of the

other. Little significance was given to peculiarly dental problems and hence in the only official work devoted specifically to dentistry, its claims to independent consideration, were largely ignored.

This is hardly surprising given the purpose behind the Committee's appointment and its terms of reference, but it is nevertheless of some importance in so far as the National Health Service's organisational arrangements were developed with little consideration of the problems of promoting better dental health. The major reports that influenced the eventual construct were, as has already been shown, preoccupied with medical and hospital concerns, and they gave little space to consideration of dental matters. Yet, as the evidence presented in the remainder of the chapter will demonstrate, information available at the time showed the problems facing the supply of dental services and the promotion of better oral health to be significantly different from those confronting the provision of hospital and medical care.

In looking at the pre-war dental arrangements a major problem is presented by the lack of information on available services. Epidemiology was very much in its infancy so little is known about who visited the dentist and for what reason, while central statistical collection had not yet come to interest itself much in this aspect of health care. Hence the available knowledge about the number of dentists in practice, the whereabouts of such practices and the kind of work done in them is clearly imprecise, yet sufficient information does exist to sustain a fairly comprehensive argument for reform.

The PEP Report of 1937 showed that it was possible to obtain dental treatment from a number of sources.[1] These included:

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1. Political and Economic Planning, *Report on the British Health Services* (London, P.E.P., 1937), pp. 180-184.

- private practitioners
- child welfare and ante-natal clinics
- school medical services
- dental hospitals and out-patient departments of large general hospitals
- Public Assistance Committees
- National Health Insurance Scheme
- some charitable organisations.

But although these types of service existed there was a marked reluctance on the part of the general public to use them. Under the NHI scheme utilisation seems to have included some 5-6% of the population (though of course by no means the whole population was insured) while the use of the other available services probably pushed this figure up to 7-8%.[1] And such evidence as is available about the general dental health of selected groups (mainly entrants to the armed forces) suggests that there was a lot of restorative work to be done. For example in 1934 98% of army recruits and 96.8% of navy recruits were in need of dental treatment, while in the same year an average of 5.1 fillings per recruit were needed to bring each RAF entrant to a position of dental fitness. The PEP Report in fact suggested that dental disease was one of the most frequent causes for the rejection of applicants to the armed services.[2]

The attribution of cause to dental ill-health is a complex issue, but for the purposes of this thesis, a simple division may be made between pathological and political factors. The concern here is primarily with the latter, but of course the two are by no means mutually exclusive. Pathologically dental disease may be identified as

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1. N.D. Richards and L.K. Cohen, *Social Sciences and Dentistry. A Critical Bibliography* (The Hague, Fédération Dentaire Internationale, 1971), pp. 217-218.

2. For these figures see PEP., *Report*, p. 182 and MoH, DoH(S), *Interim Report of the Inter-Departmental Committee on Dentistry* (Cmnd. 6565, London, HMSO, 1944), Appendix B.

a consequence of bacteriological activity, local stress within the masticatory system or systemic factors as a result of other medical diseases, but under certain circumstances political action can be invoked to reduce its incidence. In this context such action may be either preventive or curative, the former including dietary control and the promotion of high standards of oral hygiene, the latter consisting in arrangements for the physical treatment of manifestations of the disease. In more detail the preventive measures can be further divided between those that are the incidental result of developments in other areas (for example by a general improvement in dietary habits[1] as say the result of greater affluence or a reduction in the incidence of certain medical diseases) and those that represent a conscious effort to improve dental well-being (for example oral hygiene instruction or fluoridation).

In this period there is little evidence of dental health education from any source other than the dentist and so for all intents and purposes he remained the centre of effort in the pursuit of dental health by both preventive and curative means. But as attendance rates were extremely low it was unlikely that dental health would be much improved without a significant change in the patterns of attendance. Therefore it is important to understand why people were so reluctant to seek the assistance of a dental practitioner if the problems facing the public supply of services are to be understood. A number of possible reasons have been suggested:

- not enough dentists

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1. For evidence of improved dental health as a result of war-time sugar-reduced diets see R.M. Titmuss, *Problems of Social Policy* (London, HMSO, 1950), p. 526 and Department of Education, Report of the Chief Medical Officer, *The Health of the School Child 1939-1945* (London, HMSO), pp. 49-50.

- maldistribution of dentists
- the element of fear in attending for treatment
- financial constraints
- a general ignorance of the advantages of attendance.

(1) Not Enough Dentists. This is a difficult subject to say anything about in the absence of agreed indices for measuring sufficiency. What is enough? Is it enough in line with present levels of demand or perhaps some future projection of need? A profession which almost by definition encourages a certain scarcity as a guarantee of status is likely to be wary of any rapid increase in its numbers. For example, the *British Dental Journal*[1] noted in 1941 that expansion of the profession 'cannot be expected to take place until its economic condition has been improved by an increase in the actual demand for dental service'. And of course as the dentist remained the only source of both treatment and dental health education, no great improvement in oral hygiene could be expected until the numbers of practitioners had been significantly increased. A compelling problem for any scheme for reform lay in the necessity of breaking this nexus.

(2) Maldistribution of Dentists. Without any form of central direction, and with dentistry available under such a diverse range of schemes, the dentists had come to be distributed in a way largely unrelated to any conception of dental need and generally in line with the capacity of the populace of the region to meet their charges.[2] This meant first that they were concentrated in middle rather than working class areas and second that they favoured areas of high population density at the expense of predominately rural areas. This tended to reinforce the generally low standard of oral health of the

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1. 71.4 (15 August 1941).

2. Richards and Cohen, *Social Sciences and Dentistry*, p. 120ff.

period because the dentist was to be found in areas where the importance of oral hygiene and dental treatment was more likely to be appreciated and was generally absent from areas where dental attention would have to be widely encouraged if significant improvements in standards of health were to be made. But not only was there a geographical maldistribution but by 1942 there were serious anomalies in the age spread of dentists.

TABLE 3.1

AGE DISTRIBUTION OF DENTISTS ON THE REGISTER IN GREAT BRITAIN AT 31 DECEMBER 1942[1]

Age last birthday	Total Dentists on Register: Dentists Acts 1921-23	Others	Total	Percentage
20-24		440	440	2.9
25-29		1,437	1,437	9.4
30-34		1,295	1,295	8.5
35-39		1,205	1,205	7.9
40-44	235	1,242	1,477	9.7
45-49	1,294	1,126	2,420	16.0
50-54	1,386	1,017	2,403	15.8
55-59	935	656	1,591	10.4
60-64	735	608	1,343	8.8
Under 65	4,585	9,026	13,611	89.4
65+	742	839	1,581	10.4
Total:	5,327	9,865	15,192	99.8

From this Table it can be seen that 61.4% of all dentists on the Register were in fact over 45 and that the replacement of those in the older age brackets who could be expected to retire in the near future was only just being maintained by the numbers featured in the lower age

1. Adapted from Appendix A in *Interim Report of the Inter-Departmental Committee on Dentistry*, p. 23.

brackets. In other words the increase in the absolute number of registered practitioners was extremely slow. For example while the Register contained 14,422 names in 1930 this had increased to only 15,032 by 1940 and 15,327 by 1950.[1] The average annual increment in this period was a mere forty five *per annum*. These figures are significant not only because they indicate the massive recruitment that would be necessary if the demand for dental services was increased but also because of the implications they had for the provision of services at the time. There is much evidence to suggest that a dentist's workrate is by no means constant over his working life and that in fact after a 'peak' in his early forties it declines considerably.[2] Therefore the abnormal concentration of dentists in the top age range meant that their overall output was probably less than if they had been more normally distributed.

(3) Fear. This is a problem which still exists today and was surely multiplied in the pre-war period by such factors as the comparative lack of sophistication of anaesthesia and the shortcomings in the techniques of many practitioners who could still, at this stage, practice dentistry without any formal qualification. For example in 1942 over a third of the current practitioners had been registered under the auspices of the 1921 Act.[3] In its Interim Report in 1944 the Teviot Committee noted that apathy in regard to the care of teeth sprang 'mainly from a natural fear of pain and lack of any real

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1. MoH, DoH(S), *Report of the Committee on Recruitment to the Dental Profession* (Cmnd. 9861, London, HMSO, 1956), p. 45.

2. For a brief discussion of this point see *ibid.*, paras. 65-67.

3. *Interim Report of the Inter-Departmental Committee on Dentistry*, Appendix A.

understanding of the importance of dental health'.[1]

(4) Financial Constraints. The possible sources of dental treatment noted above can be divided financially into three types:

- those in which the patient met the entire cost of the treatment
- those in which all or part of the costs were covered by insurance
- those which were rendered by a governmental or charitable organisation either upon payment of at least part of the cost or else on a pauperism basis.

There is considerable evidence to show that compared with the availability of hospital and medical care the number of people entitled under this last provision was relatively small, and that where such treatment was given it almost invariably involved extractions rather than restorative work.[2] The majority of people visiting the dentist did so under the auspices of the NHI scheme but even here there were considerable disincentives to attend. Dental treatment was an "additional" rather than a "statutory" benefit like medical attention, which meant that it was available only to the members of those Societies which met particular requirements laid down by the Auditor-General. In particular these referred to evidence of a disposable surplus after a periodic valuation of assets and liabilities conducted by a Government valuer.[3] The Royal Commission on National Health Insurance estimated in 1926 that some 10.7 million people were entitled to dental benefits out of a total insured population of over 15 million[4] and the PEP Report ten years later put the equivalent

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1. *Ibid.*, para. 57.
2. Eckstein, *The English Health Service*, p. 43.
3. Royal Commission on National Health Insurance, *Report* (Cmnd. 2596, London, HMSO, 1926), p. 39.
4. *Ibid.*, p. 8 and p. 154.

figures as 13 million out of a total insured population of 19 million.[1] But in addition it was usually necessary to have been a Society member for at least two and a half years before qualifying for this benefit and even then the patient was often required to pay up to 50% of the total bill.[2] Furthermore, a percentage of patients was also required to be inspected by the Regional Dental Officer, ostensibly as a move against fraudulent claims, but also as a way of reducing the claims on the Societies' funds. In view of these impediments it is hardly surprising that attendance rates were so low. Financial constraints also affected what was perhaps the most comprehensive of the dental schemes, the School Dental Service. For example in 1938 School Dentists inspected approximately 3.5 million out of a total of 5.0 million elementary school children, finding that some 2.5 million of these required attention. However, treatment was authorised (by the parents) for only 65% of these,[3] with refusals being put down in the main to an unwillingness or incapacity to pay.

(5) No Reason To Go. The Chief Medical Officer of the Ministry of Health wrote in 1933 that

> 'the large bulk of the population, particularly among the industrial classes, is so accustomed to the condition of dental disease in themselves and their neighbours, and so little convinced that these conditions bear any relation to general health that, even if adequate dental services for all classes could be provided immediately, it is unlikely that more than a small percentage of those in need would avail themselves of the opportunity of obtaining dental treatment.'[4]

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1. PEP., *Report*, p. 12 and p. 184.

2. *Ibid.*, p. 184.

3. *Interim Report of the Inter-Departmental Committee on Dentistry*, para. 44.

4. PEP., *Report*, p. 182.

It was believed that for many people pain was the only stimulus for a visit to the dentist at which stage extraction was likely to be the only possible treatment. It appeared well nigh impossible to convince the public that they should spend money on a visit to the dentist (or in the case of the School Dental Service on recommended treatment) when they were in no great degree of personal discomfort.

The cumulative effect of these factors was the low attendance rates already referred to and the high incidence of dental disease. And although there is little evidence on which to order these factors, the Teviot Committee in its *Interim Report* felt able to comment that

> 'broadly, then, the picture is of a number of public dental services not closely correlated and each with its shortcomings, and of a public ill-educated and apathetic in regard to the care of the teeth. This attitude springs, we think, mainly from a natural fear of pain and lack of any real understanding of the importance of dental health. Economic factors must also contribute, but we are inclined to think that they are of less effect in this connection than lack of education.'[1]

Without entering into a debate on this matter it seems reasonable to propose, on the basis of the evidence that was available at the time, that if the dental health of the nation was to be significantly improved, specific political action would have to include means to encourage the much greater attendance at dental surgeries, the more equitable distribution of practitioners and efforts to increase the supply of dentists or paradental personnel to meet this new level of demand.

This conclusion draws heavily on the work of the Royal Commission on National Health Insurance and the PEP Report which, although published eleven years apart, paint a broadly similar and

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1. *Interim Report of the Inter-Departmental Committee on Dentistry*, para. 57.

unsatisfactory picture of the dental health services. In identifying the basic difficulties in attaining an 'adequate and satisfactory dental service',[1] the Teviot Committee which was appointed in April 1943 and which issued its *Interim Report* in November 1944, showed no major dissent from the other two investigations. But it is one thing to find agreement on shortcomings of the present situation and quite another to build a consensus over what should replace it. In this respect the Teviot Committee is interesting because although its *Interim Report* was released to offer the Health Ministers 'some interim guidance as to the general principles on which we think they should be working, so far as the dental aspects of any new health service are concerned',[2] the *Final Report* containing more detailed recommendations appeared only in February 1946, a matter of weeks before the White Paper indicating the Government's full legislative proposals for the NHS was itself published.[3] The impact of the *Final Report* will be considered in chapter five, and here discussion will be confined to the period up to the publication of the first NHS White Paper in 1944.

Although the *Interim Report* was some nine months from publication when the White Paper was issued, it seems reasonable to suppose that after almost a year's work some of its early conclusions would be widely known. But even if this was the case, judging by the content of the *Interim Report*, there would have been little guidance on matters of administration. The Committee advocated the appointment of a chief dental officer to each authority responsible for services,[4] that

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1. *Ibid.*, para. 1.
2. *Ibid.*, para. 5.
3. Cmnd. 6761, London, HMSO, 1946.
4. *Interim Report of the Inter-Departmental Committee on Dentistry*, para. 98.

dentists themselves should be involved in planning,[1] and that the body with whom they were to be in contract should be a dental one.[2] But this apart, their recommendations were characterised by a high level of generality. 'We envisage the idea of a general practitioner service as being broadly analogous in principle and structure to that of a general medical practitioner's service, although the special features and problems of dental practice will also need to be borne in mind.'[3] But what were these special features? The only 'point in principle' in the discussions between the government and the profession to which the Report then refers is that 'any scheme for a comprehensive dental service must have as its foundation the family',[4] and elsewhere they concluded that 'we cannot in present circumstances usefully comment on all the administrative details which will have to be settled.'[5]

In other words the official committee set up to consider and report upon, *inter alia*, 'the progressive steps by which, having regard to the number of practising dentists, provision for an adequate and satisfactory dental service should be made available for the population',[6] found itself unable to comment on the specific problems facing the supply of those services. Clearly the Committee was deliberating during a period of considerable uncertainty, and possibly

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1. *Ibid.*, para. 96.
2. *Ibid.*
3. *Ibid.*, para. 92.
4. *Ibid.*
5. *Ibid.*, para 97.
6. Terms of Reference, *ibid.*, para. 1.

felt that it was heavily bound by the general high level of political support for an universal and comprehensive scheme, but it is nevertheless surprising that it should so readily overlook the particular problems facing the supply of dental services.

In the absence of evidence to the contrary, the White Paper came to treat dentistry as being sufficiently analogous to medicine to be placed on a similar administrative footing in the well known tripartite structure, and although this is perhaps unremarkable in terms of political expediency at the time it is nevertheless significant for the subject matter of this thesis as another indication of the way in which the particular approach to the assumption of public supply tended to consider questions pertaining to administration in isolation from the subject matter that was to be administered. It will be suggested that in terms of the evidence examined in this chapter, the problems of dentistry were rather different from those of the medical and hospital services and that in consequence they were not necessarily amenable to the same "solution". However, before looking at this in more detail brief note must be taken of some of the evidence that supported this close identification on medicine and dentistry.

Two of the three reports considered in the last chapter lent weight to this particular position. The BMA Report declared that

> 'In the view of the medical profession full dental and opthalmic services should, in the interests of national health, be available in the extended service as statutory medical benefits to which all are entitled and which are administered together with other statutory medical benefits'[1]

while the Dawson Committee, twenty years before, had concluded that 'dental treatment therefore, comes into close relation with medical

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1. British Medical Association, *A General Medical Service for the Nation* (London, BMA, 1938), para. 34.

treatment at all periods',[1] and consequently recommended the inclusion of dental facilities in the Primary and Secondary Health Centres which were the centrepieces of remodelled service.[2] The third report, that of the Medical Planning Commission, ignored the question of dental health services altogether.

It is interesting to note that much of this support for the inclusion of dentistry within any national scheme derived not so much from an appreciation of the intrinsic benefits of dental health as the perceived relation of dental to general medical health. For example, a senior official of the Ministry of Health told the Royal Commission in 1926 that

> 'something like three-quarters of the industrial population, probably, are suffering from dental defects of one sort or another, and I think the experience of those Societies that have provided dental treatment as an additional benefit, does give ground for hoping that systematic dental treatment would lead ultimately to a reduction of sickness benefit claims.'[3]

This view was also reflected in the rather basic question of whether dentistry was anything other than one of the many specialities of medicine.[4] Although a Dental Board had been in existence since 1921, it was still, in 1944, effectively only an adjunct of the General Medical Council and the evidence reviewed here adds weight to the argument, or at least to the perception, that dentistry was functionally indistinct from medicine and that in consequence, no peculiar

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1. Consultative Council on Medical and Allied Services, *Interim Report on the Future Provision of Medical and Allied Services* (Cmnd. 693, London, HMSO, 1920), para. 117.

2. *Ibid.*, paras. 116-127.

3. Royal Commission on National Health Insurance, *Evidence* (Brock) Question 23,914. See also *Report*, para. 84.

4. The Consultative Council on Medical and Allied Services had concluded that 'all forms of dental treatment, even when definitely curative, constitute in the strict meaning of the term, a branch of preventive medicine.' *Interim Report*, para. 116.

administrative arrangements should be made. And in the absence of evidence to the contrary, particularly from the Teviot Committee, this view was upheld by the arrangements in the White Paper.

What significance should be attached to this failure to distinguish between the two activities? The distinction is important to this thesis in so far as it is argued that part of the explanation of the failure of the dental health services lies in the inadequacy of the administrative arrangements made to deal with specifically dental problems. The connection between the medical pressures for reform (including both diagnosis and prescription) and the NHS structure has been shown, but a similar link never developed between the problems of the inter-war dental services and the NHS. The relative strengths of the professions and their different capacities to press their cases were factors of obvious importance but at the same time the particular approach adopted to the provision of public supply which made little attempt to distinguish between the types of service being administered also made a significant contribution. The genesis and development of this approach are the subjects of the next chapter but first consideration will be given to the way in which the problems of dentistry and the public supply of dental services might be considered to be different from the medical and hospital services.

The most obvious factor concerned the availability of dental treatment. Much of the pressure for health care reform was premised on the fact that various types of medical treatment were not available where they were needed, whereas for dentistry a much more fundamental problem was whether services would be avilable at all. The number of registered practitioners was clearly inadequate to meet much more than the existing (low) level of demand and hence the need to both provide more services and to ration those that were already

available was a problem not immediately faced in respect of medical and hospital care.

A second point relates to the question of supply and demand. In the case of medicine the demand for services was already well established and attention was focussed instead on the supply of appropriate treatment. Maldistribution and inefficiencies had been among the catch-cries of the reformers and much of the NHS's administrative apparatus was directed to meeting these problems. But with dentistry the problems of demand were much more pressing: clearly the dental health of the nation could not be improved without large-scale improvements in attendance rates which depended as much on the capacity to get more people into the dental surgeries as it did on the need to increase the availability of services.

The third factor involved the question of co-ordination. Again the need for co-ordination had been an important stimulus for reform and the arrangements of the NHS came to mirror this concern. The immediate objectives in respect of medicine were easy to identify: economies of scale, specialisation, more equal distribution of specialists and other factors that were discussed in the last chapter. But in regard to dentistry the benefits are perhaps less easy to locate: the use of specialists is very small compared to medicine; dentistry has little use for major institutional facilities; dentistry requires few or no post-operative support and domicillary type services; only in exceptional circumstances is more than one practitioner (other than an anaesthetist) involved in a particular operation and only rarely will the individual practitioner require equipment that he would not normally expect to have in his own surgery. Clearly the provision of dental health services would involve problems of co-ordination (between the different sources of treatment

and to ensure, that in an environment of scarcity, those accorded priority received it) but by and large they involved different considerations to the medical problems mentioned above.

A fourth point concerns the question of curative and preventive approaches to dental health. Preventive approaches in the form of public health legislation and the like had already had a long and notable history in Britain by the inter-war period and the concern of the reports that informed the NHS White Paper was overwhelmingly with the provision of curative services. Both the administrative arrangements and the general philosophical underpinnings (to make *services* available to all) focussed on the curative aspects of health care and gave little room to preventive matters. Yet given the shortage of dental practitioners and the obvious need to educate the community on the benefits of dental care it is debatable whether this was the most appropriate approach to the improvement of dental health.

Clearly there are a number of other points which might also be made to contrast the particular needs of the medical and dental services, but these are perhaps sufficient to indicate that the problems of providing dental health services were significantly different from those of the medical and hospital services which the reports and the White Paper endeavoured to meet. The problems raised by the failure to discriminate between the types of service, and the reluctance to make any special arrangements to meet the particular problems of dentistry will be a constant theme in the remainder of this thesis and the manner in which they were reinforced by the particular approach adopted to public supply will be the subject of the next chapter.

CHAPTER FOUR

POLITICAL AND ADMINISTRATIVE APPROACHES TO PUBLIC SUPPLY

An obvious characteristic of the advocacy of health care reform discussed in the previous two chapters was the level of agreement amongst the various reports on both the problems of the existing services and the goals that should be set. But at the same time there was a great deal taken for granted in considering the means by which these goals might be achieved. References to concepts such as co-ordination, resources and authority were spread liberally through the prose, yet nowhere were they substantially discussed. They came to be taken for granted and their efficacy, in relation to the instrumental purposes of health care reform, was merely assumed. They were regarded as essentially neutral components in an approach that was perceived in overwhelmingly rational terms. It was presumed that co-ordination *would* reduce overlap; that the expenditure of public funds *could* create a national service of health provision; that the provision of such health care facilities *would* reduce the incidence of ill-health; that an organisation *could* be developed to supply health services to such a large clientele and that doctors, dentists and other health care workers *could* be accommodated satisfactorily within the bureaucratic structures suggested. It is of course a point at issue in this thesis whether the particular prescription was appropriate to dentistry at all, but this question must be submerged for the moment beneath a more general consideration of the issues involved in this particular approach to the public supply of health care services.

It will be argued that in fact very little thought was given to these matters by the advocates of an extension to the public supply of welfare services and that the seemingly inexorable movement towards such provision was not accompanied by any systematic consideration of the consequences of the trend. Such analyses as were

made tended to be fairly mechanistic and concerned with intra-organisational questions at the expense of any study of the external and more political consequences that the assumption of public responsibility would involve. The attractions of the pursuit of the instrumental purpose generally blinded those involved to any other ramifications, and thus it is suggested that even those most closely involved in the political and administrative processes came to the NHS with little more understanding of the wider implications of their intended actions than had the advocates of medical and dental reform whose work has already been considered.

That this was the case, was largely the result of the dominance of a particular set of ideas about the role of the state and its administrative apparatus which had emerged by 1944. This chapter looks at the development of these ideas, especially within the labour movement, in an attempt to understand the particular approach adopted to the assumption of public responsibility for the dental health services. As it is a central proposition of the thesis that the character of this approach has been significant in limiting possible policy achievement, obvious importance is attached to the way in which it became established.

In the period up to the introduction of the NHS it is possible to identify four main positions on the role of the state, and more particularly its bureaucratic apparatus, in the promotion of socialist goals. The first was that associated with the Fabians and their endorsement of efficiency and the proper use of elites and expertise.

The "inevitability of gradualness" is a phrase most frequently associated with their approach which stressed the need for caution and for significant support from the electorate before reform was undertaken. In the transition to socialism the state and its administrators

were to act as the midwife superintending the birth of a new society, having been cast in this role by a democratically elected and socialist majority in the House of Commons. The Fabians' confidence in the amenability of the state apparatus to democratic control was considerable and Bernard Shaw's well known remarks in his essay 'The Impossibilities of Anarchism' remain the best expression of this belief. 'Fortunately' he wrote,

> 'there is, as we have seen, a fine impartiality about the policemen and the soldier, who are the cutting edge of the State power. They take their wages and obey their orders without asking questions. If those orders are to demolish the homestead of every peasant who refuses to take the bread out of his children's mouths in order that his landlord may have money to spend as an idle gentleman in London, the soldier obeys. But if his orders were to help the police to pitch his lordship into Holloway Gaol until he had paid an Income Tax of twenty shillings on every pound of his unearned income, the soldier would do that with equal devotion to duty, and perhaps with a certain private zest that might be lacking in the other case. Now these orders come ultimately from the State - meaning, in this country, the House of Commons.'[1]

The predominance of this view, which implied the need for little change to the existing arrangements to achieve socialist goals, has led one modern historian of the Labour Party to conclude that

> 'bourgeois rationalism became socialist rationalism chiefly through the substitution of the State for the magic forces of the *laissez faire* capitalist market: the former was seen as bringing about "the greatest happiness of the greatest number" almost as automatically as the latter had been.'[2]

With this particular role and importance for the State the contribution of its servants was to be crucial. And for the most part the Fabians had little fear that they would be found wanting. 'It has

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1. G.B. Shaw, *Essays in Fabian Socialism* (London, Constable, 1932), p. 99.

2. T. Nairn, 'The Nature of the Labour Party' in P. Anderson (ed.), *Towards Socialism* (London, Fontana, 1965), p. 165.

been the supreme good fortune of Great Britain', wrote the Webbs in 1930, 'that she has, during the past century, developed a Civil Service of exceptional capacity and integrity',[1] and elsewhere their contemporaries did little but echo these sentiments. 'Make the passing of a sufficient examination an indispensable preliminary to entering the executive', argued Shaw, 'make the executive responsible to the government and the government responsible to the people; and the State departments will be provided with all the guarantees for integrity and efficiency that private money-hunting pretends to'.[2] But of course the basic Fabian position offered little scope for anything but praise for the bureaucracy which was, after all, to be largely responsible for the expert administration of the reformed capitalist system. Beatrice Webb wrote of the need for 'a dedicated order, something resembling the Society of Jesus, which would exact a high standard of training, discipline and self-control among its membership, and which would furnish, therefore a leadership of the *élite* to guide the mass of citizens to a Socialist state'.[3] Elsewhere she noted that the new society would be created by an eternal 'elite of unassuming experts ... exercising the power inherent in superior knowledge and longer administrative experience'.[4] Shaw writing under the evocative title of 'Socialism and Superior Brains' declared that 'it is not for nothing that highly educated and cultivated men go into

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1. B. and S. Webb, *A Constitution for the Socialist Commonwealth of Great Britain* (London, Longmans, 1920), p. 67.

2. G.B. Shaw, *Essays in Fabian Socialism* (First edition 1889, London, Constable, 1932), p. 42.

3. Cited in R. Barker, *Political Ideas in Modern Britain* (London, Methuen, 1978), p. 32.

4. Cited in Nairn, 'The Nature of the Labour Party', p. 165.

that part of socialism which already exists, the Civil Service',[1] and later that '[t]hat great joint-stock company of the future, the Social Democratic state, will have its chairman and directors as surely as its ships will have captains'.[2] These are but two examples of what one recent commentator has described as the

> 'development of elitist arguments within the structure of the popular democratic state, in the form of advocacy of elites of experts of one kind or another ... For Shaw it was either the new technician in the form of 'Enery Straker, or the new industrialist in the form of Andrew Undershaft. Wells had his samurai, and even Kipling's empire had its engineers and pioneers.'[3]

The Fabian approach to socialism thus focussed on the need for the central direction and control of industry and the economy and specifically denied the claims of some workers for increased autonomy at the shop floor level and for any major change in the individual's relationship to the form of production. Almost all of the reforming zeal was aimed at the mechanisms of distribution and their revision, on the basis of carefully collected and processed information, along more equitable lines. Thus the problems which might be posed by bureaucracy and bureaucratization were inherent in the Fabian conception of socialism. Yet, with few exceptions, such questions largely escaped notice as the part to be played by the bureaucracy came to be taken for granted.

A second view of the state and bureaucracy can be found in the writings of Ramsay MacDonald. MacDonald shared with Marx a belief in the historical inevitability of socialism, but he was generally anxious in most other respects to deny the premises of the Marxian arguments:

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1. Shaw, *Essays in Fabian Socialism*, p. 272.
2. *Ibid.*, p. 279.
3. Barker, *Political Ideas in Modern Britain*, p. 125.

in particular the class basis of the State. 'The State does not die out' he wrote in *Socialism and Government*, 'the State cannot die out ... the State expresses, not the will of the predominant interest, but the will of the general community ... [t]he State is, therefore, not the instrument of a class but an organ of society'.[1]

In countering the Marxian position, MacDonald was drawn to consider the State as a neutral body, which he defined to include Parliament, the Civil Service, the municipal authorities and such other executive bodies as had been properly organised.[2] Like the Fabians MacDonald perceived the aspirations of socialism wholly within the confines of the parliamentary system where a majority within the House of Commons would provide both control of the organs of the State and a capacity to effect wholesale social change. '[T]he modern State', he wrote as early as 1909, 'in most civilised communities is democratic, and in spite of remaining anomalies and imperfections, if the mass of ordinary people are agreed upon any policy neither electors, privileged peers nor reigning houses could stand in their way'.[3]

MacDonald believed this to be not only necessary but clearly possible and in stressing this view of the State he was also drawn to a similar conclusion about one of its major constituent parts, the bureaucracy. 'The permanent officials obey their Minister; he obeys public opinion',[4] he wrote in *Socialism and Government*, and elsewhere

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1. J.R. MacDonald, *Socialism and Government* (London, Independent Labour Party, 1909), ii, 115-117.

2. J.R. MacDonald, *Socialism: Critical and Constructive* (London, Cassell, 1921), pp. 241-2.

3. Cited in R. Miliband, *Parliamentary Socialism* (London, Merlin Press, 1972), p. 19.

4. MacDonald, *Socialism and Government*, ii, 34.

in the same work, 'Whitehall is the only instrument for giving effect to the decrees of the State'.[1] Pressure to consider the work of the bureaucracy came primarily from influences within the socialist movement which he perceived were making for anarchism rather than socialism and 'for political ineptitude rather than for administrative efficiency'.[2]

On the whole it was completely out of character for MacDonald to advocate 'administrative efficiency', but his hand was forced by the need to strengthen the position of himself and his supporters within the nascent labour movement. Evidence that it was out of character is provided throughout MacDonald's writings where socialism and the State were generally seen in much less precise terms. Time and again he emphasised that socialism was a matter of belief or opinion whose catalyst was to be a general education of the public rather than state action.[3]

But although he stressed the importance of education and the psychological aspects of socialism, MacDonald did find some place for the positive state. State socialism[4] (by which he understood 'the direct control of industry by the political organ working through a bureaucratic Civil Service')[5] represented for MacDonald an extremely rudimentary form of socialism which would quickly demonstrate that '[i]ndustrial transformation cannot be made by legislative action or Civil Service interference alone; it must also take place within the

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1. *Ibid.*, i, 4.
2. *Ibid.*, i, xxix-xxx.
3. For example see article in *Forward*, 16 April 1927, cited in D. Marquand, *Ramsay MacDonald* (London, Jonathon Cape, 1972), p. 458.
4. See J.R. MacDonald, *Syndicalism* (London, Constable, 1912), pp. 68-9.
5. MacDonald, *Socialism: Critical and Constructive*, p. 242.

workshops themselves ...'[1] Under such circumstances, where state socialism represented only an early and transitional phase in the inevitable progression towards socialism, there was no compelling need to set out in precise detail the necessary bureaucratic reforms. The utopian socialist must have his blueprint

> 'because his New Harmony was supposed to work straight away like a patented invention ... [but the modern socialist] ... approaches socialism as Hannibal crossed the Alps, and all he has to prove is that his theory is rational, that it is justified by modern tendencies which have not yet worked themselves out, that its criticisms on the existing condition of things are accurate and open out a practical way of social development. He can quite properly argue that the details must be settled by experience - the experimental method - and that it is vain to construct a complete social fabric theoretically, when the various elements which must enter into it will have to be made, tested and valued by the knowledge that will be gained whilst it is being built.'[2]

But of course adherence to this general approach further reinforced MacDonald's understanding of the bureaucracy as an essentially neutral and malleable tool. He presumed that the bureaucrats would be willing participants in these experimental phases of government and that they would accept the results. To this extent MacDonald stressed the importance of gaining the confidence of the Civil Service and was drawn to oppose almost every scheme of reform which might have challenged their established position.[3]

This did not mean that MacDonald ignored questions of administrative reform and in *Socialism, Critical and Constructive* he addressed himself directly to the task.[4] But in keeping with his

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1. *Ibid.*, pp. 72-3. See also pp. 242-3.
2. J.R. MacDonald, *The Socialist Movement* (London, Williams and Norgate, 1911), pp. 170-1.
3. For example see Marquand, *Ramsay MacDonald*, p. 417.
4. See chapter six 'Political Construction'.

general position the discussion became centred on Parliament and what he called adapting 'the machinery of political government and administration to a representation of millions instead of thousands'.[1] In opposition to Marx, MacDonald saw 'Labour's quarrel with capitalism [as being] not in the sphere of production but in that of distribution',[2] and believed that the problems of the latter could be solved by securing Labour control of the House of Commons.[3] And although he saw the importance of public ownership to socialism his general view was that 'The State as Lady Bountiful may be a fatal extension of Toryism but it is not the beginning of Socialism'.[4] With this in mind his latest biographer finds it completely in character that 'although he had no strategy for using power, he had an extremely clear strategy for gaining it'.[5]

In sum, MacDonald's approach to socialism gave little priority to matters of administration. Socialism was primarily associated with education and MacDonald was drawn to consider the question of bureaucracy only in response to pressure from his opponents. Under such challenge he largely fell back on the traditional Fabian perception of the bureaucracy as the instrumental tool of government.

The third position which became especially prominent immediately after the First World War represents something of a halfway house between the other two: it accepted the need for a strategy of

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1. MacDonald, *Socialism: Critical and Constructive*, p. 229.

2. J.R. MacDonald, *Socialism* (London, T.C. and E.C. Jack, 1907), cited in B. Barker, *Ramsay MacDonald's Political Writings* (London, Allen Lane, 1972), p. 41.

3. *Ibid.*, p. 31.

4. Diary 17 December 1929 cited in Marquand, *Ramsay MacDonald*, p. 525.

5. *Ibid.*, p. 289.

organisation, yet rejected the premises of the Fabian approach. It accepted something of the MacDonald belief that socialism must come from below, yet stressed the importance of production rather than distribution. Guild Socialism appeared in a number of guises, but in so far as the position on bureaucracy was concerned, there was a fair degree of consensus. Founded on the beliefs that the individual worker should have greater control over the industry of which he was part and that mere geography was an inadequate basis for representation in the legislature, the movement rejected the image of the benign state run by expert officials. 'The State', wrote G.D.H. Cole, 'cannot in the long run, be better than the citizens, and unless the citizens are capable of controlling the government, extension of the powers of the State may be merely a transference of authority from the capitalist to the bureaucrat.'[1] Thus the Fabian position was rejected because it rested on the assumption 'that the State was economically a better capitalist than the private employer', and that it simply extended 'the wage system of the civil service'.[2] Elsewhere Cole wrote that '[n]o doubt the ultimate power must reside in the democratic state; but it does not follow that the state should do all the work.'[3]

Thus the Guildsmen believed that the individual should be regarded as a producer rather than a consumer and that as goods produced within a society are so diverse, each group should have its own association, and that the State should be but one of many organisations in the community. 'The State', wrote Cole,

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1. Quoted in G.T. Glass, *The Responsible Society* (London, Longmans, 1966), p. 37.

2. S.G. Hobson cited in Barker, *Political Ideas in Modern Britain*, p. 99.

3. Cole cited in *ibid.*, p. 101.

> 'is not equally qualified in these matters which affect men differently according as they are miners or railwaymen, Catholics or Protestants ... [and in] all this diversity of human association, the State can claim an important place, but not a solitary grandeur'.[1]

The Guild Socialists stress on the importance of variety, and a pluralistic approach to socialism attracted the support, or at least the approval, of many who would disavow the guild label. The Webbs' *Socialist Commonwealth* owed something to Cole and in other ways the writings of Bertrand Russell, Hilaire Belloc and G.K. Chesterton shared the Guild Socialist's distrust of the power of the State and stressed the need for other and smaller organisational forms. A notable passage in R.H. Tawney's *The Acquisitive Society*, published in 1921, takes the form of a plea that organisation in the public sphere be adapted to the particular requirements of the industry rather than be based on a single, dogmatic set of principles. 'The merits of nationalisation', he declared,

> 'do not stand or fall with the efficiency or inefficiency of existing state departments as administrators of industry. For nationalization, which means public ownership, does not involve placing industry under the machinery of the political state, with its civil servants controlled, or nominally controlled, by Cabinet Ministers, and is compatible with several different types of management. The constitution of the industry may be "unitary", as is (for example) that of the post office. Or it may be "federal" as was that designed by Mr Justice Sankey for the coal industry. Administration may be centralised or decentralised. The authorities to whom it is entrusted may be composed of representatives of professional associations, or of state officials, or of all three in several different proportions. Executive work may be placed in the hands of civil servants, trained, recruited, and promoted as in the existing state departments, or a new service may be created with a procedure and standards of its own. The industry may be subject to Treasury control, or it may be financially autonomous. The problem is, in fact, of a familiar, though difficult order. It is one of constitution making.'[2]

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1. Cited in M. Beer, *A History of British Socialism* (London, G. Bell and Sons, 1929), ii, p. 370.

2. R.H. Tawney, *The Acquisitive Society* (First ed. 1929, London, Fontana, 1962), pp. 114-115.

But by the early 1930s Tawney was just one of many commentators who had foresaken this essentially experimental approach to socialism in favour of a much more rigourously laid down campaign of action.[1]

The approach to which Tawney and many others were attracted represents the fourth view of the state and bureaucracy. It draws from the other three but was influenced primarily by the experiences of the Labour Governments of 1924 and 1929-31. It reflects an attempt to absorb the lessons of the Party's first occupancy of the Treasury benches and placed great stress on the need to plan the activities of future Labour governments. In so far as this became the dominant position in the 1930s it is clearly the most important for this thesis.

'The gravest weakness of British Labour' Tawney wrote in 1932,

> 'is its lack of creed. The Labour Party is hesitant in action, because it is divided in mind. It does not achieve what it could, because it does not know what it wants ... Being without clear convictions as to its own meaning and purpose, it is deprived of the dynamic which only convictions supply ... it has no stable standard of political values, such as would teach it to discriminate between the relative urgencies of different objectives.'[2]

Tawney's analysis constitutes something of an indictment of the three approaches, including the one to which he himself had subscribed and it was the first of a number of contributions which led to the development of a dominant approach to the problems faced by the Labour Party in government. If Tawney related the practical issues to a general analysis of the Party's weaknesses, others mirrored his analysis with reference to the experiences of 1924 and 1929-31. Clement Attlee writing in 1936 noted that the 'greatest success was scored in foreign affairs of which I treat elsewhere. The reasons for this was that only

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1. See especially R.H. Tawney, 'The Choice Before the Labour Party', *Political Quarterly*, III (1932).

2. *Ibid.*, p. 327 and p. 329.

in this sphere had policy been clearly worked out ...'[1] Later Herbert Morrison spoke of the two Governments evolving

> 'their legislative and administrative activities too much on an "as and when" and "catch as catch can" basis ... [and that the] reason for this lack of organisation of the legislative programme, which in itself was a sign of administrative incompetence, was that there was lacking that overall conception of national need ...'[2]

Robert Skidelsky, after examining the performance of the 1929-31 Government, concluded that

> '[i]n short, there was no practical socialist economic policy, no theory of how to use Parliament for furthering socialist aims. Socialism explained the past and promised the future: it had nothing constructive to offer the present.'[3]

From this concern with the failures of the past grew the approach to government which was to be dominant in the future, although not before considerable opposition had been overcome. The events of 1931 not only divided the Labour movement between those within and those without the National Government but also to a point between those whose analysis portended extra-constitutional resistance to future Labour governments and those who took a more moderate line and for whom the techniques of planning and organisation were to be the road to salvation. The two positions have been ably portrayed by Roy Jenkins: on the one hand the experiences of 1931

> 'led Sir Stafford Cripps to announce that "the one thing that is not inevitable now is gradualness", and ... It led the Webbs enthusiastically to discover Soviet Russia in their old age. It led Professor Harold Laski to super-impose a thick layer of Marxism upon his neo-Benthamine thought ... It led to the great popularity and influence of the theoretical writings of Mr John Strachey. And it

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1. C. Attlee, *The Labour Party in Perspective and Twelve Years Later* (London, Collancz, 1949), p. 53.

2. H. Morrison, *The Peaceful Revolution* (London, George Allen and Unwin, 1949), p. 37.

3. R. Skidelsky, *Politicians and the Slump* (London, Macmillan, 1967), p. 395.

> led even Mr Attlee to write and say some things which now sound very odd indeed.'[1]

However, on the other hand notes Jenkins:

> 'There is no evidence that Arthur Henderson ever diverged from the moderate, common-sense approach ... Mr Herbert Morrison ... was already developing what can best be described as his imaginatively efficient approach to public ownership ... Mr Hugh Dalton, too ... was in no mood for wild talk or wild plans. "I discount heavily," he wrote, "in this common-sense and politically mature country, all panic talk, whether from right or left, of an 'inevitable crisis', and all theatrical nightmares of violent head-on collisions, wrecking the train of democracy".'[2]

Of particular significance for the Party's position on bureaucracy was the way in which some of the more radical thinkers either left or were excluded and how moderates such as Morrison and Dalton came to dominate. Mosley's resignation, first from the Government and then from the Party, was followed by the disaffiliation of the Independent Labour Party (ILP) in 1932 and the Socialist League in 1937. But to stress the exodus of these people and organisations is not to overestimate their importance: it is merely to emphasise the character of those that remained and whose contributions were to influence post-war behaviour.

The year 1934 marks something of a watershed in their advance: the Party's important policy document, *For Socialism and Peace* was published, reflecting this majority opinion, and at the Annual Conference the Socialist League was heavily defeated.[3] Thereafter followed a series of books which filled out the basic framework -

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1. R. Jenkins, *The Pursuit of Progress* (London, Heinemann, 1953), pp. 58-9.

2. *Ibid.*, p. 59.

3. B. Pimlott, *Labour and the Left in the 1930s* (Cambridge, Cambridge University Press, 1977), ch. 5.

of the 1934 Manifesto. Pimlott refers to Jay's work[1] making 'out the case for those who were primarily concerned about economic management for prosperity rather than the creation of a society based on new social and economic relationships',[2] while for Roy Jenkins *The Socialist Case* marked 'the beginning of the return of self confidence' and Dalton's *Practical Socialism For Great Britain* 'although written in 1934 ... is really the first swallow of the post 1935 summer'.[3]

But on what was this "confidence" based? Presumably on the generation of a gradual consensus within the Party about its future tactics and the possibilities that such tactics anticipated. Central to the approach was a concentration on research and planning, and the focus of this activity was the work of the New Fabian Research Bureau which between its inception in 1931 and 1944 produced a prodigious number of memoranda, pamphlets and reports designed to facilitate the transformation to a socialist society.[4] Yet with the exception of a memorandum entitled *The Civil Service* by N.K. Smellie in 1934[5] and a short article on 'What's Wrong with the Civil Service'[6] in 1942 none of the Bureau's work seems to have been aimed at a direct examination of the behaviour of a bureaucracy whose expansion was

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1. D. Jay, *The Socialist Case* (London, Faber and Faber, 1938).
2. Pimlott, *Labour and the Left in the 1930s*, p. 39.
3. Jenkins, *Pursuit of Progress*, p. 60.
4. See J. Parker, 'The Fabian Society and the New Fabian Research Bureau', in M. Cole (ed.), *The Webbs and their Work* (First published in 1949, Brighton, Harvester Press, 1974), ch. xv.
5. A "completed memoranda" cited in *Quarterly Journal of the New Fabian Research Bureau*, 1 (March 1934), p. 4.
6. *Fabian Quarterly*, 34 (Summer 1942), p. 25.

advocated by so much of their other work. Likewise the books of Jay[1] and Durbin[2] hardly mentioned the Civil Service let alone considered the problems that bureaucratisation might entail, and when Dalton discusses the Civil Service in *Practical Socialism For Great Britain* it is not accorded any particular importance.[3]

In this way the Service's "capacity to deliver" generally went unconsidered and in so far as those most actively involved had a "view" on bureaucracy it appears to have been equated closely to the original Fabian characterisation of an expert and technical instrument of the state. Consequently questions relating to the form of public organisation played little part in the formulation of possible policies for a future Labour government. This is a matter of obvious importance to this thesis in which it is argued that in fact policy achievement in the dental health services has been limited by the particular approach adopted to their public supply. The specific problems associated with the approach are dealt with in detail in Parts Three and Four below but first, in the remainder of this chapter, it is proposed to consider in more detail the assumptions behind this type of approach by examining some of its intrinsic values and the arguments about possible alternatives that were rejected in its formulation. Three main issues will be examined: the neutrality or the purely technical and instrumental character of public organisation; attitudes to administrative reform, and the consideration given to the consequences of increasing the responsibilities and size of the public sector.

A classic utterance of both the parameters within which civil

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1. *The Socialist Case*.
2. E.F.M. Durbin, *The Politics of Democratic Socialism* (London, Routledge, 1940).
3. H. Dalton, *Practical Socialism For Britain* (London, Routledge and Sons, 1935), pp. 11-12.

service neutrality was discussed and the general conclusions reached, was contained in an article written by the former Prime Minister Clement Attlee in 1956. Referring to his attendance at the Potsdam Conference after succeeding Churchill as Prime Minister, he noted that:

> 'I took with me precisely the same team of civil servants, including even the principal private secretary, as had served my predecessor. This occasioned a lively surprise among our American friends who were accustomed to the American system whereby the leading official advisers of the President and of the members of his Cabinet are usually politically of his and their own colour ... I doubt if this impartiality is sufficiently realised even here at home. There were certainly some people in the Labour Party who doubted whether the civil servants would give fair play to a socialist government, but all doubt disappeared with experience ...'[1]

In voicing these sentiments Attlee echoed the opinions of most of his colleagues, many of whom had had experience in the previous Labour Administrations. Morrison, for example, writing to J.H. Thomas about the 'Mosley Memorandum" on unemployment had noted with distress how '[t]hrough the document there is manifested some distrust of the civil servants, apparently on the grounds that they served under the last Government ...' and in the same letter he went on to declare with satisfaction that 'my own experience does not justify anything but respect for their loyalty, ability, and sincerity ... Provided Ministers know their minds, I do not know that there would be available much better technical advice, generally speaking, than we get in the state departments'.[2] Even Hugh Dalton whose book *Practical Socialism for Britain* is a mixture of general prescriptions and sustained invective against MacDonald and Snowden found no great cause for

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1. C. Attlee, 'Civil Servants, Ministers, Parliament and the Public' in W.A. Robson (ed.), *The Civil Service in Britain and France* (London, Hogarth Press, 1956), pp. 16-17.

2. Cited in Skidelsky, *Politicians and the Slump*, p. 406.

concern about the Civil Service:

> 'Like the Crown ... [it] should be politically neutral. It should be the loyal servant of the Government of the day, whatever its political colour. I believe that such loyalty can be counted upon, by a Labour Government not less than by any other. My experience at the Foreign Office from 1929 to 1931 supports this view.'[1]

Thus in so far as neutrality was a "problem" of bureaucracy, it was understood by Labour activists almost exclusively in terms of political loyalty. The fundamental difficulties facing the Party were perceived not in terms of the manner in which particular policies were to be implemented but in what in fact should be done.[2]

The position of the bureaucracy as the appropriate agent of implementation came to be quickly accepted by the majority of Labour leaders. Fred Jowett wrote of MacDonald in 1930 that '[h]e is firmly convinced that control over State Departments by individual Ministers, accompanied and limited only by a system of joint Cabinet responsibility, is the last word in the science and practice of government'.[3] Yet although support for this position had quickly crystallised, its premises were hardly substantial. It grew primarily out of the socialists' desires to remove certain matters from private control, and the assumption of such tasks by the bureaucracy came almost by default. In organisational terms they had a much clearer view of what they didn't want rather than what might replace it and under pressure of time and rapidly growing electoral support, the Labour leaders turned to the existing public organisation.

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1. Dalton, *Practical Socialism For Britain*, p. 11.

2. On this question see E.F.M. Durbin's review of Dalton's book: 'Democracy and Socialism in Britain', *Political Quarterly*, VI (1935), p. 382.

3. F. Brockway, *Socialism Over Sixty Years* (London, Allen and Unwin, 1946), p. 281.

Its elitist recruiting patterns found sympathy with the Fabians while its stress on general education and excellence of mind matched the socialists' general belief in the amenability of complex problems to solution by rational thought. Thus the socialists became increasingly attracted to the merits of the existing Civil Service and once the fears of loyalty had been allayed the road was open for fruitful collaboration. Only the Guild Socialists dissented substantially from this analysis of the bureaucracy, on the grounds that increased bureaucratisation only promoted the extension of wage slavery, and that to talk of the State as a more benevolent employer than the industrialist was to miss the point of the whole argument about the need for control over production as well as distribution.[1]

This argument denied the concept of a neutral bureaucracy and emphasised the view that public organisation had certain characteristics which made it far from a single technical instrument for the use of these in power. Laski, for example, challenged both the capacity of the Civil Service to cope with the expanding functions of the state[2] and the effectiveness of its modes of operation[3] and Beatrice Webb and Bernard Shaw came to question the instrumental and subordinate nature of the bureaucracy's position. Webb declared that 'the nearest thing to a puppet in our political system is a Cabinet Minister at the head of a great public office'[4] and Shaw showed in 1932 that his

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1. G.D.H. Cole, *Self Government in Industry* (First published 1918, London, Hutchinson, 1972), ch. 3.

2. H. Laski, 'The Tomlin Report on the Civil Service', *Political Quarterly*, II (1931), p. 506.

3. H. Laski, 'Bureaucracy' in D. Waldo (ed.), *Ideas and Issues in Public Administration* (New York, McGraw Hill, 1953), pp. 37-39.

4. B. Webb, 'A Reform Bill for 1932', *Political Quarterly*, II, (1932), p. 6.

earlier enthusiasm for the bureaucratic capacity had waned:

> 'over-worked Ministers have no control of the departments they are nominally responsible for, and often no real knowledge of the work done by them, the effective Government being really the bureaucracy or permanent Civil Service ...'[1]

But the significance of these matters, most particularly the maintenance of political control and the limitations imposed by the Civil Service's *modus operandi*, was largely overlooked as the issue of neutrality became focussed on the loyalty of the Civil Service to a future Labour Government. Once this question had been resolved, at least to the satisfaction of those who led the Party through the nineteen thirties, the instrumental view of the Civil Service was never seriously challenged. Furthermore there appears to have been little discrimination applied in extending this view to other forms of public organisation. This matter will be pursued further in the next section which looks at the attitudes and approaches to administrative reform in the period prior to the introduction of the NHS.

A considerable number of strategies of administrative reform were adumbrated between the wars, emanating from both official and unofficial sources,[2] but with the exception of the increased use of public corporations there was little significant change. The bulk of the wartime regulatory apparatus had been dismantled by 1921[3] and in fact civil service numbers declined from this time until

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1. Shaw, *Essays in Fabian Socialism*, p. 312.

2. For example: Ministry of Reconstruction, *Report of the Machinery of Government Committee* (Cmnd. 9230, London, HMSO, 1918); Royal Commission on the Civil Service, *Report* (Cmnd. 3909, London, HMSO, 1931); Committee on Ministers' Powers, *Report* (Cmnd. 4060, London, HMSO, 1932) and on the "unofficial" side see the Webbs, *A Constitution For the Socialist Commonwealth of Great Britain.*

3. A.J.P. Taylor, *English History 1914-1945* (Harmondsworth, Penguin Books, 1970), p. 188.

1934.[1] However, from about 1929 the Government began to play a greater role in the regulation of the economy[2] and in so far as this involved the expansion of the administrative machinery the public corporation was usually the chosen form. A brief examination of the support for this type of organisation gives some indication of the dominant themes informing administrative reform.

Although they represent an important structural departure from the form of the Ministerial Department, the use of the corporations nevertheless reflected the overwhelming desire to see administration in purely technical terms. Both the justification for such bodies and their eventual form were based on the dominance of particular ideas about efficiency of operation and the need to take certain issues "out of politics". The fact that "into administration" did not necessarily mean "out of politics" was not generally understood as the perceived success of some of the corporations, most particularly the British Broadcasting Corporation and the Central Electricity Generating Board, engendered further support for the particular administrative form. Explanations of this popularity are frequently given in terms of the relationship of the structure to the type of the function to be performed, but perhaps more important were the overtly political justifications. For example, Geoffrey Fry contends that:

> 'Ministers and officials may have been sympathetic to a form of organisation that minimised parliamentary control over them. Labour suspicions of the Civil Service perhaps led them to favour independent boards. The Conservatives possibly thought that if State activity had to be extended, public corporations were more acceptable because they were at least similar in appearance to private enterprise

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1. G.K. Fry, *The Growth of Government* (London, Frank Cass, 1979), p. 182.

2. See A.J. Youngson, *Britain's Economic Growth 1920-1966* (London, George Allen and Unwin, 1967), pp. 61-63 for details.

> undertakings. Moreover, their expenditure did not count as supply expenditure, the level of which was a sensitive political indicator. So was the number of Civil Servants, and - apart from the Forestry Commission - the corporations' staffs did not count as such'.[1]

Elsewhere H.R.G. Greaves has suggested that in addition there was 'a certain unwillingness [on behalf of the Labour Party] to entrust the running of a socialised service to anti-socialist successors who might see some advantage in proving it unworkable'.[2] However, some tension was seen in the competing claims of efficiency and ministerial responsibility, and various attempts at compromise were written into the statute books.[3] But in general the particular arrangements for individual corporations reflected the perceived importance of efficiency (seen as requiring autonomy), and much greater independence was accorded than in later periods when the demands for a more comprehensive and co-ordinated approach to planning increased the pressures for ministerial control.

Thus although the public corporations were to an extent innovatory, their organisation came, nevertheless, to perpetuate the values of administration that were becoming dominant at the time. Their general structure reflected this trend which was emphasised more emphatically by their internal organisation. In particular two issues stand out: the actual structure of the corporations and the composition of their executive boards. Such boards are familiar today, but it must be remembered that at the time other forms were being suggested. For example, writing as late as 1937, W.I. Jennings

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1. Fry, *The Growth of Government*, p. 190.

2. H.R.G. Greaves, 'Public Boards and Corporations', *Political Quarterly*, XVI (1945), p. 70.

3. D.N. Chester, 'Public Corporations and the Classification of Administrative Bodies', *Political Studies*, I (1953), p. 271.

detailed four main ideas within the labour movement for the organisation of national services: administration under a Minister responsible to Parliament; workers' control or guild socialism; some form of co-operative organisation, and finally the public board.[1]

But although the boards became accepted as the most appropriate form, their composition remained problematical. The basic clash was between the causes of managerial efficiency and the representation of interests and it was crystallised in the debates between Herbert Morrison and Harold Clay at the Labour Party Conferences of 1931 and 1932.[2] Representation was urged on the grounds that such executive boards needed to be humanised and that the stratification of society had to be broken down. Morrison's plan, argued his opponents, only perpetuated the inequalities of the existing situation in the form of an uncontrollable bureaucracy.[3] His retort to this accusation was entirely predictable and consisted in a defence of the combination of managerial efficiency and ministerial responsibility. Discussing the question in Chapter X of *Socialisation and Transport*[4] he concludes with three main justifications: that the new authorities are *public* authorities and that the representation of share holders is inconsistent with the public status of the new board; that appointees rather than representatives are likely to be more efficient in carrying out their

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1. W.I. Jennings, 'Review of Public Enterprise: Developments in Social Ownership and Control in Great Britain', *Political Quarterly*, VIII (1937), p. 454.

2. See R.A. Dahl, 'Workers' Control of Industry and the British Labour Party', *American Political Science Review*, XLII (1947), pp. 875-900 and Pimlott, *Labour and the Left in the 1930's*, pp. 63-67 for details.

3. B. Donoghue and G.W. Jones, *Herbert Morrison: Portrait of a Politician* (London, Weidenfield and Nicolson, 1973), p. 185.

4. H. Morrison, *Socialization and Transport* (London, Constable, 1933).

duties; and that if representation were allowed there would be great difficulty in choosing what interests were to be represented and the result would be 'a Board of interests instead of ... a Board of capacity and public spirit'.[1]

Essentially Morrison's position comprised almost complete support for the traditional dichotomy between politics and administration and a rejection of any idea of using the administration itself to achieve political goals. In taking this position over the public corporation, he merely reflected the more widely held views about administration in general, which presumed administrators to be both politically neutral and responsive to political authority. Administration was seen primarily in terms of Weber's ideal type, a technique to be used in pursuit of particular political goals and as such, apart from fairly rudimentary considerations of authority structures and grouping of functions, held little intrinsic interest for the policy planner or analyst. Circumscribed by the traditional conventions of British governmental practice the business of administration was seen to be separate from politics and indeed even in some circumstances as an alternative to it. With such a position it is hardly surprising that no real consideration was given to the social and political consequences of the increased use of bureaucratic organisation, especially when as has been shown, "political" was construed in terms no wider than those of the immediate partisan debate.

If the architects of the NHS specifically rejected the public corporation as the appropriate administrative form,[2] they nevertheless accepted the dominant approach articulated in the debates in which

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1. *Ibid.*, pp. 185-187.

2. MoH, DoH(S), *A National Health Service* (Cmnd. 6502, London, HMSO, 1944), p. 13.

administration was seen as an instrumental and technical activity restricted only by the supply of its fundamental ingredients, resources and authority. In face of such a universal and attractive political proposition, the potential consequences of such administrative activity brooked little attention. However, it is intended to examine the consideration given to this question in view of its importance to the general explanatory theory of this thesis.

Like the debate over the significance of the State for socialist endeavour, consideration of the possible dangers and consequences of bureaucratisation also enjoyed a period of considerable ferment before a dominant position began to emerge. Analytically the issues can be divided betwen two main heads: those problems associated with the "power of officials" and those resulting from the perceived "rule of the bureau". Opposition to the power of officials united conservative individualists such as Belloc or Chesterton with socialists like Cole and it was fired by a belief in the need for pluralistic arrangements and the avoidance of a hegemonic state apparatus. Statism or collectivism was associated with servility, oppression and the denial of individual liberty. Harold Laski, for example, perhaps the most eminent pluralist theoretician of the time, regarded the extension of governmental controls in wartime with distaste, but found that

> 'the alternative of complete state-management [is hardly] more inviting. Indeed, it may without exaggeration be suggested that the evils such a regime would imply are hardly less great than those of the present system. For to surrender to government officials not merely political but also industrial administration is to create a bureaucracy more powerful than the world has even seen. It is to apotheosise the potent vices of a government department. It is to make certain a kind of paternalism which, perhaps above all other systems, would prevent the advent of the kind of individual freedom we desire.'[1]

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1. H.J. Laski, *Authority in the Modern State* (New Haven, Yale University Press, 1919), pp. 94-5.

But if Laski was preoccupied with the state as such, others and particularly Cole, addressed themselves more directly to the consequences of the greater use of public bureaucracies.

Cole's emphasis on the denial of personal freedom is brought out particularly strongly in his book *Self Government in Industry* which was first published in 1917 and in which he declared that:

> 'The idea that the State is not only supreme in the last resort, but also a capable jack of all trades, offers to the bureaucrat a wide field of petty tyranny. In the State of today, in which democratic control through Parliament is little better than a farce, the Collectivist State would be an Earthly Paradise of bureaucracy.'[1]

He then suggested that most realised this but that they also believed that

> 'it could be corrected if Parliament were democratised. The "conquest of political power" becomes the Alpha and Omega of his political method; all his cheques are post-dated to the Greek Kalends of the first Socialist Government.'[2]

Thus the "constitutional" palliatives offered by the advocates of the dominant approach to public organisation, had little appeal for Cole: they patently missed the point. 'However democratically minded Parliament might be', he wrote,

> 'it nonetheless remains for the worker in any industry, a purely external force, imposing its commands from outside and above.'[3]

And elsewhere in the same volume he noted that:

> 'we nationalise, but we do not, save to an insignificant extent, socialise ... [e]ven if ... we succeed in freeing ourselves from the burden of interest which nationalisation lays upon us, we shall still be saddled with a bureaucratic control of industry that will leave us as far as ever from the true industrial democracy. If after a voyage almost as

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1. Cole, *Self Government in Industry*, p. 43.
2. *Ibid.*, pp. 43-4.
3. *Ibid.*, p. 44.

> lasting as that of the Flying Dutchman, we round in the end the Cape of State Capitalism, we shall only find ourselves on the other side in a Sargossa Sea of State Socialism, which will continue to repress all initiative, clog all endeavour, and deny all freedom to the workers.'[1]

In other words, for Cole, the problems of power and authority did not simply disappear because they were exercised by the State.

This was a theme to which Tawney was also drawn. 'The view' he wrote,

> 'that socialism consists in socialising everything except political authority, on which all else depends, is puerile. The question for socialists is not merely whether the State owns and controls the means of production. It is also, and even more important, who owns and controls the State.'[2]

Although written in 1952 this reflected the position that Tawney had held for some time that such ownership and control did not come merely from the occupancy of the Treasury benches. 'Socialism' writes his biographer, summarising the subject's position,

> 'is not a goal which exists the other side of the problem of power. The problems of power are permanent. Rule by a new class (the proletariat) will not eliminate them. The creation of "will" in a continuous way is an aspect of socialism in action.'[3]

And in fact Tawney himself had written in 1932 that the Labour Party was deceiving itself,

> 'if it supposes that the mere achievement of a majority will enable it to carry out fundamental measures, unless it has previously created in the country the temper to stand behind it when the real struggle begins.'[4]

In other words both Tawney and Cole emphasised that the reform

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1. *Ibid.*, pp. 127-8.

2. R.H. Tawney, *The Radical Tradition* (Harmondsworth, Penguin Books, 1966), p. 178.

3. R. Terrill, *R.H. Tawney and His Times* (Cambridge, Harvard University Press, 1973), p. 152.

4. Cited in *ibid.*, p. 52.

of society was not merely a question of the application of particular administrative techniques and drew attention to the fact that conflict and the exercise of power would not disappear with the creation of the machinery of a socialist state. Cole in particular argued that such power would merely be concentrated in new hands and that the bureaucratic officials were likely to be the greatest beneficiaries of such a change.

But if Tawney and Cole couched the problem of the power of the officials in fairly wide terms, the response of others was more predictably narrow. If centred on what one author has termed the 'centuries old English tradition of natural constitutionalism'[1] and reflected the established liberal attitude of a distrust of political power, around which fences should be erected whose purpose is

> 'the dissolution of power into legal relationships, the elimination of the element of personal rule, and the substitution of the rule of law in which all relationships are to become purposive-rational, that is predictable and calculable.'[2]

This type of approach dominated the responses in the 1930s to expressions of concern about bureaucratic power. The publication in 1929 of the *New Despotism*[3] by Lord Hewart, in which he argued that the growing power of the civil service was subverting the traditional role of the judiciary, led to the appointment of the Committee on Ministers' Powers to investigate the issue and more particularly the increased use of delegated legislation. However, in its *Report*[4] the Committee argued

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1. W.B. Gwyn, 'The Labour Party and the Threat of Bureaucracy', *Political Studies*, XIX (1971), p. 388.

2. F. Neumann, *The Democratic and the Authoritarian State* (New York, Free Press, 1957), p. 6.

3. London, Ernest Brown, 1929.

4. Committee on Ministers' Powers, *Report* (Cmnd. 6060, London, HMSO, 1932).

that the growth of such legislation was "inevitable"[1] and suggested that proper means should be found to encourage its expansion rather than limitation. No fault could be found with the Civil Service: there was no reason to suppose that the constitutional machinery was developing in any adverse way and if the right safeguards were taken 'there is no ground for possible fear'.[2]

Two notable Labour lawyers, W.I. Jennings[3] and W.A. Robson,[4] welcomed the *Report's* findings. Each supported the idea of additional constitutional safeguards and both became outspoken advocates of the need for the development of a code of administrative law in Britain: a topic to which Robson had addressed himself at some length in his pioneering work *Justice and Administrative Law*[5] in 1928.

What is interesting to note in each case is the way in which the problems that worried Cole and Tawney came to be perceived in almost wholly legalistic terms. The possible tyranny of the official was interpreted in an essentially *ultra vires* sense which invited solution by juridicial means and if it was recognised that the problems of power did not disappear by inclusion within the public realm, it was presumed that they could at least be formally contained.

If the problems associated with the "rule of the bureau" are considered it can be seen that they fall under three main heads: the

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1. *Ibid.*, p. 4.

2. R.V. Vernon and N. Mansergh, *Advisory Bodies* (London, Allen and Unwin, 1940), p. 78.

3. W.I. Jennings, 'The Report on Ministers' Powers', *Public Administration*, 10, 4 (October 1932), p. 333.

4. W.A. Robson, 'The Report of the Committee on Ministers' Powers', *Political Quarterly*, III (1932), pp. 346-64.

5. W.A. Robson, *Justice and Administrative Law* (London, Macmillan, 1928).

character of the bureaucracy and its consequences for public policy making, the use of the "expert" and the consequences of the state becoming a major employer. Laski, for example, was consistently vocal on the problems posed by the nature of bureaucratic organisation[1] and argued consistently that the operational characteristics of the bureaucracy were inappropriate for the new tasks of the state. He was strongly critical of the narrow findings of the Tomlin Royal Commission on the Civil Service[2] and later declared that:

> 'One of the dogmas with which this country entered the war was the adequacy of its civil service for any task to which it might be called ... The administrative division ... has shown an absence of imagination and audacity, an unwillingness to attempt experiments proportionate to the urgency, which makes the future of civil service organisation one of the major problems of the post war period ... the predominant temper and outlook of the administrative class represents that of a single section only of opinion ... the result was that not only did tradition control the normal problems in their new scale, tradition controlled also the new problems. The men in charge were by definition wedded to habits they were largely incapable of questioning.'[3]

Laksi believed that this inflexibility was due, at least in part, to adherence to the conventions of ministerial responsibility and in this view he was supported by T.S. (later Lord) Simey who argued that complexity was a result of pressure for the maintenance of central responsibility and that

> 'the consequence of the strict application of the doctrine of Ministerial responsibility is the creation of an excessive degree of rigidity in the administrative system, making it impossible to achieve a correct measure of decentralisation of authority within the department, and to attain the ideal form of social administration.'

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1. See for example Laski, 'Bureaucracy'.

2. Laski, 'The Tomlin Report on the Civil Service'.

3. H. Laski, 'Some Reflections on Government in Wartime', *Political Quarterly*, XIII (1942), pp. 62-63.

'What is required' continued Simey,

> 'is the preservation of local adaptability, combined with central control wherever there must be uniformity, together with mutual trust and co-ordinated action between the local officials. Unified direction should go hand in hand with decentralised administration; decentralised to maintain contact with the persons or bodies for whose benefit a service is provided, centralised to obtain consistent policy.'[1]

But if these two writers criticised the concept of ministerial responsibility their central concern was to suggest that the contemporary form of the bureaucracy might not be appropriate for the kind of programmes that it was envisaged the state might undertake. But their position on this question generated little support and in fact the perceived correlation between ministerial responsibility and bureaucratic character helps to explain the issue's eclipse as a problem for Labour theorists. Those who after 1931 believed, with Sir Stafford Cripps, that 'the one thing that is not inevitable now is gradualness'[2] concerned themselves with the possibilities of extra-constitutional resistance and the likely need for emergency legislation in which consideration of bureaucratic behaviour paled beside the perceived threat from the City. Those who rejected such cataclysmic conclusions evinced a strategy based on planning which, with its concomitant need for control, was to be manifested through the mechanisms of ministerial responsibility and its direct correlative ministerial authority. Under the leadership of men such as Morrison and Dalton who had both held ministerial office and expressed overwhelming satisfaction with the performance of the Civil Service, consideration of the foibles of bureaucratic performance again appeared

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1. T.S. Simey, *Principles of Social Administration* (London, Oxford University Press, 1937), pp. 79-80.

2. Quoted in Jenkins, *Pursuit of Progress*, p. 58.

insignificant alongside the task of preparing the blueprints for a future Labour Administration.

The second issue to be examined under the heading of the "rule of the bureau" is the role of the "expert" whose importance to the Fabian position on public organisation has already been stressed. A number of objections were raised to their employment. L.T. Hobhouse, for example, who generally supported an expansive role for the state noted that what he termed "official socialism" 'proceeds to a measure of contempts for average humanity in general ... Socialism so conceived has in essentials nothing to do with democracy or with liberty. It is a scheme of the organisation of life by the superior person'.[1] This theme was pursued at greater length in *Democracy and Reaction* where he wrote that:

> 'Collectivism is liable to a corresponding distortion, which appears in particular to have befallen certain forms of Socialism in England ... all the interest is concentrated on the machinery by which life is to be organised. Everything is to fall into the hands of an "expert", who will sit in an office and direct the course of the world ... [and] as the "expert" comes to the front, and "efficiency" becomes the watchword of administration, all that was human in Socialism vanishes out of it ... instead ... we have the conception of society as a perfect piece of machinery pulled by wires radiating from a single centre, and all men and women are either "experts" or puppets. Humanity, Liberty, Justice are expunged from the banner, and the single word Efficiency replaces them ... [and] in the working of a machine there is only one test - whether it runs smoothly or otherwise'.[2]

The identification of the rise of expert adiministration with the demise of humanistic values was a theme pursued through a diverse range of literature at this time. Its most able chronicler was probably George Orwell who, for example, in *The Road to Wigan Pier*, portrayed

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1. L.T. Hobhouse, *Liberalism* (First published 1911, London, Oxford University Press, 1964), pp. 89-90.

2. L.T. Hobhouse, *Democracy and Reaction* (First published 1904, Brighton, Harvester Press, 1972, pp. 227-9.

the "middle class expert" as an 'outer suburban creeping Jesus ... who goes about saying "Why must be level *down*? Why not level *up*?" and proposes to level the working class "up" (up to his own standard) by means of hygiene, fruit juice, birth control, poetry, etc.'[1] The underlying motive for this 'is simply a hypotrophied sense of order. The present state offends them not because it causes misery, still less because it makes freedom impossible, but because it is untidy'.[2] The consequences of this approach by these "little men"[3] are ably portrayed in Orwell's discussion of the disruption caused by slum clearance programmes.[4] The dominant themes are the lack of individual choice, the restrictions on behaviour and perhaps above all, the kind of gate-keeper role such experts play in the planning of new communities. In the particular example he cites there is simply no place either for the independent shopkeeper or the publican, or indeed for the patterns of traditional behaviour with which they were associated. 'It is a great achievement', he concludes, 'to get slum dwellers into decent houses, but it is unfortunate that, owing to the peculiar temper of our time, it is also considered necessary to rob them of the last vestiges of this liberty.'[5]

Even Attlee (at a time which Jenkins has suggested led him 'to write and say some things which now seem very odd indeed')[6] expressed

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1. G. Orwell, *The Road to Wigan Pier* (First published 1937, Harmondsworth, Penguin Books, 1962), p. 142.

2. *Ibid.*, p. 157.

3. See R. Williams, *Culture and Society* (Harmondsworth, Penguin Books, 1961), p. 279 for a discussion of Orwell's use of "little".

4. Orwell, *The Road to Wigan Pier*, ch. 4.

5. *Ibid.*, p. 64.

6. Jenkins, *Pursuit of Progress*, p. 59.

concern about the organisation of a

> 'society in which all controlling power would be entrusted to a few super-men by whose orders, through an obedient bureaucracy ... the activities of all the peoples [would be] directed to produce certain results ... I do not believe that there are human beings who are fit to be entrusted with such absolute power. I believe, too, that such a country would be spiritually very poor'.[1]

But of such human consequences of the expert and his methods the mainstream of the Fabian movement was largely contemptuous. Perhaps the best exposition of their attitude was given at the Labour Party Annual Conference in 1918. Tom Nairn has described part of the proceedings:

[reference to the ownership of the [see insert]]

> 'The more clairvoyant of the Left Wingers noticed the absence of any definite means of production and distribution, and a Mr Fairchild of the British Socialist Party rose to protest. This resolution was hardly in accordance with the fine new constitution, he pointed out, and might even be interpreted as advocating "co-operation" between workers and employers. "The resolution entails the creation of an army of bureaucrats and experts", he insisted, "and there is no recognition of the claims of *Labour* to direct the means of production in the interests of the class represented at this Conference ..." No less a person than Sidney Webb replied to Fairchild (a typical example of the Left-Wing group Webb characterised elsewhere as 'nonentities ... fanatics, cranks, and extremists'). It was true, he admitted, that the constitution said what Mr Fairchild claimed, But really, they all had a great deal of work to do, including no fewer than twenty-six more resolutions, and "... they did not want repeatedly, over and over again, to ring the changes on the old shibboleths".'[2]

Alongside the importance of expertise to the Fabian approach to public organisation the possible consequences of its use paled in comparison. The almost wholly instrumental perception of the civil service meant that it was always seen as subordinate to the political leadership and more especially the parliament and the general belief in something akin to a science of society and the predictive and

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1. Attlee, *The Labour Party in Perspective - And Twelve Years Later*, p. 114.

2. Nairn, 'The Nature of the Labour Party', *op. cit.*, p. 184.

intellectual capacities of the experts played down the importance of dysfunctional or unintended consequences. There might be costs associated with the approach but they would have to be borne in the pursuit of an ordered society.

The third question to be considered under the title of the "rule of the bureau" related to the State as an employer. Of the positions discussed in this chapter almost all envisaged, even if it wasn't always openly stated, a massive increase in state employment. Yet with only a few exceptions the prominent writers and theorists of the period seem to have avoided addressing themselves to the possible implications of this development. Like the question of power, the subject of employment relationships was treated as no longer problematical when included in the public sphere. But while industrial relations may have been of limited importance in the traditional Civil Service there appears to have been little reason to anticipate such quiescence from the more strongly organised unions and professional associations (for example the mine workers and the doctors) who were to be included on the public payroll.

The Guild Socialists' position on these matters was the most straightforward: their concern with the mechanisms of production as well as distribution led them to emphasise the question of employment. But in respect of its performance the State received a no more charitable commendation than the private industrialists. Cole, for example, lamented the failure to distinguish between nationalisation and socialisation[1] and in discussing the relative merits of private and public employment found that while 'the State is not a bad sweater,

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1. See Cole, *Self Government in Industry*, ch. V.

and that in most cases, it pays Trade Union rates',[1] it was also 'adamantine in defence of the bureaucratic omnipotence and all-wisdom of the permanent officials'.[2] Unified management and hierarchies were anathema to the Guild Socialists' conception of society, and Cole could conclude his discussion of public employment on no more an optimistic note than '[t]he French worker knows well that the accompaniment of State ownership is administrative tyranny.'[3]

Apart from the Guild Socialists only the Webbs seem to have touched upon the possible problems of the State assuming a most significant employment role. Their concern was three-fold. That it was inappropriate to both attempt to impose certain traditional disciplinary characteristics on say postal workers and to then accuse them of disloyalty 'because they exercise their legal right of withholding their labour in strict accord with their contracts of service'.[4] That it was likely to encourage a government faced with a major dispute in one of its employment areas to use employees from another to continue the service and hence 'evoke a combination of physical violence with industrial action'.[5] Finally that the

> 'very growth of the government business, and the enormous multiplication of the number of persons directly in the government service makes almost inevitable - if every public service is administered by one and the same executive hierarchy - a development of that "Administrative Law" by means of which a bureaucracy entrenches itself against interference.'[6]

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1. *Ibid.*, pp. 134-5.
2. *Ibid.*, p. 135.
3. *Ibid.*, p. 136.
4. Webb, *A Constitution for a Socialist Commonwealth of Great Britain*, p. 77.
5. *Ibid.*, p. 76.
6. *Ibid.*, p. 78.

In so far as the Webbs offered a solution to these problems it lay in the advocacy of a pluralistic approach to organisation, rights of self determination for each vocational group and the increasing professionalisation of the public services.[1] In fact this last idea enjoyed some considerable currency at the time, being taken up by Tawney in *The Acquisitive Society*[2] and later by T.H. Marshall[3] immediately prior to the Second World War. The central focus for each of the writers was the contrast between professional and commercial behaviour and the desirability of infusing the former into the state administration. In short it amounted to the promotion of some notion of public or civic virtue: a sense of respect for the community as a whole instead of mere personal gain. But beyond this level of prescription and Marshall's observation that 'the professions are being socialised and the social and public services are being professionalised',[4] little was explained about how employment within the public sector would promote these ideals.

These issues associated with the development of thought about the activities of the state and its administrative agencies have been dealt with in some detail because it is felt that their particular resolution, in the form of what has been termed the dominant approach to public supply, has had considerable bearing on the performance of the dental health services. It has already been suggested that the way in which public responsibility for the services was assumed has placed

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1. *Ibid.*, Part II, chs. I, V and VI.

2. Tawney, *The Acquisitive Society*, chs. VII and IX.

3. T.H. Marshall, 'The Recent History of Professionalism in Relation to Social Structure and Social Policy' in *Citizenship and Social Class and Other Essays* (Cambridge, Cambridge University Press, 1950).

4. *Ibid.*, p. 147.

significant limits on policy achievement and in the chapters that follow it will be argued that none of the major assumptions behind the approach can, in practice, be justified. Hence it is proposed to relate the shortcomings of the dental health services directly to these particular assumptions and it remains in this chapter to summarise the more important of these as a way of emphasising the features that characterised the taking over of public responsibility for the provision of dental health services.

The developments and arguments just discussed undoubtedly informed the character of the approach to public supply which offered, on the surface at least, an obvious response to the kinds of problems, discussed in the previous two chapters, which would have to be overcome if medical and dental services were to be properly co-ordinated and provided on a basis of medical need rather than the capacity to pay. The dominant position developed by the second World War was an essentially Fabian one which made four explicit assumptions about the expansion of state activity.

The first and perhaps the most important was the belief in the capacity of the state, and more particularly of public organisation, to administer complex policies. This included confidence in the availability of the required expertise and in the ability of the involved agencies to make decisions in respect of need and to be able to allocate resources in line with predetermined values and aspirations. Little consideration was given to the techniques and practical problems associated with such tasks but great confidence, as has been repeatedly shown, was placed in the capacity of the Civil Service to cope with any difficulties involved. This view centred on the belief that problems such as those likely to be faced in the expansion of public policy could be resolved by a process of rational

thought and became almost synonymous with the assumption that practically all problems were amenable to administrative solution and that "administration" in this sense was a set of techniques of universal application. Thus, in respect of dentistry, there was never any serious questioning of the view that the provision of services in pursuit of improved oral health was a subject suitable for public administration.

The second assumption centred on the capacity to maintain what might be termed "political control". Sired by consideration of the constitutional convention of ministerial responsibility which incorporated a particular view of the authority of those at the head of the offices of state and informed by the idea of parliamentary sovereignty which understood nothing to be beyond the competence of that body, the "dominant view" assumed a politics/administration dichotomy in which the second would be sensitive to changes in the first. Power was equated with the possession of public office and once held, control over the administration was believed to be complete. The administration was thus seen to be both neutral and instrumental, and consequently little consideration was given to models of organisation other than the traditional, hierarchical, command structure.

The third assumption was more negative in the sense that it dismissed claims that particular problems might arise either from the increased power necessarily acquired by those involved in the administration and provision of new public undertakings or from the role the state would play as a major employer. If the problems of power did not altogether disappear by their incorporation in the public sector, they could at least be contained by formal, legal means and hence no great concern was expressed over the extent to which those most closely involved with a particular policy would be in a position

to influence both its administration and outcome. State employees were presumed, as has been shown, to be both loyal to the party in government and neutral in the sense that they would not oppose political initiatives and hence little consideration was given to the consequences of such a major disruption to the *status quo* as the public provision of health services portended.

The fourth assumption was also an essentially negative one in so far as the dominant approach gave little consideration to the proposition that in undertaking public supply, policy goals and aspirations might be subjected to adaptation to the norms of organisational practice and that this would affect policy achievement. Under the general belief in the technical nature of administration, little importance was attached to possible tensions between the values of the particular policy area and those of public organisation and little concern was felt for the distortion or displacement of goals that might result.

No details of the support for these positions have been included in this summary as their development and articulation has already been well documented. The positions were closely inter-related and while it is not perhaps possible to claim that a definite theory of public organisation had been established in 1944, the emergence of a dominant and particular approach is indicated. But it is important to note that the identification of these assumptions, which later chapters will show to have been crucial in determining the performance of the dental health services, does not derive from a position of hindsight but from the challenges and responses that were made at the time. Indeed the whole approach to the assumption of public responsibility for the supply of goods and services was the subject of debate and disagreement and it has been the particular endeavour of this chapter to examine the

issues that were involved and to show how a number of factors, including the analysis made of the 1931 debacle, the events following that year and the rise to prominence of a particular group of politicians, combined to substantiate and reinforce the dominant position of Fabian orthodoxy.

The approach was one which emphasised, above all, the potential of rational thought and its capacity when harnessed by public organisation. Politics, as Morrison and others frequently explained, offered no home for such an approach to problem solving and hence once the political authority necessary to undertake a project such as the NHS had been given (by occupancy of the Treasury benches), it was believed that implementation should consist primarily in the process of organisational construction. But it is important also to note that the development of this view was based almost entirely on the experience and consideration of a traditional bureaucracy and career civil servants, whereas in the NHS the vast majority of the positions would be filled by people with no background at all in public organisations. This added a further dimension to the assumptions that have just been discussed and in later chapters it will be shown that not only were the assumptions quite untenable in practice, but also that the attempt to base the provision of the dental health services on the kind of organisation that the assumptions dictated, has been largely responsible for the particular shortcomings that the services have manifested. However, before these issues are considered, chapters five and six will show how the dominant approach to public supply determined the way in which the policy was put into effect.

PART THREE

IMPLEMENTATION

CHAPTER FIVE

THE IMPLEMENTATION OF THE DENTAL HEALTH SERVICES

Before considering the question of the implementation of the dental health services between 1944 and 1948 a brief review of the evidence accumulated in the previous three chapters will be made. It has been shown that much thought was given by people closely concerned with the provision of health services to the obvious shortcomings of the existing arrangements, and that specific problem areas were identified and measures for their solution outlined. Yet almost without exception these strategies included little consideration of the political and administrative problems involved and they put considerable trust in the potentialities of planning, governmental authority and public finance.

At the same time those who would be in a position to introduce such a service showed scarcely more concern than the medical reformers for the potential problems involved. They readily accepted the capacity of public organisation to administer complex policies and concerned themselves primarily with the delineation of matters suitable for public intervention while largely avoiding considerations of how this might be done.

The result was that when the introduction of some form of national health service became a possibility, there was little accumulated knowledge or thought concerning the administrative and political problems that might arise. And of course once the realisation of such a project became practicable, the consuming interest of the government was to put it into operation as soon as possible in order to reap the maximum electoral reward. Thus considerable pressure was necessarily applied to quickly distil a complex political objective into a manageable administrative project, and in line with the dominant position examined in the previous chapter, recourse was made to the established bureaucratic approach to implementation and supply.

In this chapter an attempt will be made to show how the assumptions of this approach influenced the process of policy implementation and how, in particular, they militated against the resolution of the specific problems facing the supply of dental health services which were outlined in chapter one.

The concept of implementation has received a lot of attention in recent years, but clearly the process if not the name has a lineage to match that of the idea of public policy. Dunsire notes references in *Exodus*, the Constitution of Chow and Plato's *Republic*,[1] and of course each empirical study of the policy process has dealt to some degree, if only implicitly, with the topic. From a search of the literature Andrew Dunsire has suggested that two main images of the implementation process emerge. One, associated with the structure of a pyramid, which emphasises the importance of organisational structure and the transmission of commands up and down known hierarchical ladders, and a second in which the metaphor is a chain linkage and where much less emphasis is placed on authority and rather more on establishing and maintaining the support of those units whose particular talents are needed to complete a chain which is seen as a network of connections.

The first image derives primarily from the work of Weber, Barnard, the early Simon, Tullock and Downs. The second from March and Simon and Pressman and Wildavsky.[2] The one emphasises what might be termed traditional administrative concerns: it tends to assume the legitimacy of the structure but is concerned with problems such as the

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1. A. Dunsire, *Implementation in a Bureaucracy* (Oxford, Martin Robertson, 1978), p. 20.

2. *Ibid.*, especially ch. 2.

interpretation of commands, spans of control, the improvement of communication, the reduction of ambiguity and so on. The other is more obviously political: it assumes some degree of independence on behalf of the individual units and emphasises the construction of linkages between them, by means of bargaining, contracts, threats and so forth. The pyramid model is closely related to constructs such as Weber's ideal type of bureaucracy whereas the network is much more akin to a classical market situation. But as Dunsire observes the choice of models presents something of a dilemma, for as with most models neither adequately portrays all that needs to be demonstrated. Yet for the purpose of examining the implementation of the dental health services the two models are useful in so far as they can be taken to represent the perceptions of the implementation process held by the two main participants, the government and the dentists.

The command approach can be identified in much of the work discussed in the last chapter from the early political writings of Shaw to the whole approach of the New Fabian Research Bureau in the immediate pre-war years. It associated power with the possession of public office and understood little to be beyond the competence of that office. Thus Bevan in considering the NHS remarked that

> 'There has been no negotiation, and there will be no negotiation in this matter. The House of Commons is supreme, and the House of Commons must assert its supremacy, and not allow itself to be dictated to by anybody, no matter how powerful and strong he may be.'[1]

But clearly neither Bevan nor his predecessors who had articulated similar sentiments expected this to be the whole picture: particular interests had to be accommodated and if necessary included within the executive machinery, yet the underlying presumption was that such

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1. 422 H.C. DEB. 5s. Cols. 60-1.

concessions should be resisted and that in so far as possible deviance from the traditional command structure should be minimised.

In contrast, as will be shown, the British Dental Association approached the question of implementation with a pluralistic and open attitude which was more characteristic of the network model. The relationship with the government was seen as a matter for negotiation, discussion and careful consideration of the problems of dentistry and the Association believed, for example, that as the NHS was intended to cover the entire population the Minister of Health would need the co-operation of the whole dental profession and that the bargaining position of the latter would consequently be enhanced.[1]

The rest of this chapter will look at the period of implementation and show how it was characterised by the ascendancy of the command approach over the network view and how this prejudiced consideration of the specific problems facing the supply of dental health services.

The examination begins in 1942 not because it is possible to say that implementation started in that year but rather because the period prior to the beginning of war has been discussed in the previous two chapters and it was not until 1942 that there were obvious signs that consideration of dental matters would become a significant part of the growing agenda on post-war reconstruction. Not only was the Beveridge Report[2] with its famous "Assumption B" on "Comprehensive Health and Rehabilitation Services" (which included dentistry)[3]

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1. BDA, *Minutes of the Proposed NHS-Dental Consultative Committee* (London, British Dental Association). Meeting on 22 February 1945.

2. Sir William Beveridge, *Social Insurance and Allied Services* (Cmnd. 6404, London, HMSO, 1942).

3. See para 435: 'That the insurance title to free dental service should become as universal as that to free medical service is not open to serious doubt.'

published in November but also earlier in the year both the dental organisations and the Ministry of Health had taken steps to begin consideration of the post-war dental situation.

The period from 1942 until the beginning of the Service in July 1948 will be loosely divided into three parts: from 1942 until early 1946 when the content of the NHS Bill became known; from March to November 1946 when the legislation was before the Parliament; and the post-legislative period when the contents of the proposed Regulations provided the focus of attention.

The early part of the period was characterised by a distance between the dentists and the Government as each pursued its work largely independently of the other. The profession for its part had begun preparation in 1942 with the appointment of the Joint Committee on Post War Dental Policy[1] which was required to

> 'investigate and report upon the position of dentistry and the provision of dental service for the Nation in post-war Britain'.[2]

Enquiry ranged quite widely, and in four reports issues such as dental health propaganda, recruitment and professional education were considered.[3] A "National Dental Health Association" was envisaged to promote greater dental awareness[4] and a greater intake of students was urged but the 'Employment of Dental Hygienists' or the 'Dilution by dentists with shorter training'[5] were emphatically rejected. Yet

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1. Appointed by a joint decision of the British Dental Association, the Incorporated Dental Society and the Public Dental Service Association.

2. Joint Committee on Dental Post-War Reconstruction, *Report* (London, December 1943), p. 1.

3. *Ibid.*

4. *Ibid.*, pp. 16-21.

5. *Ibid.*, p. 15.

apart from these particular recommendations the work of the Committee was characterised by a high level of generality even on questions which were later to prove contentious. Two obvious examples occur in the report on "A Dental Health Service for the Nation". The Committee first exhibited considerable equanimity over the use of salaried practitioners: it clearly favoured private practice but was nevertheless 'of the opinion that the provision of dental service as part of a National Health Service can best be achieved by the establishment of a salaried dental service to function side by side with existing private practice'.[1] Second, on the question of remuneration it examined the merits of salary, capitation payments and an itemised scale of fees, but apart from rejecting the concept of a wholly salaried service, found itself with 'no direct recommendation at this stage ... [about the] basis for payment'.[2]

Such comments are typical of the Report as a whole which reads in places more like an utopian construct than the considered opinion of representatives of the professional groups most closely involved. Argument is juxtaposed with counter-argument and in many cases like those detailed the topic is left unresolved. Certain features of any possible dental health scheme are stressed: the importance of priority being given to the adolescent patient;[3] the need for dental control and supervision of dental matters[4] and the importance of there being one level of service for the whole population,[5] but in so far

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1. *Ibid.*, p. 9.
2. *Ibid.*, p. 10.
3. *Ibid.*, p. 5.
4. *Ibid.*, p. 3 and p. 8.
5. *Ibid.*, pp. 7-8.

as the place of dentistry within a national health service is considered it is only that it 'must be regarded as complementary, and not ancillary to any form of national medical service which may be adopted'.[1] The Report appears to have been imbued with some of the optimism of the immediate post-Beveridge era as it endorsed both universal coverage and the disassociation of the availability of treatment from the capacity to pay the fees,[2] and concluded that:

> 'If, after careful consideration, a National Dental Service is decided upon by the Government, it is the view of the Joint Committee that the dental profession should be recommended to co-operate in the preparation of such a scheme provided that the character, terms and conditions of the National Dental Service are determined by agreement with the profession and also provided that those members of the community who decide not to avail themselves in part or in whole of the benefits of the service open to them should not be precluded from obtaining the dental service they desire from dentists within the scheme, paying for such service privately, with the necessary safeguards to prevent abuse'.[3]

This level of openness and generality which characterised the profession's approach to dental reconstruction until at least 1946 contrasted markedly with the endeavours of the Ministry of Health or more particularly its Post-War Dental Policy Committee which had also been set up in 1942. Where the profession busied itself with a general consideration of the place of dentistry in society as a whole and the changes needed to promote greater oral health, the Government's Committee focussed narrowly on matters pertaining directly to the provision of a public dental service after the end of the war. Writing to the Board of Education the Secretary noted that the 'Committee will be a purely official body reporting to the Minister and there is of

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1. *Ibid.*, p. 2.
2. *Ibid.*, p. 7.
3. *Ibid.*, p. 11.

course no intention of making its existence known, still less of publishing the report'.[1] However its secrecy was shortlived as a letter from the Dental Secretary of the British Dental Association (who had obviously been taken into the confidence of at least one Committee member) reported that the Committee's appointment had been discussed at a recent Association meeting.[2] But such a disclosure appears not to have inhibited the work of the Committee, which was composed of civil servants from the two Health Departments[3] and the Board of Education, and which reached its conclusions without formal representation from the professional organisations. In so far as it took cognizance of the dentists' views they appear to have come primarily from the evidence submitted to the Beveridge Committee,[4] which in the case of the Association consisted almost entirely in a commentary on the existing dental arrangements and suggestions for their extension to the whole insured population by bringing dentistry within the classification of a statutory benefit.[5]

The Ministry of Health's Committee met on only four occasions but a considerable number of papers were presented and in a very short time the possible problem areas were crystallised. Considerable attention was given to the need for priorities, the demand rates for

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1. Dated 13 July 1942 in MoH, *National Dental Service: Post War Policy Committee*. PRO MH77/183. File No. 93286.

2. Letter from W.G. Senior to A.G. Bearn, Controller of Health Insurance, Ministry of Health, 8 December 1942 in *ibid.*

3. That is the Ministry of Health and Department of Health for Scotland.

4. The Inter-Departmental Committee on Social Insurance and Allied Services.

5. For full details see BDA, *Memorandum to the Interdepartmental Committee on Social Insurance and Allied Services* (London, May 1942).

treatment and the supply of dentists,[1] and the Government Actuary was employed to research this area. A major paper from the Department of Health for Scotland which included a detailed list of possible problems was discussed on 4 November and shortly afterwards "A Summary of the Major Issues involved in the Establishment of a Comprehensive Dental Service"[2] was drafted. Within a few months the Committee had distilled a vast amount of material (which was largely foreign in terms of content to most of them) into three main areas of consideration. These were:

(1) Population to be covered and extent of treatment to be provided
(2) Dental manpower
(3) The provision of treatment under a post-war dental scheme.

Under this last heading the following items were discussed:

- the fact that all dentists should be employed by competent authorities
- the need to provide treatment to a particular standard
- the inspection of offices and equipment
- a system for authorisation of estimates
- the inspection of treatment given
- remuneration
- whether records of treatment should be maintained and periodic reports required
- the progressive remuneration of staff
- disciplinary actions.

To quote these details at some length is not to suggest that they represent the last word in the consideration of this particular topic, but is rather to demonstrate how, at this comparatively early stage, the civil servants who would be charged with the administration of the service had already narrowed the focus of matters over which they believed there would be concern. The filter through which

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1. See Minutes of meeting, 16 October 1942 in MoH, *National Dental Service: Post-War Policy Committee*.

2. Paper (n.d.), ref. D.4 in *ibid.*

material relating to the supply of dental services passed was of a very specific structure and the residue of the matters considered to be significant were a natural corollary of such a design.

It represented a particular approach to policy implementation in which the assumptions were not stated but whose acceptance by those involved was manifest. The emphasis was unashamedly on control: control of the available resources and the way in which they were to be utilised, but control not so much in the positive sense of co-ordination to ensure say treatment for all as control in a more negative way to facilitate compliance with certain rules in respect of matters such as expenditure and the types of treatment allowed. That such a position should be adopted by this committee was unsurprising but the important point to note is the way in which it was established: in secret; without consulting the dental profession or other interested groups and by a small body of which some members were dentists but who were all primarily career public servants. This Report of the Committee on Post-War Dental Policy set the tone in terms of both content and approach for the proceedings that followed.

This brief consideration of the work of the two committees is sufficient to demonstrate the way in which the profession and the Government perceived the situation at hand: for one the opportunity to establish the place of the dentists and dentistry in society, for the other the need to fit dentistry within the rapidly forming structure of post-war health organisation. The first major conjunction between the two sides took place with the appointment of the Teviot Committee and the work and experiences of this Committee provide an excellent focus for consideration of the factors that influenced this first period of the implementation process.

The Committee's[1] appointment was officially announced on 8 April 1943 but preparations for its formation had been under way for some time. Its appointment and terms of reference had been suggested in the Report of the Committee on Post-War Dental Policy and had been re-iterated in a memorandum from Sir John Maude[2] to the Minister which accompanied an early draft of the Report.[3] Some difficulty was experienced in effecting a balance between competing interests[4] and in finding a suitable chairman: Maude supported the appointment of Sir Will Spens, who was offered the position but turned it down and eventually Lord Teviot[5] was invited to take the chair. His letter of acceptance represents a classic utterance of the generalist, gifted-amateur approach to the solution of complex social and political problems. Writing to the Minister he explained that dentistry was

> 'a subject in which I am most interested and I think I will be able to help the Committee as I gained some knowledge and experience while in China in regard to teeth. The most amazing thing in China is that the Chinese in all walks of life have the most beautiful teeth. I have my own ideas as to why this is and I think they will be of interest to the Committee.'[6]

The Committee's terms of reference which had been set by the Government's Post-War Dental Policy Committee and not subsequently revised were:

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1. Its full title was the Interdepartmental Committee on Dentistry.

2. Permanent Secretary, MoH.

3. Draft dated 30 January 1943 in MoH, *National Dental Service. Inter Departmental Committee. Formation and Terms of Reference.* PRO. MH77/189. File No. 93286/2/1.

4. A full list of the interests finally represented can be found in the statement by the Minister of Health, 8 April 1943 in *ibid.*

5. Chairman of the Liberal-National Party and Former Lord Commissioner of the Treasury 1937-9.

6. Letter, 15 March 1943 in PRO. MH77/189.

> 'To consider and report upon:
> (a) the progressive stages by which, having regard to the number of practising dentists, provision for an adequate and satisfactory dental service should be made available for the population;
> (b) the measures to be taken to secure an adequate number of entrants to the dental profession;
> (c) existing legislation dealing with the practice of dentistry and the government of the dental profession;
> (d) measures for the encouragement and co-ordination of research into the causation, prevention and treatment of dental disease.'[1]

Altogether it met on twenty four occasions, received oral and written submissions,[2] examined sitnesses and issued both an Interim[3] and a Final Report.[4]

The announcement of the Committee's appointment was generally well received: the editor of the *British Dental Journal* thought it would be 'generally welcomed throughout the profession' and was gratified to be able to report that

> 'the appointment ... makes it clear that the dental side of the health service is not to be considered merely as ancillary to the medical service, but is to be approached as a separate, although related, problem to the solution of which the dental profession will be called on to contribute the knowledge and experience which it alone possesses.'[5]

This judgement reflected something of a collective sigh of relief by many members of the profession at being perceived as at least partially distinct from the medical fraternity and the appointment of the Teviot

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1. MoH, DoH(S), *Final Report of the Inter-Departmental Committee on Dentistry* (Cmnd. 6727, London, HMSO, 1946), p. 4.

2. A full list is given in the Appendix to the *Final Report of the Inter Departmental Committee on Dentistry*. See also MOH, *National Dental Service. Inter Departmental Committee. Circulated Papers D.1 - D.30.* PRO. MH77/189. File No. 93286/2/3A and *Circulated Papers D.31 - D.80.* PRO MH77/190. File No. 93286/2/3B.

3. Cmnd. 6565, London, HMSO, 1944.

4. Cmnd. 6727, London, HMSO, 1946.

5. *BDJ*, 74, 8 (16 April 1943), p. 213.

Committee seemed to afford considerable scope for further improvement.

The British Dental Association's sense of the importance of the occasion was well illustrated in the preamble to its evidence. The Council of the Association, it declared,

> 'was deeply conscious of the importance of the opportunity thus afforded of placing on record its considered opinion before a body whose deliberations will have a profound bearing on the future of dentistry in this country.'[1]

The Association presented some twenty-four pages of written evidence, which was later supplemented by oral submissions from a number of members, within the general framework of the four terms of reference of the Committee. But while it touched on many of the points which the dentists considered to be crucial to their entry into any suggested scheme, the general tenor of the submission was one which attempted to emphasise the importance of dentistry and dental health, the need for protection from unscrupulous practice and its eligibility to be considered a profession in its own right. In other words it recognised the importance of the moment, especially in an historical development sense, but failed at the same time to grasp the significance of the occasion in terms of the decisions to be made about the immediate future. Thus the evidence reads more like competent background research into the history and contemporary problems of dentistry rather than the contribution of a group which had a considerable interest in the government's stated intention of becoming involved in this area. The evidence was addressed primarily to the question of dentistry's status and its recognition as an independent profession rather than attempting to substantiate the profession's position in the intended service.

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1. BDA, *Memorandum to the Interdepartmental Committee on Dentistry* (London, November 1943), p. 3.

Even where the submission covers such matters as the 'Free Choice of Dentist', 'The Priority Classes', 'Conditions of Service' and 'Professional Control' the prescription was both vague and inconclusive. For example on the question of remuneration the Association declared that:

> 'Whatever method of remuneration may ultimately be found acceptable to the State, the public and the profession alike, it is emphasised that its order must of necessity be such as to enable a dental surgeon to maintain that state of culture which the public has a right to expect of him, to maintain and educate his family and to allow of provision for retirement at a reasonably early age. The rate of remuneration must be related to reasonable working hours, due allowance being made for adequate recreation and holidays.'[1]

Such an approach represented a marked contrast to that of the Government for whom dentistry was but a single aspect of a complex scheme for post-war reconstruction. Such a position was taken in a paper prepared by "M.R." (Miss M. Ritson) shortly before the appointment of the Teviot Committee in which she expressed the view 'that we've not given the subject sufficient consideration to enable us to concur in the setting up of a committee with such comprehensive terms of reference'. Her objections to such an enquiry were that

> 'We have always considered the post-war medical and dental services to be component parts of a comprehensive treatment service and it seems to me the consideration of the type and organisation of the post-war dental service cannot be divorced from the plan on which it is proposed to organise the medical services.
>
> Some of the problems arise in connection with both services so it will be highly undesirable to have to organise the services along different lines ...'[2]

This she concluded might well be forced upon them if the decision had been taken to negotiate with the medical profession and the local

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1. *Ibid.*, para. 72.

2. Paper dated 23 November 1942 in PRO. MH77/183.

authorities and then the Committee reported along totally different lines.

But the events of the next few years showed that she need not have been so concerned. For if the British Dental Association failed to take up the challenge of the immediate future, the Teviot Committee showed even less inclination for the first of its terms of reference. And in this it was actively encouraged by the Minister who wrote to Teviot suggesting that:

> 'Much of the field of your inquiry is likely to bear less upon the contents of this Bill than the subsequent policy and administration adopted for running the health service when it is set up; while much - no doubt - will bear upon general problems of dentistry which belong to the sphere of the Dentists' Act rather than the Bill setting up a national health service organisation.'[1]

In fact the Committee seemed to need little encouragement to direct its endeavour along such a path and if its Reports have been recognised as significant contributions to the development of the dental profession,[2] it is less easy to attribute any overwhelming importance to them in respect of the implementation of the public dental health services. The Interim Report which had been specifically requested by the Minister was more obviously aimed at the immediate problems but of its twelve specific recommendations, seven can be found in the NHS White Paper,[3] an eighth was contained in principle in the White Paper but related specifically to medicine,[4] while the remaining four if of

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1. Letter, dated 9 September 1944 in MoH, *National Dental Service. Inter Departmental Committee. Circulated Papers D.81 - D. 119.* PRO. MH77/191. File No. 93286/2/3C.

2. See, for example, J.S. Ross, *The National Health Service in Great Britain* (London, Oxford University Press, 1952), pp. 253-4.

3. Comprehensive service; analagous to medical service; dental health centres; freedom for patient and dentist; use of dentists in administration and planning; "special classes"; co-operation between levels of service.

4. The type of contract body to be used.

some originality, were hardly of great consequence.[1] The Final Report had its sights far more pointedly set on reporting the whole dental picture and in this regard highlighted many of the problem areas that the dental health services would face and which were outlined in chapter one. The fate of these recommendations will be considered in more detail below.

The suggestion is that while the Committee's appointment cannot be classified as a deliberate diversion its deliberations nevertheless did serve to absorb much of the attention that was being focussed on dental matters at this time and that furthermore its very existence offered some credibility to the government's stated intention of acting to promote the dental health of the nation. Hansard in the period between 1944 and 1948 is full of references by the Minister either to the work or the reports of the Committee, yet in a sense these represent something of a substitute for action: the wider problems of the dental health services were considered the province of the Teviot Committee and had little influence on the implementation of the dental health services where general administrative questions, whose agenda had by and large been fixed as far back as 1942, dominated the proceedings.

In this first stage of the implementation process the Government was assisted by the profession's obsession with status but it also acted positively to confine the area of debate during both the legislative and post-legislative periods. Thus while the Teviot Committee made some attempt to come to grips with what might be termed the "political problems", the question of values, priorities and

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1. Appointment of a chief dental officer; paid leave for treatment; improved dental health education; measures to be taken upon the cessation of hostilities.

allocation of resources, the government instead pursued a "lowest common denominator" approach to its community of interest with the dentists. 'Unfortunately' exclaimed the Minister towards the end of the Committee stage of the NHS Bill, 'we have to get the dentists to contract in, and we have to provide conditions they are prepared to support at the outset'.[1] Thus while the Government might be forced from its ideal command model of implementation, it only gave ground to secure immediate advantage, and in this atmosphere the dialectic between the Government and the profession afforded little opportunity for consideration of the implications of the approach that was being made.

That a government conscious of its electoral position and cautious lest it lose the initiative should act in this way is not surprising, yet its behaviour adds weight to the argument of the thesis that under the particular approach to the supply of dental health services considerations pertaining directly to those services had little part to play. 'There is no fundamental difference between the National Health Service and the railways in terms of administration' wrote Bevan in *In Place of Fear*,[2] and by the same prescription the problems of dentistry appear to have been of only marginal importance to the architects of the dental health services.

The contrast between the activities of the two parties is instructive in emphasising their different perceptions of the situation. On the government side there was a conscious desire to introduce health service legislation as soon as possible, but despite

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1. House of Commons, *Official Report, Standing Committees A, B, C, D. 14 May - 11 July 1946.* (London, HMSO, 1946), Col. 1793.

2. A. Bevan, *In Place of Fear* (London, Quartet, 1978), p. 127.

the Minister's[1] continual assurances in answer to Parliamentary questions none was forthcoming before the change of government in July 1945. But such a delay had nothing to do with dentistry and can be explained partly by the suspension of many discussions at the time of the Normandy landings but more significantly by the fact that the whole-hearted support of the medical profession for such a service was by no means assured. The British Medical Association had sent a questionnaire to all its members (accompanied by a copy of the White Paper provided without charge by the government)[2] and the results indicated particular concern about the proposals for administration by local authorities and the intention to extend services to the whole population rather than the ninety per cent which the Medical Planning Commission had advocated. The medical profession was clearly the focus of the government's attention and such Parliamentary time as was spent on the health service proposals was largely filled with attempts by the opposition (especially Aneurin Bevan and Dr Edith Summerskill) to suggest that the Minister was being overwhelmed by the demands and tactics of the doctors and that considerable concessions had in fact been made.[3]

The point to be made from this is the simple but nonetheless telling one that despite the dentists' overwhelming interest, the dental health services were clearly of much less importance to the government. This was to be expected given the generally greater significance attached to medical and hospital services but its

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1. Henry Willink.

2. See 399 H.C. DEB. 5s. Cols. 43-44. No such gesture was made to the dentists.

3. See especially: 408 H.C. DEB. 5s. Cols. 1054-58 and 1987; 410 H.C. DEB. 5s. Cols. 380-2 and 1095ff; 411 H.C. DEB. 5s. Col. 1511ff.

consequences shouldn't be overlooked. That some form of dental service was necessary to and compatible with, a comprehensive health service had been decided as far back as 1942 and although the Teviot Committee provided a forum for debate it added, as has been seen, little of substance to the proposed form. The White Paper gave the topic only the most cursory coverage and only one speaker, Mrs Hardie, addressed herself in debate to dental matters[1] before the Question was put and agreed 'that this House welcomes the intention of His Majesty's Government, declared in the White Paper presented to Parliament, to establish a comprehensive National Health Service'.[2] In other words the very approach determined that dentistry had little chance of being considered on its particular merits: it was strictly an adjunct to the medical and hospital services and the government saw no reason to single it out for special attention.

For the dentists on the other hand the future of the profession was, perhaps naturally, their major preoccupation. But as has already been suggested, they appear to have been unwilling to admit any distinction or inconsistency between the general goal of increased status and the plan for a public dental service. In fact the pressure to introduce such a service was interpreted as an important support of the wider aspiration and it was not until 1946 that the leaders of the profession came to acknowledge that the government, for its part, clearly distinguished between the two propositions.

After the publication of the NHS White Paper the dentists were generally confident about the strength of their position. A "Manifesto"[3]

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1. 398 H.C. DEB. 5s. Col. 596.

2. 398 H.C. DEB. 5s. Col. 633.

3. BDA, *The Necessity of Private Practice to the Dental Health Service* (London, April, 1944).

issued in April 1944 spoke of 'the "three freedoms" of the Government White Paper on health [being] heartily endorsed by the British Dental Association',[1] but added that the

> 'Association will strenuously oppose any attempts ... to popularise dental treatment centres in a manner which stresses their advantages over those of free private practice ... The Association will discourage any form of propaganda which implies or attempts to foster the belief that the best form of State dentistry is better, in any way, than the best form of private dentistry ... the Association looks with great disfavour, even repugnance, upon any attempt to socialise dentistry in its entirety.'[2]

A similar confidence emerged from a meeting of the Consultative Committee[3] in which the view was expressed that the profession would be in a good position to get safeguards written into the NHS Bill and that as the NHS was dealing with the whole population, the Minister would need the co-operation of the whole dental profession, a fact which would considerably enhance its position in the negotiations.[4]

But if the tone was confident there was nevertheless some concern that the Association was to an extent misinterpreting the importance of the moment. Edward Samson in submitting the "Manifesto" to the Representative Board, noted how the evidence to the Teviot Committee had omitted to consider 'the place of the private practitioner in this perspicacious scheme'[5] and at the same meeting on 22 April 1944 the

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1. *Ibid.*, preamble.

2. *Ibid.*, paras. 1, 5 and 9.

3. Which had been set up in February 1945 to undertake contacts with the government and to continuously review the developing situation.

4. *Minutes of the Proposed NHS - Dental Consultative Committee*, meeting 22 February 1945.

5. Note accompanying the "Manifesto": presented to the Representative Board on 22 April 1944. See *Minutes of the Representative Board of the BDA*.

possibility was raised of both sponsoring a questionnaire of the entire membership (similar to that used by the British Medical Association) and of establishing a Parliamentary Dental Committee in the House of Commons. The Chairman headed off debate on each of these issues but nevertheless such a challenge to the leadership's position added a definite edge to the Association's meetings and after the first major consultation with the Minister in January 1945 a more acute sense of the drama unfolding began to percolate into the debate. For example it was suggested that members of the Consultative Committee should be required to respond to the question:

> 'Are you opposed to the dilution of the profession of dentistry in any form, including what we understand as prosthetists and hygienists?'[1]

and at the same meeting the view was expressed that one of the supreme crises in the history of the Association and of the profession had been reached.[2]

Yet despite the developing concern two issues continued to hamper consideration of the Association's position in regard to the immediate future. One was the government's insistence that matters of general administration (which involved a great deal more than dentistry) should be resolved before conditions of service were discussed, but the second was of its own making and involved the inability to agree on and articulate its own views. At a Council meeting on 10 November 1944 Mr Grandison introduced a discussion on the urgent need for a policy for the future but his initiative was opposed by Sir Norman Bennett who argued that there would be

> 'considerable difficulty at that juncture in arriving at

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1. *Ibid.*, meeting on 27 January 1945.

2. By Dr. Livingston.

> any definite policy. He felt that all avenues should be explored and that it might be better to await the publication of the report of the Interdepartmental Committee before his Sub-Committee considered further its terms of reference.'[1]

This position was reiterated at the next meeting of Council on 14 December 1944[2] and it was not until the Representative Board met on 28 April 1945 that some change in approach was signalled. 'The attitude of the Association', declared the Chairman,

> 'on the question of policy has been necessarily to a large extent negative; it had merely held a watching brief, watching the government ... it seemed to him the time had come when the Association need not assume that the Government had power to over-ride the members of the dental profession and impose upon them anything to which they definitely objected.'[3]

The policy statement, contained in the document *Proposals for A Dental Health Service for the Nation*, was finally presented to the Representative Board meeting on 25 and 26 January 1946 when it was examined and discussed paragraph by paragraph before being approved and ordered circulated to all members. It was divided into three parts: "Relevant Policy Approved by the Representative Board", "Proposed National Dental Health Service" and "Schedule". The first section contained general principles of action to be followed in the provision of public dental health services while the second and third consisted in proposed arrangements for such services. The document was notable for the detail of its contents and in this respect showed a marked contrast with the previous statements from the Association. Gone were considerations about the importance of dentistry to the community,

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1. BDA, *Minutes of the Meeting of Council.* 10 November 1944.
2. *Ibid.*, 14 December 1944. A report from the Council sub-committee stated that 'it could make no real progress until some indication was known of the government's intentions'.
3. *Minutes of the Representative Board*, 28 April 1945.

about the relative priorities of certain "at risk" groups, about the relationship between dental and general health and about the relative merits of different forms of dental practice. Instead the paper was intended to serve as a basis for negotiation with the government over conditions of service that would be acceptable to the profession. But no sooner had the "proposals" been issued than the NHS Bill was before Parlaiment and its contents demonstrated that the government had no intention of getting itself involved with the minutiae of organisational detail let alone "negotiating" over conditions of service. This is perhaps an appropriate point at which to move on to consider the second phase of the implementation process during which the NHS legislation was before Parliament.

The first and most obvious point to make in regard to the legislative stage of implementation is that while the Bill was both long and complex and took over six months to complete its legislative course, the dental provisions were in fact few in number and only four clauses included references of real substance. Clause Twenty-One dealt with treatment in health centres; Clause Twenty-Two required local authorities to make arrangements to inspect and treat certain "priority" groups; Clause Forty included the basic administrative arrangements for the general dental services; and Clause Forty-Four prescribed certain conditions for the supply and payment of applicances. Thus the dental clauses could not stand alone: they depended for interpretation on provisions and arrangements enunciated elsewhere in the Bill and by the same token the extent to which they might be amended without affecting other areas of the Bill was quite limited.

Nevertheless the Association sought to try. Having concerned itself in the early months of 1946 with matters of detail and possible conditions of service, the Association found itself confronted with a Bill of the

most general nature and was immediately pushed back on the defensive in attempting to thwart its passage through Parliament. A number of projects were sanctioned in an attempt to win support for the Association's position. A small public relations committee was set up with considerable freedom to expend the Association's funds; the Council was empowered to issue an appeal for special subscriptions from the membership; an editorial on the topic of the Bill was approved for the *British Dental Journal*;[1] a statement was issued to the press;[2] an appeal was made for the support of the profession[3] and a list of desired amendments was put together which, with a covering letter, was circulated to members of Parliament known to be interested in dental matters. Finally, meetings were organised within each constituent area of the Association.[4] At each of these a general motion was passed that

> 'The members of the Dental Profession here assembled, while approving whole-heartedly the principle of a comprehensive health service for the nation, within the framework of which dental treatment is to be included, consider that the proposals relating to dentistry in the NHS Bill are contrary to public interest and so inimical to the profession. They, therefore, pledge themselves to support such amendments to the Bill as will ensure the provision of a dental service under conditions completely acceptable both to the public and the profession and will participate in the scheme on the appointed day only if the regulations to be made under the Act do in fact make such a service possible.'[5]

But the impact of all this on the legislation was slight. No

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1. *BDJ*, 80, 7 (5 April 1946), pp. 235-6.

2. Full text in *ibid.*, pp. 244-5.

3. *Ibid.*, p. 243.

4. Full details of these meetings are given in *BDJ*, 80, 8 (18 April 1946), p. 283.

5. *Minutes of the Representative Board*, 4 May 1946.

significant amendment to the dental provisions was accepted by the government and the Bill received the Royal Assent largely unscathed. In the course of his second reading speech Bevan alluded to the difficulties facing the dental services. On the one hand there was the problem of shortages:

> 'We have not enough dentists and it will therefore be necessary for us, in the meantime, to give priority treatment to certain classes - expectant and nursing mothers, children, school children in particular and later on we hope adolescents. Finally we trust that we shall be able to build up a dental service for the whole population.'[1]

On the other hand were the limits to the types of service that would be provided:

> 'The State will provide a certain standard of dentistry free, but if a person wants to have his teeth filled with gold, the State will not provide that.'[2]

But Bevan's speech is best remembered for his defence of the Legislature: a tactic which perhaps owed a lot more to his continuing difficulties with the professional groups and his desire to resolve as much as possible within the parliamentary arena where a reasonable degree of control was possible, than any significant reverence for the House of Commons. Thus, claimed Bevan:

> 'Can anyone argue that this is not adequate consultation? Of course, the real cricitism is that I have not conducted negotiations. I am astonished that such a charge should be in the mouth of any member of the House. If there is one thing that will spell the death of the House of Commons it is for a Minister to negotiate Bills before they are presented to the House. I had no negotiations, because once you negotiate with outside bodies two things happen. They are made aware of the nature of the proposals before the House of Commons itself; and furthermore the Minister puts himself into an impossible position, because, if he has agreed things with somebody outside he is bound to resist amendments from Members of the House ... So there has been no negotiation in this matter. The House of

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1. 422 H.C. DEB. 5s. Col. 45.

2. 422 H.C. DEB. 5s. Col. 57.

> Commons is supreme, and the House of Commons must assert its supremacy, and not allow itself to be dictated to by anybody, no matter how powerful and how strong he may be.'[1]

But if this approach was essentially tactical it nonetheless represented a strong theme in Labour Party thinking which has already been documented in chapter four and which asserts the supremacy of Parliament and hence presumes that the implementation of a policy such as the NHS is an administrative rather than a political activity.

In the remainder of the second reading dentistry was afforded little attention. Mrs Corbet expressed concern over the ratio between teeth extracted and conserved and, invoking the arguments of Major-General Helliwell,[2] she bemoaned the fact that conservative treatment and the supply of dentures were provided from the same source and concluded (as George Bernard Shaw had done in similar vein for the doctors) that the dentists had a vested interest in removing teeth.[3] Captain Baird, one of two dentists in the House,[4] drew attention to the working class' ignorance of conservative dentistry, to the desirability of encouraging more working class children to become dentists, to his general disbelief that dental hygienists could make any great contribution to the problem of a shortage of dentists[5] and to the opportunity which should be taken to raise significantly, the status of the profession. The Hansard Report bears witness to the problems faced on this question and indeed in getting the whole

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1. 422 H.C. DEB. 5s. Cols 60-1.

2. A member of the Teviot Committee and the author of its minority report. See *Final Report of the Inter Departmental Committee on Dentistry*, pp. 49-52.

3. 422 H.C. DEB. 5s. Cols. 267-70.

4. The other was Mr. H.G. McGhee.

5. 422 H.C. DEB. 5s. Col. 311.

question seriously debated in the House, where it records that at one point laughter greeted Baird's claim that the removal of five or six teeth was a major surgical operation.[1]

Thus the Bill went to Committee with little more known about its dental provisions and although some clarifications were then made at this stage, they were done in only the most general terms. Some indication of the problems facing the consideration of dental matters was given in an early exchange over Clause Three. Captain Baird had sought clarification of the position of dental specialists (as the suggestion had been made that all NHS specialists would have to be on the Medical Register) and Sir H. Webbe had expressed the hope that 'the dental profession will be given parity of esteem with the medical profession in the great new service which is being set up'.[2] Bevan's reply is worth quoting in full:

> 'The person described as a specialist will be the person I am advised to describe as a specialist by the body which I hope to consult'.[3]

The response suggests two things: first the stress the Minister was laying on non-interference with the traditional structures of medicine and second, that the position in regard to dentistry had just not been thought through. The similarities with medicine were merely assumed and no separate arrangements made.

For the rest of the Committee stage debate, the dental interest focussed on three issues. The first was the attempt by Baird to move an amendment to Clause Twenty-two to require local authorities to

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1. 422 H.C. DEB. 5s. Col. 309.

2. *Official Report, Standing Committees A, B, C, D. 14 May - 11 July 1946.* Col. 1118.

3. *Ibid.*, col. 1126.

inspect and treat adolescents as well as children under five and nursing and expectant mothers on the grounds that from the dental point of view this was the group at greatest "risk".[1] Bevan expressed some sympathy for the proposal but maintained that the difficulty lay in the shortage of dentists and not in the wording of the statute. 'As soon as we have the necessary practitioners' he promised, 'the next priority class is that of the adolescents'.[2] Yet while the shortage was undoubtedly real at the back of the Minister's mind in giving this response must have been the concern articulated at an earlier departmental meeting of the great administrative difficulties in offering a service to this section of the community.[3]

The second major issue was how to attract practitoners to the less popular areas. Baird cited the findings of a committee on post-war resettlement of dentists which indicated that 90% of service dentists wished to live in the South of England and moved that Clause Forty be amended to provide a subsidy, possibly along the lines of that already in operation in the Highlands and Islands scheme, to encourage dentists to work in the less attractive areas. The Minister's response was wholly uncompromising: he acknowledged the problem, but suggested that its resolution was a suitable topic for resolution by the Spens Committee.[4] This Committee did in fact make such a

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1. *Ibid.*, cols. 1531-2.

2. *Ibid.*, col. 1533.

3. See letter from A.S. Marre to W.D. Bosworth Smith dated 20 May 1946 in MoH, *National Health Service. Dental Services Policy, Jan. 1946 - Oct. 1948.* PRO. MH77/125. File No. 93285/10/1B.

4. On the Remuneration of General Dental Practitioners see MoH, DoH(S), *Report of the Inter Departmental Committee on the Remuneration of General Dental Practitioners.* (Cmnd. 7402, London, HMSO, 1948).

recommendation but offered no suggestion as to how it might be arranged.[1]

The third significant issue was raised by Mr. Hopkin Morris and generated the most significant discussion of dentistry that was to take place during the whole legislative process. The subject of the amendment to Clause Forty-four was of fundamental importance to the British Dental Association and concerned the provision of a certain amount of "private" treatment within the NHS. The argument had two parts: first that it would encourage the participation in the NHS of a number of dentists who would not otherwise be involved and second that it was consistent with other provisions in the Bill which provided for the recovery of payments in respect of appliances which were more expensive than the generally prescribed ones.[2] Baird took issue with the amendment on the grounds that money and the capacity to pay for "extras" would decide the ordering of the queue for services[3] whereas the Minister showed himself rather more concerned with administration and overall costs. If the amendment was accepted, he argued, everybody would think that the government had gone grazy and that

> 'the answer is that we are prepared to provide, under the regulations, a certain amount for prescribed services. If the patient wishes ... to succumb to the blandishments of the dentists and get something over and above that, he must pay for it.'[4]

Questioned on this he emphasised that the government was not prepared to underwrite an agreement between the dentist and the patient and just

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1. *Ibid.*, para. 26.

2. *Official Report, Standing Committees A, B, C, D. 14 May - 11 July 1946.* Cols. 1783-4.

3. *Ibid.*, cols. 1784-8.

4. *Ibid.*, col. 1789.

hand the money over. Such provisions as the amendment anticipated would result in there being 'no reasonably cheap treatment available anywhere. All the fees would be stepped up, and the sky would be the limit.'[1] Baird interjected that the dentist must be allowed to decide between possible alternative courses of treatment and drew an immediate retort from the Minister: 'Who is to decide that - the dentist alone? Oh no'.[2]

During the remainder of the Committee's deliberations dentistry received only minor attention. Amendments were moved to Clause Forty to change the arrangements for prior approval of estimates[3] and Clause Fifty-seven to deny the Minister the capacity to take over the duties of the Dental Estimates Board under certain circumstances[4] and some assurance was sought that dentists in health centres would not have to provide monthly statistical breakdowns of the work they had done.[5] The Minister confirmed that no such figures would be required but the two amendments were withdrawn. Finally, in respect of the Fifth Schedule, the Minister refused to allow an insertion that would divide dental representation on the local Executive Councils between those with different types of qualification.[6]

The Bill was returned to the Committee of the whole House on 22 July 1946 and was read for a third time the next day. Some

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1. *Ibid.*, col. 1790.

2. *Ibid.*, col. 1790.

3. *Ibid.*, col. 1728.

4. *Ibid.*, cols. 1829-36. The work of the Board is described at some length in chapter nine below.

5. *Ibid.*, cols. 1500-02.

6. For example between those with degrees and those registered under the Acts of 1878 and 1921. See *ibid.*, col. 1944.

amendments were suggested in the House of Lords, particularly in respect of Clause Forty-four, but the government remained uncompromising and with its dental provisions unaltered the NHS Bill was returned to the Commons before receiving the Royal Assent on 6 November 1946.

With the passing of the legislation the character of the implementation process was fundamentally changed as discussion, negotiation and political manoeuvring between the prospective employers and employees increasingly dominated the centre stage. The essentially "public" part of the performance was over: the much talked about principles of health care provision had been largely incorporated into the NHS Act and it was only a question of time before the Service itself would be in action. But if the issue of principle had been decided there was much still to be resolved about the arrangements for practice. The Act was a most general piece of legislation and nowhere more so than in its dental Clauses which are largely incomprehensible if read alone and which need to be interpreted in light of both the medical provisions and the more detailed Regulations. The determination of the content of these Regulations is considered in the last part of this chapter.

A gradual narrowing in the focus of the British Dental Association has already been noted and in particular its concern with the establishment of a strong bargaining position at the expense of considerations pertaining to the social need for dental services. This changing but tardy response evolved as the Association began to understand that concerns outside the immediate instrumental purpose of the policy (seen in this case as the establishment on the due date of a system of dental health services) were largely irrelevant to the implementation process.

The NHS legislation almost completely avoided any substantial

reference to the particular problems of the provision of dental health services and provided only the most basic skeletal outline which it was presumed that the Regulations would fill. The British Dental Association had objected to this approach but it seems to have been well into 1946 before they realised its full implications. Writing in the *British Dental Journal* on behalf of the Council of the Association, Mr A.P. Husband noted that there were a large number of matters needing careful consideration but that the

> 'attitude of the Ministry is that all these can be considered at a later date after the introduction of the Bill. The profession is entitled to resent this. We are in danger, if we are content to maintain an ineffective defensive attitude, of being put into a position from which it will be extremely difficult to extricate ourselves.'[1]

A month later addressing the meeting of the Association in London to consider the NHS, Mr W.G. Senior the Dental Secretary was reported as saying that the

> 'objections were to the method proposed for the provision of dental treatment under the Bill and to the fact that the everyday things that mattered to the dentist [illegible]

The clearing of the cheque implied no great concern, for example, that all would be treated equally, that all would be equally entitled to the available treatment or that the problem of the shortage of dentists (and hence of available treatment) would be squarely faced. And if these and the other problem issues had not been attended to in the essentially public environment of the Parliament and the debate over the legislation, then there was much less reason to suppose that they would be resolved in the largely private dialogue between the Government and the profession over the conditions of service which are considered below.

It is intended not to give complete details of the meetings, discussions and manoeuvring that took place but rather to indicate the general flavour of the process and more importantly to illustrate the manner in which the focus of concern in respect of the dental health services was narrowed to consideration largely of the concessions that would have to be made by the Government to ensure the dentists' co-operation. Even where the dentists showed an interest in extending the range of concern, the Government's rigid control over the whole process of drafting and promulgating the Regulations ensured that attention never strayed far from the immediate problems associated with commencing the Service on the appointed day.

The basic dialogue centred on a number of meetings between representatives of the profession and the Minister or his representatives from the Ministry of Health and a limited amount of correspondence in which several substantive issues were repeatedly raised. Yet such contact was only the formal manifestation of the struggle between the two sides to obtain what each saw an an optimum solution. Optimum in this context almost invariably reduced on the one hand to maximum financial gain and on the other to minimum financial cost. In the

pursuit of these positions and in their general neglect of other considerations the two sides followed largely different courses.

The Government was committed to its "command model" of implementation with a need for maximum control, and clearly believed that with the backing of both the NHS legislation and its electoral victory, it had a strong case to see its plans fulfilled. Its greatest asset was undoubtedly the "paying patients" that it could bring to the individual dentist's surgeries (a factor which was to prove crucial after 5 July 1948), and in a more tactical sense it was supported by control over the *Regulations* timetable, the limited time available before the Service was to begin and the relative unimportance of dentistry in comparison with the medical and hospital provisions. Nevertheless, it was still fairly crucial in a political sense to ensure that "free" dental treatment became available from the start.

For the dentists, though, the issue of public supply was of crucial importance, yet they were constrained in seeking their objectives by a number of factors. Most obvious was the lack of unity in the profession: a single Association was to be formed in 1949, hastened by the drama of the immediate post-war years but at the time in question the presence of three separate organisations slowed and complicated communications[1] and afforded considerable opportunity to the Government to exploit some obvious divisions. A second problem which has already been identified related to the democratic nature of the British Dental Association which made it difficult for negotiators

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1. For example the Dental Consultative Committee, set up to discuss matters with the government, consisted of 14 representatives of the British Dental Association, 7 of the Incorporated Dental Society and 7 of the Public Dental Service Association. It had 7 "contact men" to meet the Minister and his officials but had no authority to agree to terms. See *BDJ*, 82, 4 and 5 (7 March 1947), p. 109 for details.

to commit the Association without the considerable delays involved in seeking plenary approval. Associated with both of these points was concern whether the leadership had caught the mood of the thousands of individual dentists scattered around the country and whether their support and solidarity could be maintained in face of considerable governmental pressure.[1] A third problem concerned the desire to maintain a professional monopoly over the supply of dental services when the dental technicians were pressing for greater autonomy and when the very volume of work to be done suggested that the use of para-dental personnel might be appropriate.

Thus one way or another the Government held most of the major cards and with its superior understanding of the "rules of the game" was well placed to resist the demands of the dentists whose performance was visibly affected by the constraints just detailed. Much energy was expended by the profession in attempting to maintain support amongst the rank and file dentists for the positions adopted[2] and the *British Dental Journal* was used to detail the moves that were being made to further the profession's claims. More than anything the pages of the *Journal* attempted to raise the consciousness of the profession to the dangers that were perceived by the leadership and in support of this members of the Council and the Association's secretariat attended and addressed many emotional meetings of dentists throughout the country.[3]

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1. See comments by Sir Norman Bennett, *BDJ*, 82, 4 and 5 (7 March 1947), p. 110.

2. See Capt. Baird's speech, 447 H.C. DEB. 5s, col. 100.

3. Details in *BDJ*, 80, 7 (5 April 1946), p. 244. The largest meeting, in London, was attended by about 700 dentists and a further 1800 were present at the provincial meetings.

Yet the volatility and self-righteousness of these occasions contrasted starkly with the meetings held with the Minister or his staff which although generally courteous[1] were marked by the generation of little or no support for the dentists' position. Some concessions were made: the right, for example, to treat private patients in public hospitals,[2] but on the whole the profession's demands were met with a briefly sympathetic ear and total intransigence in matters of substance. Some of the issues varied between meetings but four themes came to dominate the Association's approach: demands that payment be made by a grant-in-aid system; that the minimum number of operations should require prior approval; that persons other than dentists should not be allowed to operate directly on the patient; and that when a patient had begun treatment they should be required to attend until dentally fit. Secondary issues discussed consisted mainly in the question of professional appointments to such advisory and executive bodies as the local Executive Councils, the Local Dental Committees, the Standing Advisory Committee on Dentistry and the Central Health Services Committee.

The single most important issue of the post-legislative period was undoubtedly the question of remuneration, but not so much the actual amounts that were to be paid as the principles governing their allocation. The Government had acted to head off discussion of levels of income by offering and getting support for the appointment of what was known as the Dental Spens Committee, after its chairman Sir Will Spens who had already conducted a well-received inquiry into

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1. Though this was to change later in the proceedings. See *BDJ*, 84, 10 (21 May 1948), p. 225 and 450 H.C. DEB. 5s, col. 1018.

2. See letter from the Permanent Secretary, MoH, to the BDA and the other organisations, dated 16 June 1948 in PRO. MH77/125.

remuneration for medical practitioners. Nevertheless the British Dental Association remained concerned lest a service of salaried dentists working in health centres be introduced and continually expressed its general commitment to what was known as a grant-in-aid system of payment.

Its basis was a relative points table for all dental operations whose ratios would remain fixed. The government could over time vary the amount of money paid for each point and for the work done on each patient the government would pay the amount owing on the points scored, although the dentist could charge more for the operation and collect the difference from the patient.[1] In commending this system to the Government, the Remuneration Sub-Committee of the Teviot and White Paper Committee of the Association argued that it would avoid all the unseemly wrangling over remuneration which had gone on under the Dental Benefit Regulations of the NHI Scheme and which they maintained had 'done an extremely large amount of harm to the morale and status of the profession'.[2]

But if it was initially justified on the grounds of its relative simplicity the whole concept of grant-in-aid grew to symbolize the Association's objection to the Government's policy and in so doing attracted a number of arguments in support. The issue had been the subject of Hopkin-Morris' proposed amendment in Committee to Clause Forty-four of the Bill[3] and was to remain on the agenda until the

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1. Full administrative details in BDA, *Proposals for a Dental Health Service for the Nation* (London, British Dental Association, 1946), para. 29 and Schedule, part V.

2. Memo. to J.J. Gillard-Bishop, Hon. Sec. of the Committee (n.d. - January 1946?) in PRO. MH77/125.

3. See above p. 161.

Regulations were tabled. At least six distinct arguments were used at varous times: that there should be differentials in income to reflect matters such as age, skill and experience of the individual practitioner;[1] that the public ought to be able to pay more for treatment by a better dentist;[2] that the freedom of choice for both dentist and patient was impossible without the grant-in-aid system;[3] that the standard rate fee gave no reward for the employment of well-qualified staff or the use of the best materials;[4] that the standard rate fee would encourage quick rather than quality work[5] and that dentists would not join a scheme in which they felt their talents were being ill-rewarded.[6] But each of the arguments fell on deaf ears. The Minister was wholly uncompromising in his refusal to countenance such a system and offered but a single explanation: that 'grant-in-aid ran completely counter to the principles that the dental services provided under the NHS Act shall be free of charge and [that] he could not agree to any arrangement of the kind suggested.'[7] When it was argued that this would result in many dentists not joining the Service Bevan merely replied that

> 'if a considerable number of dentists refuse service, as indeed they are entitled to do, there is no compulsion on

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1. Minister's meeting with Dental Consultative Committee, 25 November 1947 in PRO. MH77/125.

2. *Ibid.*

3. *Minutes of the Representative Board*, 31 January 1948.

4. Memo by the BDA Council to a Joint Meeting of the Dental Organisations cited in *BDJ*, 82, 12 (20 June 1947), p. 271.

5. Editorial, *BDJ*, 84, 11 (4 June 1948), pp. 244-5.

6. Mr. Condry at meeting with the Minister, 25 November 1947. Reported, *BDJ*, 84, 1 (2 January 1948), p. 21.

7. PRO. MH77/125. Paper NHS (47) 30.

> them, then he would have to put up with it and make use of the service of those who would participate.'[1]

In maintaining this position the Minister had been encouraged by support from a number of sources. In a memorandum Mr F.J. Ballard of the Public Dental Service Association had stated that he would urge his organisation to reject grant-in-aid and had expressed concern at the British Dental Association's pursuit of 'unrestricted private practice' in face of the electorate's expressed desire for a national health service.[2] An internal memorandum to the Minister and the Permanent Secretary on the state of negotiations had reported that they 'are going quite well and once the grant-in-aid part is finally disposed of, I do not think we shall have any further difficulties. We do not think that the dentists seriously expect to get grant-in-aid: this seems to be more in the nature of a final demonstration.'[3] Thirdly, support came from Captain Baird who, in a memorandum prepared at the Minister's request, strongly urged an emphatic rejection of the scheme and who in the debate in the House in February 1948 provided perhaps the most complete statement of the case against the use of grant-in-aid. *Inter alia* he argued that:

> 'The dentists today are asking for a perpetuation of that two standard system of treatment ... [i]f we give the dentists the grant-in-aid system, they will continue the system whereby they will provide treatment for those patients who can pay over and above the State fee, and the devil take the rest of us. I believe that the British Dental Association want to perpetuate that class distinction which has existed for so long ... one cannot trust the dental profession either with a system of grant-in-aid or of clinical freedom ... I have every confidence that ... the solution to this question of remuneration and freedom is to see that the State pays the dentists adequately for a high

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1. Meeting 25 November 1947 reported *BDJ*, 84, 1 (2 January 1948), p. 21.
2. PRO. MH77/125. (n.d.).
3. Memo. (n.d.) (written by Dr Mahoney?) following receipt of letter (dated 15 July 1947) from Joint Committee of Dental Associations. PRO. MH77/125.

standard of work.'[1]

The second issue in the conflict over the Regulations focussed on the degree to which dentists might enjoy clinical freedom and in particular the capacity to undertake as much treatment as possible without prior approval from another authority. That some such approval would be necessary had been accepted by the Association in their pamphlet "Proposals for a Dental Health Service for the Nation"[2] published in January 1946 and most of the subsequent debate consisted in arguments over where the approval/non-approval line should be drawn, and emphasised the tensions between the demands for autonomy and control.

Four lines of argument were used by the dentists in support of their demands for a minimum of external control: that such control would impair the confidence of the individual practitioner; that it would interfere with his clinical freedom; that there would be delays in starting treatment;[3] and that it would lead to a standardisation and uniformity of treatment and a predisposition to avoid more complex and less routine operations on the grounds that they would invite increased scrutiny and involve considerable delays.[4] The more obvious bogey of the deadweight of paperwork was raised occasionally[5] but on the whole the profession had difficulty in articulating a substantive position. Their approach was always one that demanded more autonomy

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1. 447 H.C. DEB. 5s. Cols. 104-105.

2. See 'Schedule', para. 26 in *Proposals for a Dental Health Service for the Nation*.

3. These three arguments were put at the meeting with the Minister, 25 November 1947. See PRO. MH77/125. Paper NHS (47) 30.

4. See editorial, *BDJ*, 84, 6 (19 March 1948), p. 122.

5. By various speakers, for example, in the debate on the Prayer to disallow the Regulations. See report in *BDJ*, 84, 10 (21 May 1948), pp. 228-9.

than the Government was, at any time, prepared to allow and was predicated on the need for collective trust in the profession with only individual recalcitrants being punished.[1]

The Minister, perhaps naturally, worked from the opposite premise, and his rejection of these claims was based on the need to maintain strict financial control. Speaking at the meeting on 25 November 1947 Bevan argued that as the Service was to be paid for by the State, the State should have an interest in the cost and standard of service; that 'some degree of control for the protection of those paying for the service was implicit'[2] and that 'public finances are so deeply involved that it is not possible to allow two people, one of whom is an immediate beneficiary, in effect to arrange between them behind closed doors what the State should pay. The State must protect itself ...'[3] Finally at this meeting the Minister assumed a more aggressive stance and argued that the result of complete dental freedom would be the need for a wholly salaried service which he thought would operate against the interests of the profession itself. The *British Dental Journal* reported that 'the Minister purported to advance the advice to avoid it as being of a friendly nature to the profession'.[4] But more positively he acted to assauge the dentist's concern on the question of clinical interference by first persuading Mr W.G. Senior, the Dental Secretary of the BDA, who had been most active in promoting the dentists' viewpoint, to take

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1. Debate on BDA Council Memo. discussed at the Joint Meeting. See *BDJ*, 83, 1 (4 July 1947), pp. 22-4.

2. PRO. MH77/125.

3. Reported, *BDJ*, 84, 1 (2 January 1948), p. 20.

4. *Ibid.*, p. 20.

the position of Senior Dental Officer to the Minister of Health[1] and then appointing two long-standing members of the Association's Representative Board, Mr. W.L. Boness and Mr V.W. Humpherson to full time positions with the newly created Dental Estimates Board.[2]

The third area of concern centred on the use of paradental personnel and in particular dental hygienists and dental mechanics or technicians. The New Zealand school dental service had made extensive use of hygienists and a number had been employed in the RAF during the war to promote a greater awareness of oral hygiene and to undertake relatively simple fillings and other tasks such as scaling and cleaning. In its Final Report the Teviot Committee considered the arguments for and against the use of hygienists[3] but explained that there was a wide diversity of opinion on the Committee and that the only matter on which they could agree was that no significant action should be taken until it had been decided whether or not there were sufficient dentists to provide a comprehensive service.[4] However, a limited experiment was suggested to help ascertain the possible value of such personnel. Yet even in advocating this limited trial, the Committee was mindful of the difficulties involved:

> 'we have tried also to recommend something which will not forgo the co-operation of the profession. That has been one of our considerations in confining our proposals for delegation within quite narrow limits.'[5]

The dental technicians on the other hand were a rather different issue. Many were qualified and worked under the supervision

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1. *BDJ*, 83, 4 (15 August 1947), p. 83.
2. See report in *BDJ*, 84, 9 (7 May 1948), p. 197.
3. *Final Report of the Inter Departmental Committee on Dentistry*, paras. 177-89.
4. *Ibid.*, para. 190.
5. *Ibid.*, para. 191.

of dentists, but nevertheless a considerable number of the infamous "repair shops" still remained. The British Dental Association hoped to secure their closure by legislation associated with the NHS but as their concern over the Service narrowed less was heard on the topic as it became obvious that under a "free" service the demand for such repairs was likely to decline. In the debate on the Prayer to disallow the Regulations some support for the repair shops was forthcoming but with strong denials in this instance from the Parliamentary Secretary to the Ministry of Health[1] and on another occasion from the Minister himself[2] the concern largely faded away and the issue of ancillaries became the issue of hygienists.

The Teviot Committee's recommendation of a controlled experiment was endorsed by the Ministry of Health and put to the Dental Consultative Committee on 5 February 1947. The initial response was encouraging: that this would 'probably not be too unfavourably received by the profession', yet there was little hard evidence to suggest that this would be the case. The Association had been a long-time opponent of what it had come emotionally to term "dilution" and Captain Baird showed superior intelligence in warning the Minister of the need to find a "neutral" or "anti" member of the Committee set up to supervise the hygienists' "experiment" in view of the fact that the two members first appointed supported the whole idea.[3] Almost immediately afterwards Dr Mahoney[4] in an internal memorandum to the

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1. Reported, *BDJ*, 84, 10 (21 May 1948), p. 228.
2. Speech to the British Dental Students Association. See *BDJ*, 83, 1 (1 August 1947), p. 67.
3. PRO. MH77/125.
4. The Principal Dental Officer at the Ministry of Health.

Minister noted that 'the dental organisations have refused to nominate a member of this committee, and in fact have expressed their hostility to the experiment'.[1]

The Association's position was discussed at the meeting of the Dental Consultative Committee on 14 February 1947 where the experiment was described as 'dilution ... [which] would have to be dealt with firmly';[2] at the next meeting of the Representative Board which recommend that strong representation be made to the Minister; and at the Joint Meeting of dental organisations on 4-5 June 1947 which resolved

> 'That this Joint Meeting is of the opinion that the operation of scaling and polishing forms so important a part of parodontal treatment and preventative dentistry, that it cannot be considered as minor dental work. The meeting, therefore, strongly condemns the delegation of this operation to any person not registered as a dental practitioner, as being detrimental to the public interest and to the health of the community.'[3]

But although Bevan further baited the profession by emphasising that the experiment had been recommended by a committee on which dentists were in a majority,[4] the Government made no serious attempt to incorporate the hygienists into the NHS. Its attitude was best indicated by Miss Russell Smith of the Ministry of Health who wrote in an internal memorandum that:

> 'The Dental Organisations and especially the groups use the bogey of dilution to whip up the enthusiasm of their supporters and it would be a mistake to say anything which might raise the question again just before the Minister sees the Consultative Committee.'[5]

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1. PRO. MH77/125.

2. Mr. Flitcroft. *Minutes of the Proposed NHS - Dental Consultative Committee*. Meeting 14 February 1947.

3. *BDJ*, 82, 12 (20 June 1947), p. 272.

4. Speech to British Dental Students Association. See *BDJ*, 83, 1 (1 August 1947), p. 67.

5. PRO. MH 77/125 (n.d. - November 1947?).

In other words with a panache reminiscent of the way in which they had dealt with grant-in-aid the officials at the Ministry of Health acted to defuse the potential issue by removing the straw which the profession was attempting to grasp.

The fourth major issue between the Government and the dentists consisted in the complaint that neither the Act nor the Regulations made any stipulation that once a course of treatment had been started the patient should be required to attend until adjudged dentally fit. The Association's position was essentially that if dental health was to be maintained dental decay must be treated early otherwise the costs would be enormous. The way to do this was to move the understanding of dentistry beyond merely the response to and treatment of pain and treat the disease before it became extensive. Legislative support for such a position would thus be most desirable.[1] Furthermore the Association also argued that the absence of such provisions was directly inconsistent with Clause One of the Act which placed on the Minister the specific duty of promoting and establishing a *comprehensive* health service.[2]

The Minister's response to these questions focussed completely on the issue of the freedom of the patient. 'It would be incompatible with this position' (that of a "free" service) he argued 'to deprive an applicant for the dental services of the freedom to decide how much treatment he would undergo.'[3] Support for this position, which he reiterated on a number of occasions, came from the Editor of the *Times*

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1. *Ibid.* Meeting 25 November 1947.

2. British Dental Association Council submission to Joint Meeting. Reported *BDJ*, 82, 12 (20 June 1947), p. 271. Emphasis added.

3. PRO. MH77/125.

who wrote that 'the BDA is claiming for the dentist a power over the patient such as no doctor would dream of requesting and Mr Bevan has naturally rejected it'.[1] And although the leadership remained firm on this issue there is some evidence to suggest that there was less than wholesale support in the profession generally. An editorial in the *Journal* in March 1948 referred to many members having written in support of the Minister's position[2] and a number of speakers at the Joint meeting in June 1947 had been less than enthusiastic about it.[3] Nevertheless, despite this, it remained one of the issues used to justify advising the Association's membership not to participate in the NHS.[4]

Finally brief consideration must be given to the issue of dental appointments to both administrative positions within the NHS and to the various NHS Committees. The matter was by no means as divisive as those just discussed but it remained, nevertheless, a source of some considerable irritation to the profession throughout the negotiations over the Regulations. The point at issue was the extent of such dental representation in both absolute terms and relative to the medical profession. The Association pushed specifically for the appointment of a Chief Dental Officer for each local authority[5] and statutory dental representation on Regional Hospital Boards[6] as well

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1. *Times*, 2 March 1948, p. 5.
2. *BDJ*, 84, 6 (19 March 1948), p. 127.
3. Reported *BDJ*, 83, 1 (4 July 1947), pp. 18-25.
4. *Minutes of the Representative Board.* Meeting 31 January 1948.
5. *Ibid.* Meeting 8 July 1948.
6. Meeting of the Dental Consultative Committee, reported in *BDJ*, 82, 4 and 5 (7 March 1947), p. 10.

as a high level of dental representation on the professional advisory committees. But by and large their efforts were ill-rewarded and their submission to the Joint Meeting in June 1947 noted that

> 'In spite of all possible Parliamentary action, the dental profession is still inadequately represented on all the major advisory and executive bodies set up under the Act. There are only 3 dentists on the Central Health Services Council out of a total membership of 41 (21 of whom are doctors). There are only 3 dentists on each Local Executive Council out of a total membership of 24, and there is no specific provision for general dental practitioners on any of the Regional Hospital Boards. With such a scanty representation it is considered that the dental side of the Health Service must receive inadequate consideration, to the detriment of both patient and dentist.'[1]

And by and large the position remained unaltered at the date of commencement in July 1948.

But although these individual issues generated considerable heat, their combined impact on the implementation process was slight. From the passing of the *National Health Service Act* until the start of the Service the Government rarely deviated from either its timetable or its intentions. It has already been shown that the profession's endeavours on each issue largely came to nought but the overall context of government-profession relations in which they were being discussed might also be noted.

Although the Association had worked hard and largely without reward to secure amendments to the NHS Bill, it nevertheless offered some qualified support for the legislation once it was on the statute book. An editorial in the *Journal* noted that

> 'the general principles underlying the Act are accepted by the profession. That much could have been taken for granted in view of its constant endeavours to make adequate dental service more widely available to the great mass of the population.'

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1. Reported, *BDJ*, 82, 12 (20 June 1947), pp. 271-2.

The Association's concern was 'whether the scheme outlined ... in the Act will in fact achieve its aim'.[1] The editorial then argued that the success of such a scheme would depend upon the greatest possible dental co-operation and implied that this would only be given if the administrative details were acceptable to the profession. Thus as the implementation process continued and concessions to the dentists were not forthcoming the leadership of the profession gradually moved towards a position of non-cooperation.

A resolution that 'the Service will not be one in which association members could be advised to participate' was discussed at a meeting of the Dental Consultative Committee in October 1947, but allowed to lie on the table on the grounds that it was perhaps a little ahead of its time.[2] However "time" seems to have been reached shortly afterwards at the meeting on 25 November 1947 when the Minister's refusal to concede any of the dentists' main claims led to an aggressive response from the profession. The Dental Consultative Committee which met the following day appointed a drafting committee to prepare a memorandum on 'The Undesirable Features of the Dental Benefit Regulations'[3] and at its next meeting spent some considerable time discussing whether contact with the Government should be maintained.[4] However the most significant repercussion took place at the Representative Board meeting on 31 January 1948 at which the following resolution was approved:

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1. *BDJ*, 81, 10 (15 November 1946), p. 323.
2. *Minutes of the Proposed NHS - Dental Consultative Committee.* Meeting 8 October 1947.
3. *Ibid.* Meeting 26 November 1947.
4. *Ibid.* Meeting 15 January 1948.

> 'That the Representative Board of the British Dental Association, having given due consideration to the proposed details of the General Dental Service under the National Health Service Act of 1946, finds that the provisions thereof which the Minister of Health seeks to impose are not in accordance with the principles which the Association advised the Minister were essential to provide a satisfactory dental service for the nation. The Representative Board, therefore, recommends all members of the Association to exercise their right under the Act to refuse to enter the Service until the Act and its Regulations are amended so as to include the principles advocated by the Association.'[1]

However a rider was added to the effect that the Association was prepared to 'maintain with no sense of commitment' its contact with the Government in an effort to secure mutually acceptable terms of service. In fact the final resolution was more moderate than had seemed likely at some stages of the debate. For example Mr. R.H. McKeag had suggested that:

> '... if the medical and dental professions stood firm and the Minister failed to make the Act work, he would almost certainly resign'.[2]

But Professor Humphreys had brough a sense of perspective back to the meeting with the suggestion that:

> 'If the [original] resolution were carried and implemented there was no doubt in his mind that the Minister would accept the challenge. What forces were available and what chance did they stand? To fight they must have first the support of a large body of public opinion and secondly the support of the political party in opposition. There was no proof that they had either.'[3]

The resolution as passed was conveyed to the profession by letters from the Chairman of the Representative Board and the President of the Council which took the form of an editorial in the *British Dental Journal* on 20 February 1948 and it remained the position of

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1. *Minutes of the Representative Board.* Meeting 31 January 1948.
2. *Ibid.*
3. *Ibid.*

the Association through to the beginning of the new Service. The position was endorsed at an Extraordinary General Meeting in Birmingham on June 19 and thus the Association became the only professional body to advise its members not to participate in the NHS. But after the appointed day it quickly became obvious that despite the assertions of solidarity which had characterised the Birmingham meeting the rank and file dentists had largely ignored the Association's recommendations and by 4 November 1948 some 8,343 dentists (over 80%) had registered to participate in the Service.[1]

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1. 457 H.C. DEB. 5s. Col. 1020.

CHAPTER SIX

THE ADMINISTRATIVE STRUCTURE

Some considerable space has been given to the issues involved in the implementation of the dental health services because it is clear that the particular resolution of the conflicts has had important consequences for subsequent policy operation and performance. The form of the administrative arrangements is the most obvious manifestation of the outcome and in this short chapter it is proposed both to outline the administrative structure and to consider the extent to which it was influenced by the goals and aspirations of the health care reformers and the assumptions behind the Labour Party's preferred approach to public supply.

The nature of these aspirations, which included commitments to making the receipt of treatment depend upon an assessment of medical need rather than the capacity to pay and the equal availability of all required services, were discussed in chapter two and the particular problems which would have to be overcome if dental services were to be provided on these terms were detailed in chapter three. The most obvious issue was the shortage of practitioners which would require the introduction of a system of priorities whose order was to be determined by dental criteria, and in this and a number of other ways the supply of dental health services presented problems which were significantly different from those of the hospital and medical services whose influence on the content of the White Paper has already been noted.

The implementation process is thus important not only because it led to the introduction of the dental health services but also from a more analytical point of view, because it was the forum in which the possible differences and conflicts between the aspirations and organisational techniques had to be reconciled. There were three main inputs: the goals of health care reform which had been developed by

way of a critique of the existing medical and hospital services, the problems peculiar to the provision of dental health services and the assumptions and techniques behind the chosen approach to public supply. In outlining the administrative arrangements that resulted, some comment will be made about the extent to which they came to reflect these different concerns.

Overall, the process of implementation was shown to be primarily an exercise in organisational construction in which considerations pertaining to administration and the maintenance of political control predominated throughout. A concern with the overall administrative structure was followed, after the publication of the White Paper, by attention to the administrative arrangements of the dental health services and finally, negotiation over the specific terms of service for the individual practitioners. At the same time a concern with the issues of political control was indicated by the insistence on central funding, the rejection of the use of a statutory corporation and later, and more emphatically, by the emphasis given to the maintenance of financial control and the policing of the activities of the individual dentists through the use of the "prior approval" system and inspection by Regional Dental Officers.

But the concern with these matters was at the expense of other considerations: in particular it was shown that questions relating specifically to the supply of dental health services largely failed to make the agenda of serious consideration and that once stated in fairly general terms (for example in the White Paper), the principles underlying the assumption of public responsibility for supply played little part in determining the particular form of the administrative arrangements. But in addition there was no evidence of concern either about the possibility that policies might be distorted by being

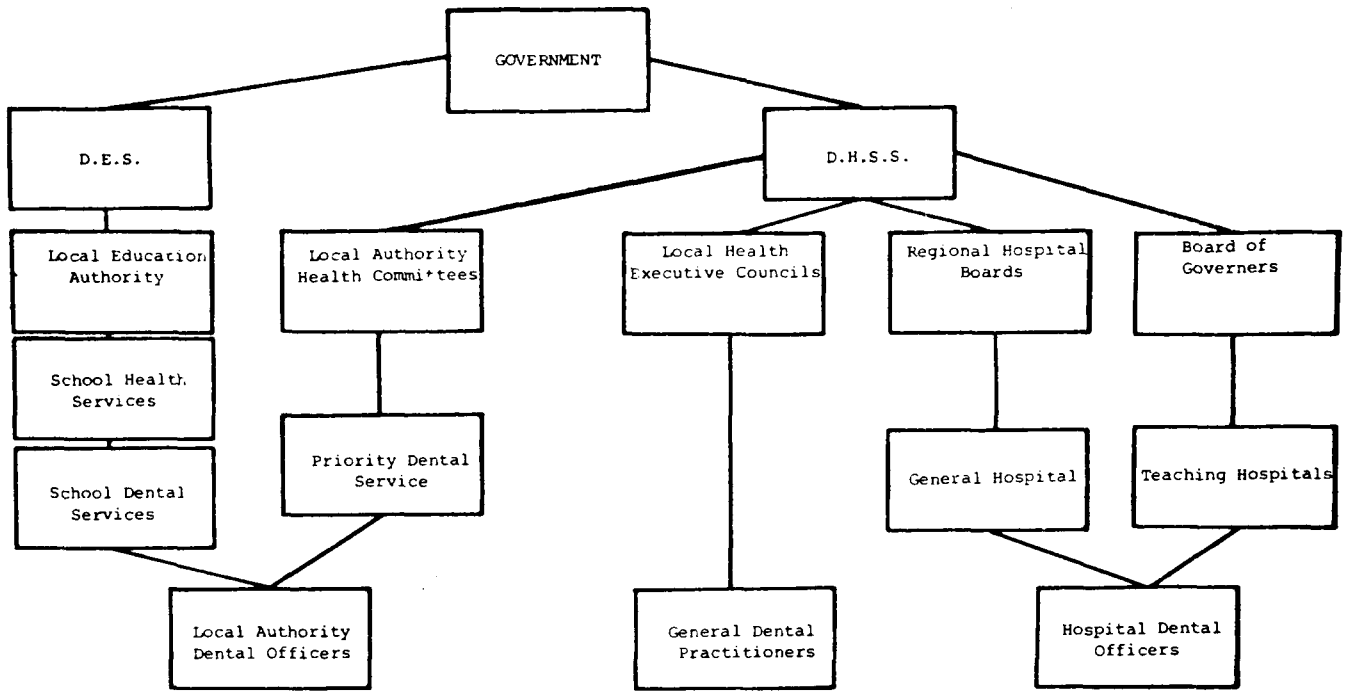
administered through a large public organisation or that the power acquired by those involved might affect the eventual policy outcome. Little consideration was given, for example, to the possible effects on the behaviour of both patients and practitioners of the use of the fee-for-service system of payment and no reservations were expressed about the increasingly powerful position of the dentists as they were accorded monopoly status in a single, universal system.

That these matters went undiscussed can, it is argued, be explained by the particular approach to public supply which exhibited an overwhelming preoccupation with matters pertaining to administrative structure and political control in the belief that if these issues were satisfactorily attended to, the resulting arrangements would not only be omni-competent but also have universal application. With a belief in such capacities and under the obvious political pressure of needing to ensure that the Service was brought into operation on the appointed day, the whole implementation process took on a particular character which clearly influenced the resulting administrative arrangements. Two aspects of these arrangements will be considered here: the organisation of the dental services within the overall context of the NHS and the arrangements pertaining to practice within the general dental services.

THE PROVISION OF DENTAL HEALTH SERVICES UNDER THE NHS

Under the scheme introduced in 1948 the arrangements for providing dental health services closely mirrored the overall organisational structure of the NHS with its essentially tripartite form. Figure 6.1 gives a schematic view of these arrangements.

FIGURE 6.1 THE ADMINISTRATION OF THE DENTAL SERVICES IN THE NHS PRIOR TO 1974[1]



Notes: (1) DHSS = Department of Health and Social Security, formerly called the Ministry of Health.

(2) DES = Department of Education and Science, formerly called Ministry of Education.

The three parts can be readily identified. On the left of the diagram are the dental officers associated with the local authority health services who provided the school service and the service for nursing and expectant mothers and pre-school children. On the right are the salaried and sessional officers of the Hospital Dental Service who provided both specialist advice and treatment upon referral from general practitioners as well as ordinary dental treatment for various categories of hospital patients. Salary scales in both the local authority and hospital services were determined nationally, but the dentists were contracted directly to the appropriate local authority

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1. Source: G.L. Slack (ed.), *Dental Public Health* (Bristol, John Wright, 1974), p. 135.

(for example the Regional Hospital Board or the Local Education Authority). Within each service there was a modest career structure with higher positions available to those with experience and additional qualifications. The dentists in general practice who appear in the centre of the diagram were employed under rather different conditions. They were to operate as independent practitioners and although they contracted into the Service through the Local Health Executive Councils they were largely free to move and work as they wished. There was no career structure and remuneration was to be based on a fee-for-service system.

A number of points might be made about these arrangements: first the extent to which they were modelled on those already in existence; second the similarities between the provisions for medicine and dentistry and finally the way in which they reflected a particular understanding of concepts such as responsibility and control. In describing the developments which made up the implementation process it was shown that considerations pertaining either to the particular problems of providing dental health services or to the realisation of the goals that first informed the move towards health care reform were subordinated to the more practical considerations involved in introducing a service on the appointed day. Behind this subordination lay the major assumptions about the capacity of the administration and the ability to maintain political control. That the dental health services could be successfully administered and that they could be administered in line with certain objectives was never seriously questioned under an approach to public supply which, as has been shown, placed great emphasis upon public administration as a universally applicable, instrumental technique. Hence in building upon the existing administrative arrangements little effort was made to consider

the particular problems of dentistry as the concern with financial control and responsibility dominated both the legislation and subsequent negotiations over the regulations.

These features survived the 1974 reorganisation which, although it introduced some fundamental changes into the NHS, nevertheless left the three groups of dentists readily identifiable. The new Area Health Authority became the centre of dental activity: it took over and now administers the contracts of dentists employed by the local authorities and provides a combined Schools and Priority Service within the general ambit of the Community Health Services; it employs the consultants[1] and their subordinates who provide dental treatment in hospitals and it is required by statute to set up and service the Family Practitioner Committees (the equivalent of the Executive Councils in the previous arrangements) which administer the contracts of the dentists in general practice. Thus although the administrative structure was changed in an attempt to promote greater Area responsibility for, and control over, all aspects of health care provision, the functional division of dental labour in respect of the client groups served remains largely unaltered. A recent editorial in the British Dental Journal provides perhaps a typical dentist's view of the 1974 reorganisation:

> 'Little has changed for the 70 per cent of the profession who work in the general dental service. Their independent contractor status is unaffected and their remuneration by way of the family practitioner committee is through a separate budget over which the area health authorities have no direct control. The majority of consultants working in district general hospitals will have noted little effect on their daily work attributable directly to re-organisation beyond that resulting from a proliferation of administrators, especially at district level. In some ways it is only the community dental service that has

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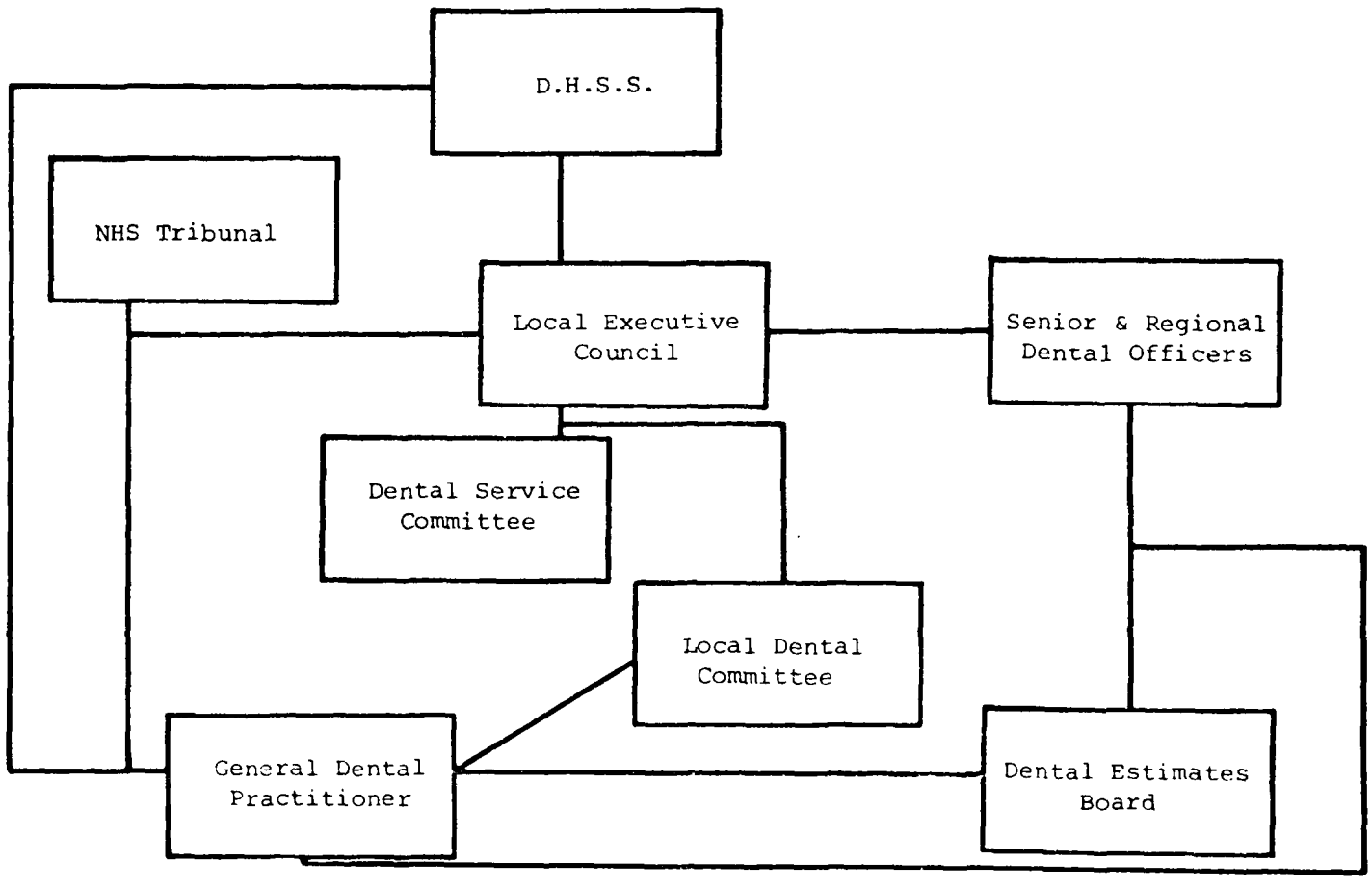
1. A few are employed by the Regional Health Authorities.

> derived some tangible benefit from reorganisation as a result of its transfer to the N.H.S. from the Department of Education. The availability of capital finance has permitted considerable improvement in such things as the standard of equipment in many former local authority clinics. However, revenue finance is a very different matter and funded establishments for staffing have generally remained at 1974 levels with little prospect of much improvement in this situation for some years.'[1]

THE ADMINISTRATIVE ARRANGEMENTS OF THE GENERAL DENTAL SERVICE

The administrative arrangements pertaining to the salaried NHS dentists are relatively straightforward, but this is not the case with the general dental practitioners for whom a relatively complex network of arrangements have been made. These are represented diagramatically in Figure 6.2.

FIGURE 6.2 THE INTER-RELATIONSHIP OF OFFICAL BODIES WITH ADMINISTRATIVE RESPONSIBILITIES IN THE GENERAL DENTAL SERVICES, 1971[2]



1. *BDJ*, 145, 12 (19 December 1978), p. 351.

2. Source: Slack, *Dental Public Health*, p. 143. Note that purely advisory bodies have not been included.

The particular nature of the relationships represented in the diagram will be discussed in chapters nine and ten and here brief reference will be made only to the functions of the individual agencies which reflect, in a number of ways, the dominant concerns of the implementation period.

Department of Health and Social Security (formerly the Ministry of Health). The Department has a number of responsibilities relating to the general dental service including the provision of advice to the Secretary of State on dental matters, the employment of Regional Dental Officers and the conduct of negotiations with representatives of the profession over the terms of service and other related topics.

Local Executive Councils. Dentists wishing to practice within the NHS are required to register with a Council and the latter maintain lists of local practitioners who are willing to accept NHS patients. The Councils also have a responsibility to ensure that local arrangements are adequate to meet the needs of the public.

Regional Dental Officers. Experienced practitioners, these officers undertake clinical examinations of a sample of patients in an attempt to check on the quality of treatment provided by general practitioners and also report on a sample number of those cases for which the "prior approval" of the Dental Estimates Board has to be sought before treatment can be commenced.

Dental Estimates Board. The Board is responsible for the professional and financial scrutiny of claims for payment of fees and provides the Local Executive Councils with the necessary authority to pay practitioners.

Local Dental Committees. These are committees of elected practitioners who nominate the dental members of the Executive Councils and with whom the Councils are required to consult on matters of administration and

planning within the general dental service.

Dental Service Committees. These are quasi-judicial bodies responsible for the investigation of cases where the dentist is alleged to be in breach of his terms of service.

National Health Service Tribunals. The Tribunals, before whom legal representation is allowed and witnesses may be subpoened, are responsible for deciding, in cases where complaints have been made, whether practitioners may be allowed to remain on the Executive Council lists. Appeals from the Tribunal may be heard either by the Secretary of State or the High Court.

The most obvious feature of these arrangements was the emphasis placed on the concept of responsibility: the responsibility both of the government to see that money was expended only in line with the regulations and the responsibility of the dentist to carry out his work in a satisfactory manner. Responsibility, understood in the wider sense of a 'duty to see ... that the service *is* provided'[1] was not so obviously reflected in the arrangements. Only the Executive Councils, with an obligation to see that the local services were adequate to meet local needs, were afforded this kind of role and then without the resources to see it fulfilled. In reflecting the dominant themes of the implementation process the arrangements were concerned, above all, with administering the employment of a large number of semi-autonomous professional people within the public sector, in which issues relating directly to the form of that employment and to the relationship between the dentist and the patient in whose favour money was being spent, predominated. In essence, the basis of the

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1. MoH, DoH(S), *A National Health Service* (Cmnd. 6502, London, HMSO, 1944), p. 12.

administrative arrangements was the interaction between the individual practitioner and the individual patient and there was little scope for inputs which considered the provision of general dental services from a more community-oriented perspective.

The 1974 reorganisation did little to alter this position.[1] New advisory and consultative machinery was established but the system of payment and the disciplinary apparatus remained unchanged. Thus in a typical case a dentist may move to a particular area, register with the Executive Council (since 1974 termed Family Practitioner Committee), set his plate on the door and await the attendance of patients for treatment. Such treatment could be one of three types: normal courses of treatment; normal courses requiring prior approval and emergency courses of treatment. In a normal course the dentist is required to carry out all treatment necessary to secure dental fitness which the patient is willing to receive and once completed he submits a claim for payment to the Dental Estimates Board where it is processed and if approved is added to the other claims made by that dentist. At the end of each month the total amount due to the particular dentist is calculated and payment is authorised through the local Executive Council. The work carried out might subsequently be subject to a random check by a Regional Dental Officer. In cases where prior approval is necessary the dentist is required to submit a treatment plan for approval by the Dental Estimates Board before he can commence work. These plans are generally considered directly by the Board but in some cases an opinion on the appropriateness of the

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1. For a general discussion of this point see G. Madden, 'Consultation and the Dental Profession', *BDJ*, 144, 7 (18 April 1978), pp. 253-7 and A.G. Green, 'The General Practitioner: His Representation and Political Lines of Communication in England', *BDJ*, 136, 7 (2 April 1974), pp. 285-8.

proposed treatment might be sought from a Regional Dental Officer. Once approved the same payment schedule is followed. The only difference for emergency treatment is that the dentist is only required to undertake the treatment necessary to relieve pain (and not secure dental fitness) before payment can be claimed. The types of treatment which fall into the three categories are detailed in the Regulations.

Thus the comprehensiveness of the arrangements pertaining to the control of the behaviour of the individual practitioner contrasts markedly with the general absence of any arrangements designed either to resolve the particular problems facing the supply of dental health services or to secure the realisation of the more general goals behind the public assumption of responsibility for health care provision. The way in which these arrangements have influenced the development of the dental health services will be the subject of the next two chapters.

PART FOUR

THE OPERATION OF THE DENTAL HEALTH SERVICES

CHAPTER SEVEN

THE DEVELOPMENT OF THE DENTAL HEALTH SERVICES UNDER THE NHS

There can be no doubt that the availability of dental health services under the NHS has led to a substantial growth in the provision of dental treatment in Britain. It has been estimated that about two million courses of treatment were provided by general dental practitioners in the years immediately before the NHS began[1] but by 1950 there had been a more than three-fold expansion to 7.179 million courses.[2] Since then there has been a steady annual increase with some 26.973 million courses of treatment provided in the general dental services in 1977.[3] In the School Dental Service the growth has been less spectacular but nevertheless nearly 5 million children were inspected in 1972 compared to 3.453 million in 1947. However, it should be noted that this represents a fall from 67.9 to 53.8 per cent of the total maintained school population.[4] At the same time the amount of money expended in respect of dental services has increased substantially and the cost of £329m.[5] to run the general dental services in 1978-79 compares with an estimated figure of £8-8½m. for 1947.[6] In this chapter it is intended to examine from a number of perspectives the expansion indicated by these indices to give some understanding of the

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1. House of Commons, *Seventh Report of the Estimates Committee, Session 1948-49.* 'The Administration of the National Health Service', (London, HMSO), para. 313.

2. MoH, *A/Rep. 1950-51* (Cmnd. 8655), p. 40.

3. DHSS, *A/Rep. 1977* (Cmnd. 1394), p. 24.

4. Data from House of Commons, *First Report of the Estimates Committee, Session 1962-63.* 'Dental Services', (London, HMSO), p. 107 and 'Fit For The Future', *Report of the Committee on Child Health Services* (Vol. II, Cmnd. 6684/1, London, HMSO, 1976), Table E.9.

5. Royal Commission on the National Health Service, *Report* (Cmnd. 7615, London, HMSO, 1979), Table E.9.

6. *Seventh Report of the Estimates Committee, Session 1948-49*, para. 309.

pattern and the character of the development which the public supply of service has promoted.

The initial approach to this characterisation will be made by separately examining the development of the three main sources of dental services under the NHS: the general dental services, the local authority (community health) dental services and the hospital dental service. The distribution of practitioners among these three areas can be seen in Table 7.1.

TABLE 7.1

PROFESSIONAL STAFF IN THE DENTAL SERVICES IN ENGLAND AND WALES (1974)[1]

General Dental Service	
General Dental Practitioners	11,408
General Dental Practitioner Orthodontists	120
School Dental Service	
School Dental Officers	1,585 (wte)
Consultant Orthodontists	12 (wte)
Hospital Dental Service	
Consultant Dental Surgeons	241 (wte)
Consultant Orthodontists	81 (wte)
Other Hospital Dental Officers	510 (wte)

Note: wte means 'whole time equivalent'

THE HOSPITAL DENTAL SERVICE

Dental Services in hospitals were largely non-existent before 1948 (except for hospitals related to the teaching of dentistry) and although it is difficult to obtain comprehensive figures on the total number of patients treated[2] the number of out-patient attendances for

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1. Committee on Child Health Services, *Report*, p. 206.

2. On this problem see C.A. Moser, K. Gales and P.W.R. Morpurgo, *Dental Health and the Dental Services: An Assessment of Available Data* (London, Oxford University Press, 1962), p. 20.

treatment in the hospital service had reached 2.38 million in 1974.[1] Further evidence of this gradual improvement can be found in two reports on the hospital dental service made by the Standing Dental Advisory Committee of the Central Health Services Council. The first in 1952[2] showed that the facilities in the hospitals were often woefully inadequate, that the equipment was often primitive and that 'oral hygiene among chronic and mental patients was sadly neglected.'[3] Because there was so wide a gap between the existing services and what was desirable the Committee felt obliged to make both short term recommendations in regard to staffing, frequency of examinations and other matters in order to cope with the immediate problems, and rather more ideal long term plans. Reporting again in 1964 the tone of the Committee's report was quite different: it suggested that because of advances in modern medicine the demand for in-patient treatment had been falling and went on to concern itself almost wholly with staffing trends in the consultant services (dental surgery and orthodontics).[4] The impression gained is of major improvements made in this area of health care and a growing emphasis on specialist work. By 1974 the equivalent of 832 full-time dentists (including consultants) were employed in hospitals.[5] However, despite the overall growth in the consultant services, the expansion has been by no means uniform.

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1. BDA, *Dental Care for the Community; Dental Education and the Developing Role of Dental Ancillary Personnel* (London, BDA, n.d.), p. 11.

2. Central Health Services Council, *A/Rep. 1952* (London, HMSO), paras. 61-69.

3. *Ibid.*, para. 64.

4. Central Health Services Council, *A/Rep. 1964*, paras. 9-17.

5. *Report of the Committee on Child Health Services*, p. 207.

Figures produced by the British Dental Association in 1962 showed that the number of consultants per million inhabitants ranged from 1.40 for the Welsh Hospitals Board and 1.88 for the Manchester Regional Hospital Board to 5.10 for the Newcastle Regional Hospital Board.[1] A more recent survey of orthodontic services demonstrated that while a vast area was covered by the service there were still a number of locations, most particularly in rural Wales and parts of the north of England, where no facilities were available within a range of 20 miles.[2] The authors suggest that their survey reveals 'how thinly the consultants' services were spread in many areas'[3] and how a considerable time was spent by the consultants in travelling between the hospitals at which they worked. They also found that:

> '60 per cent of regional consultants held appointments to clinical areas containing populations of 400,000 to 1 million. 20 per cent had areas even above this and only 20 per cent of regional consultants served areas of less than 400,000 people.'[4]

Thus the story of the hospital dental service has been one of very great improvement under the NHS, but also one in which the benefits of the improvements have not been uniformly felt. The changing pattern of hospital treatment, with an increased emphasis on short term care, has undoubtedly facilitated the growth and concentration on specialist care, and as the figures in Table 7.1 attest, a considerable pool of expertise has been built up in the period since 1948.

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1. P.J. Cook and R.O, Walker, 'The Geographical Distribution of Dental Care in the United Kingdom', *BDJ*, 122, 10 (16 May 1967), p. 447.

2. D. Seel and P. Burke, 'The Consultant Orthodontic Service', *BDJ*, 134, 7 (3 April 1973), p. 294.

3. *Ibid.*, p. 293.

4. *Ibid.*

LOCAL AUTHORITY DENTAL SERVICE

The local authority services which since 1974 have been known as the School and Priority Service are made up of two parts: a service for school children and one for nursing and expectant mothers and children under five. The first school dental clinic was opened in Cambridge in 1907 and in the same year the *Education (Administrative Provisions) Act* empowered local education authorities to provide medical (including dental) inspections of children in schools.[1] The *Education Act, 1918* obliged education authorities to provide or make arrangements for dental treatment for children at public elementary schools and the *Education Act 1944* extended this obligation to cover secondary schools.[2] The service for expectant and nursing mothers and pre-school children was authorised by the *Maternity and Child Welfare Act, 1918* but was not made obligatory until the *National Health Service Act* was passed in 1946. The same dentists have usually worked in both services (splitting their time in the ratio of 10:1 in favour of the Schools' side) and their combined workforce rose from a total of 270 dentists (68 full time, 202 part time) in 1918 to 921 (full time equivalents) in 1947.[3]

The *Chief Medical Officer's Report* for 1924 stressed that 'the chief obstacle to success in school dentistry at the present time is the reluctance of parents to consent to conservative treatment of their

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1. G. Turner, *Organisation in the School Dental Service* (London, BDA, n.d.), p. 3.

2. S. Gelbier, 'The Local Authority Dental Services - Their Future in the United Kingdom', *BDJ*, 126, 7 (1 April 1969), p. 332.

3. See DES, *The Health of the School Child 1956-57* (London, HMSO), p. 49 and BDA, *Memorandum on the Local Authority Dental Services* (London, BDA, n.d.), p. 3.

children's teeth'[1] but nevertheless over the next fifteen years a significant attempt was made to overcome this problem through the extension of the Schools service. There was, apparently, no shortage of applicants for the salaried positions and by 1932 only 4 of the 316 local education authorities had failed to introduce a dental service.[2] In 1948, with the equivalent of 921 full time dentists, the School Dental Service was able to inspect 64.7% of the 5.4 million children in maintained schools.[3] The point is emphasised because in the absence of any other substantial public dental service it represents quite a record of achievement and suggests that by the time the NHS began considerable progress had been made towards meeting the dental needs of this "at risk" part of the population.

From its inception the Service was part of the School Medical Service and in consequence the staff, however senior, were always subordinate to the Principal Medical Officer. Despite the recommendations of the Teviot Committee for the appointment of a Chief Dental Officer with direct access to the employing authority,[4] the general grant of autonomy which was given to the profession in 1956[5] and further support for the principle of direct access to the executive which was contained in a report by the Estimates Committee in 1963,[6]

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1. *The Health of the School Child 1956-57*, p. 50.

2. *Ibid.*, p. 51.

3. Memorandum submitted on behalf of the Minister of Education and the Minister of Health to the Estimates Committee. See *First Report, Session 1962-63*, pp. 106-7.

4. MoH, DoH(S), *Interim Report of the Inter Departmental Committee on Dentistry* (Cmnd. 6565, London, HMSO, 1944), para. 98.

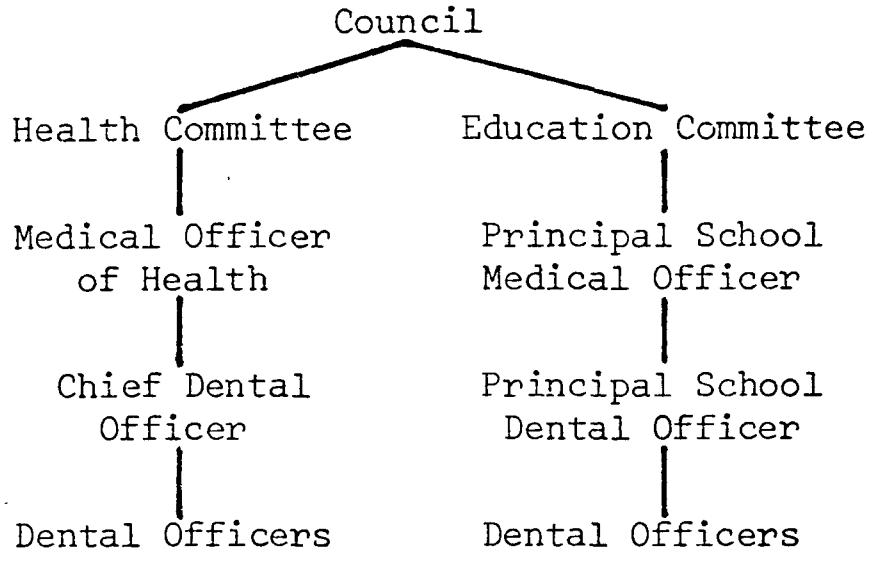
5. By the setting up of the General Dental Council.

6. *First Report of the Estimates Committee, Session 1962-63*, paras. 55-6.

no change was effected until the 1974 re-organisation.[1] A typical administrative arrangement is shown in Figure 7.1 below.

FIGURE 7.1

ADMINISTRATIVE STRUCTURE OF LOCAL AUTHORITY DENTAL SERVICES[2]



In each area the Chief Dental Officer was the same person as the Principal School Dental Officer as indeed the same person combined the offices of Medical Officer of Health and Principal School Medical Officer.

This subservience of the dental to the medical services was also manifested in the relevant central government department, and the Estimates Committee made much of this in its criticism of the Service. In the debate on its Report, the Chairman of the Committee, Sir Eric Errington suggested that:

> 'It is an extraordinary thing that, with seven million children throughout the country, we had evidence before us from the Ministry of Education to show that their Ministry had only one dental officer to look after them

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1. The nature of the medical/dental relationship had been laid down in a Joint Circular on Local Authority Dental Services. See Gelbier, 'Local Authority Dental Services', for details.

2. Adapted from *ibid.*, p. 333.

> all and that he preferred to call himself a medical officer. This is an indication of the Cinderella position of the dental services ...'[1]

In coming to this conclusion Sir Eric undoubtedly drew upon a series of exchanges which occurred while the Committee was examining the Principal Medical Officer, Ministry of Education (Dr P. Henderson). It quickly emerged that Dr Henderson who had professional responsibility for the School Dental Service (and who subsequently admitted that he was 'a bit prejudiced on the medical side rather than the dental')[2] had in fact only one dental adviser on his staff and that the man, who had both medical and dental qualifications, had been appointed as a medical officer. Asked about this, Dr Henderson replied:

> 'It has been going on since the beginning of the Service, since he was appointed. He was always put down as a doctor ... In fact we never tumbled to this until the British Dental Association themselves came and complained about it. We said we would look into it and in the next published report we put down Dr Wynne as Medical Officer, and, in brackets, Dental Adviser to the Department. We did not think it was very important'.[3]

But the Committee clearly had a different view as the following exchange suggests:

> '2678 (Chairman) ... this is an extraordinary position. As Dental Adviser, what staff did he have? - (Dr Henderson) He has not got a staff. He works on his own.
>
> 2679. What duties has he? - His duty is to advise us on school dental arrangements.
>
> 2680. How could he do it if he did not have any staff? - He goes round himself ...
>
> 2682. He is directly responsible for the dental health of how many children? - Seven million'[4]

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1. 680 H.C. DEB. 5s. Col. 1612.
2. *First Report of the Estimates Committee, Session 1962-63*, Q. 2688.
3. *Ibid.*, Q. 2677.
4. *Ibid.*, p. 335.

Although Dr. Henderson went on to emphasise that the 'actual responsibility for the School Dental Service is virtually on the Local Education Authorities',[1] the point can nevertheless be made that his comments reflect the lack of importance which the Ministry of Education attached to its role in the School Service. This is evidenced both by the paucity of the staffing arrangements and the "Cinderella status" the service enjoyed in relation to its medical counterpart. The significance of these points will be shown later in this section where the problems of productivity and regional inequality are considered.

Since the 1974 reorganisation the situation has been changed by the appointment of Area Dental Officers (ADOs) with responsibility, within each Area Health Authority, for both the School Service and the priority service for mothers and children. The management arrangements declared that:

> 'Unlike the present Principal School Dental Officer, the ADO will be accountable directly to the Authority and not to its medical officer'.

However,

> 'He will not be a member of the Area Team of Officers, since much of the team's work will not be of interest to him ... it should be the responsibility of the Area Administrator to ensure that appropriate matters arising in the Area Team of Officers are brought to the ADO's attention'.[2]

Thus after 67 years the local authority dental officers were released from medical control but at the same time they were denied a place at the high table in the new arrangements. Clearly much of the Area Team's work would be of little interest to the ADO but nevertheless it seems

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1. *Ibid.*, Q. 2682.

2. DHSS, *Management Arrangements for the Reorganized National Health Service* (London, HMSO, 1972), paras. 5.9-5.11.

unlikely that dental matters will receive their due attention when the appearance of their representative at the senior professional executive body is only on an occasional basis.

But if the problems of medical domination had been with the local authority service since its inception, the difficulties with staffing levels can be directly attributed to the introduction of the NHS. The steady development between the wars has already been demonstrated and by 1948, after a drop in numbers due to mobilisation between 1939 and 1945, there were the equivalent of 921 full time dentists employed making a dentist/pupil ratio of approximately 1:5870. By 1952 the number of dentists was down to 713 and coupled with a rising school age population this led to a ratio of only one dentist for over 8,400 pupils. Since then there has been a generally steady growth in the number of dentists employed but as the school population has similarly expanded the dentist/pupil ratio has showed little change from the original 1948 figures and in 1974 it stood at approximately 1:6000.[1] An official explanation of the staffing problems was contained in a memorandum by the Ministry of Education to the Estimates Committee in 1963:

> 'the establishment in 1948 of the general dental service as part of the National Health Service led to the resignation of a number of school dentists because of the higher incomes obtainable as general dental practitioners in the new service, and by 1952 the number of school dentists had fallen to the full-time equivalent of 713. Thereafter, some improvement was effected by the establishment of new negotiating machinery for salaries and a national salary scale, while the introduction of certain charges under the general dental service eased the pressure on general dental practitioners and led more of them to take part-time appointments as school dental officers. Since 1952, the general staffing position has improved gradually, but

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1. Data from the *First Report of the Estimates Committee Session 1962-63*, the Committee on Child Health Services, *Report* and DES, *A/Reps*, particular years.

> the number of salaried officers who make their career in local authority service has shown signs of falling, while the improvement in total staffing has barely kept pace with the increase in the school population'.[1]

However the calm of this *post facto* judgement hardly reflects the emotional responses that the problem generated at the time. The School Dental Service was the subject of numerous Parliamentary Questions and two Adjournment Debates[2] and also received considerable coverage in the media.[3] The major problem was the comparatively low remuneration which the local authorities could offer in relation to general practice, but in addition the authorities themselves were slow to respond to the problem and the Minister showed little inclination to push them.[4] The *Economist* reported that the local authorities were bidding against each other for dentists and that much of the blame could be laid at the Government's door for failing to give the priority service the priority it deserved.[5] In reply to this kind of criticism the Government claimed that it was waiting for the Dental Whitley Council to be set up and that once national salary scales were introduced the recruitment problem would become less acute.[6] In general terms this proved to be an accurate prediction but probably only because demand in the general dental services dropped (partly due

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1. *First Report of the Estimates Committee, Session 1962-63*, p. 103.
2. See Debates on 26 November 1948: 458 H.C. DEB. 5s, Cols. 1592-1604 and 8 May 1950: 475 H.C. DEB. 5s, Cols. 106-126.
3. See, for example, *The Times*, 20 March 1950, p. 5.
4. See, for example, 464 H.C. DEB. 5s. Col. 1990.
5. *The Economist*, 7 January 1950, p. 4.
6. See, for example, comments of the Parliamentary Secretary, MOH, 475 H.C. DEB. 5s. Cols. 123-126. Note also that the Chief Medical Officer, MoH later suggested that he felt that 'the establishment of negotiating machinery was probably of greater value than the new rates of pay themselves'. See *The Health of the School Child 1956-57*, 'Fifty Years of School Dentistry', p. 55.

to the imposition of charges in 1951 and 1952) and because a number of dentists agreed to work on a part time sessional basis in the School Service. In fact the number so engaged rose from 193 in 1951 to 701 in 1959.[1]

Some insight into the Government's attitude towards the local authority service at this time can be gathered from its response to the British Dental Association's well publicised offer of '10,000 hours of surgery time each week for the treatment of children'.[2] The Association had undertaken a survey of its members and found that about a third were prepared to undertake the treatment of children in their own surgeries under the aegis of the general dental services. In offering these facilities the Association hoped that 'no administrative difficulties will be allowed to stand in the way of utilising to the full the declared desire of the profession to contribute in this way towards the solution of a very grave national problem'.[3] The Government's response was nothing if not defensive:

> 'The Ministers welcome the interest shown by the Association in the problem of providing dental treatment for the priority classes ... there are, however, certain principles which they consider to be fundamental to the proper organisation of a dental service for the priority classes and to which in their view both short term and long term policy must have regard.'[4]

These "principles" were threefold: that the most effective way of providing treatment for children was in clinics associated with the school routine; that it was more cost effective to treat children

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1. *The Health of the School Child 1958-59*, p. 33.

2. See *BDJ*, 93, 8 (21 October 1952), p. 218. Original letter dated 10 October 1952.

3. *Ibid.*

4. Letter published in *BDJ*, 93, 11 (21 December 1952), p. 301.

in this way rather than in general practice and that with the great shortage of dentists, dental manpower could be most effectively used in clinics.[1] Not surprisingly the dentists concluded that the Government 'would rather save cash than children's teeth' and further expressed their surprise that

> '[n]owhere in the letter is there the slightest sign of any sense of emergency. The Ministers, it seems, are only prepared to consider any help in providing school dental treatment if it falls into line with their preconceived iders of how a school service should be run. One looks in vain for any sense of the immediacy of the problem ...'.[2]

Notwithstanding the dentists' obvious interests in this matter the Government's attitude nevertheless deserves some comment: not only did they refuse this opportunity to supplement the manifestly inadequate school service but this action followed on earlier decisions to reduce the fee for the conservation of a deciduous tooth undertaken in general practice, and to make such a fee payable once only in the lifetime of the tooth.[3] It is difficult to conclude other than the Government's over-riding concern was to keep children's dentistry within the confines of the local authority service where, whatever the shortcomings in respect of performance, the costs could be more easily controlled. Furthermore it is ironic that the Government should choose to defend its position on the grounds of economy, efficiency, and the need to develop school services within a particular institutional framework when, over the next few years the Service showed no growth *vis à vis* the school population and came under increasing criticism for

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1. *Ibid.*

2. *Ibid.* Further correspondence was published with the agreement of both parties in the *BDJ*, 94, 11 (2 June 1953), pp. 312-3 and 95, 1 (7 July 1953), p. 28.

3. See *BDJ*, 87, 9 (4 November 1949), p. 253.

its poor productivity. Indeed it was probably only because an increasing number of children eventually sought treatment in the general dental rather than the school service that the latter didn't collapse entirely. These matters will be discussed in more detail below but first, to conclude this section on the problems of staffing, the regional and social consequences of the shortages need to be considered.

By 1951 four local education authorities were without a dentist at all[1] and even though the overall position improved thereafter, the improvements were by no means uniform. The Ministry of Education recommended a figure of one dentist for every 3000 schoolchildren[2] but in 1956, for example, only two counties, Anglesey and Merionethshire had attained this figure[3] and overall the range stretched from Anglesey at 1:2800 to Derbyshire with a ratio of 1:18,700.[4] By 1965 the disparities had not been markedly reduced: approximately 250,000 children lived in areas where the dentist/pupil ratio was better than 1:3000 but for almost half of the school population (almost 4 million children) the ratio was 1:6000 or more.[5] These ratios must of course be read alongside the figures for the general dental services to give a composite picture of any particular area but nevertheless the general impression is that wherever there were shortages in general practice there were similar problems in the school service.[6] Typical

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1. *The Health of the School Child 1950-51*, p. 45.
2. *The Health of the School Child 1954-55*, p. 57.
3. And they employed only five dentists between them.
4. MoH, DoH(S), *Report of the Committee on Recruitment to the Dental Profession* (Cmnd. 9861, London, HMSO, 1956), Appendix V.
5. *The Health of the School Child 1964-65*, p. 98.
6. *The Health of the School Child 1962-63*, p. 103.

references to the problem came from Derbyshire where, in 1964:

> 'Barely a hundred [dentists] ... to serve a population of three quarters of a million with about 120,000 school children, and of these a mere half dozen endeavour to keep the school dental service alive'.[1]

and West Suffolk where, in 1960, the Principal School Dental Officer, who was the only whole time employee, reported that,

> 'there is still no prospect of obtaining full time staff, and that it is actually fourteen years since such an appointment was made'.[2]

The obvious point to make is that the basic data of the dentist/student ratio masks the considerable variations which existed and that even in periods of general improvement the benefits were by no means uniformly felt. As recently as 1976 the Court Committee on Child Health Services drew attention to the problems of unequal recruitment in particular areas and noted that 'Wales and the North of England were particularly handicapped in this respect'.[3]

This shortage of staff combined with problems of productivity to severely inhibit the school service in its stated aims of ensuring that

> 'as far as possible, children shall leave school without the loss of permanent teeth, free from dental disease and irregularity, and trained in the care of the teeth'.[4]

More specifically the service attempted to ensure an annual inspection for every school child, the offer of treatment to those who needed it and the provision of treatment for all those who accepted the offer.[5] That

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1. *The Health of the School Child 1964-65*, p. 99.
2. *The Health of the School Child 1960-61*, p. 183.
3. *Report of the Committee on Child Health Services*, para. 13.30.
4. 'Conditions of a Satisfactory School Dental Service' included as Appendix A to *The Health of the School Child, 1954-55*.
5. Memorandum submitted on behalf of the Minister of Education and the Minister of Health to the Estimates Committee. See *First Report, Session 1962-63*, p. 103.

it has failed in the first of these objectives can be seen from the figures in Table 7.2 below.

TABLE 7.2

SCHOOL DENTAL SERVICE. NUMBER AND PERCENTAGE OF PUPILS INSPECTED: SELECTED YEARS 1938-74[1]

YEAR	NUMBER OF PUPILS INSPECTED ('000)	PERCENTAGE OF SCHOOL POPULATION
1938	3,531	69.3
1948	3,503	64.7
1952	2,788	46.2
1956	3,524	52.4
1960	3,721	53.3
1966	4,140	55.6
1970	4,578	55.0
1974	4,950	53.9

The inherent difficulties in measuring productivity in a service like this didn't inhibit the inquiries of the Estimates Committee which, in its Report in 1963, was particularly critical of the School Service. The focus of their complaint was the fact that while in 1952 each school dental officer treated about 1,900 children, the equivalent figure for 1961 was only 1200.[2] And in fact by 1974 it had fallen below a thousand.[3] Any number of hypotheses were offered to the Committee to explain this drop, which was in direct contrast to the trend in general practice, but in its Report the Committee concluded that poor

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1. Sources: *First Report of the Estimates Committee, Session 1962-63,* [illegible]

organisation within the individual authorities was the most important factor[1] and went on the criticise the Ministry of Education for its failure to exercise more supervision in this area.[2] This conclusion was based largely on a study in Scotland which had indicated enormous differences in productivity in individual authorities[3] and a series of experiments carried out in Edinburgh and London which had involved considerable co-operation with general dental practitioners.[4]

In moving to focus attention on this particular explanation the Committee perhaps skated rather too quickly over a number of the other suggestions offered. The first point was the age of the practitioners involved: the Chief Dental Officer of the Ministry of Health suggested that those who left the service in the early 1950s were the young and middle aged dentists who could expect to earn more money in general practice and hence 'the people who stayed in the service were the older people whose output you would expect to be lower'.[5] In this view he was supported by a Treasury witness, the Chief Medical Officer of the Ministry of Education[6] and by figures released by the Ministry of Health which showed that in 1957, 46.3% of all full time dentists in the local authority service were over the age of fifty.[7] A second factor, and a rather more subjective one, was

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1. *First Report of the Estimates Committee, Session 1962-63*, para. 64.
2. *Ibid.*, paras. 72 and 80.
3. Details given in 'Local Authority Dental Services: Output Per Dentist' published as Appendix V to *ibid.* at pp. 369-70.
4. *Ibid.*, para. 71.
5. *Ibid.*, Q. 1310.
6. *Ibid.*, QQ. 2617 and 2713.
7. MoH, *A/Rep. 1957* (Cmnd. 495), p. 176.

raised by the Chief Medical Officer for Derbyshire who suspected

> 'that we tend to get the less competent and less active members of the dental profession in the local government sphere because they are probably men - this is a sweeping statement, I know - who could not earn so much in private practice - I suspect that, and we are inclined to think it is much the same on the medical side.'[1]

Other witnesses were perhaps more tactful, attributing lack of ability either to age or recent qualification, but nevertheless the point was often made.[2] A third factor was the rapid turnover of staff: a memorandum submitted by the London County Council showed that while it had a total strength of 120 dentists, between January 1960 and April 1962 there had been 89 appointments and 86 resignations.[3] Further evidence of this problem can be found in the biennial reports of the Principal School Dental Officers: for example Mr T.H. Liptrot wrote from Wolverhampton in 1956 to say that:

> 'In the past four years over 30 different dental surgeons both part-time and full-time, have occupied the 7 available surgeries. Such changes of staff would be disruptive in any occupation, but in professional work of this nature it is most unfortunate.'[4]

Taken together these factors paint a picture of a service whose status was undoubtedly inferior to that of general practice and which, consequently, was largely unable to attract the services of the better dentists. From the evidence there is little doubt that the service was being "used" by both young graduates supplementing their income with a part-time appointment while building up their own practices, and older dentists whose productivity was declining and who

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1. *First Report of the Estimates Committee, Session 1962-63*, Q. 2326.
2. See for example Appendix 4 in *ibid.*
3. *Ibid.*, Table iii, p. 272.
4. *The Health of the School Child 1956-57*, p. 60.

preferred a salary to piece rate payments. While these factors do not themselves necessarily explain poor productivity they do support the contention that the local authority service suffered from a lack of commitment from a considerable proportion of its staff and that in consequence the services cffered must have been affected.

The results of these problems have already been noted statistically in terms of the failure during the first twenty-five years of the NHS to ever inspect significantly more than half of the school population. At the same time the number of children actually treated in the school service declined from 30.1% of the maintained school population in 1948 to 13.9% in 1974.[1] To a degree this drop has been offset by a very significant increase in the number of children receiving treatment in general practice[2] but these overall statistics mask both the nature and the extent of the problems involved. The Committee on Child Health Services noted in its Report in 1976 that

> '[t]he General Dental Service and the School and Priority Service tend to care for different sections of the community, with the latter mainly providing services in rural areas and for children from the lower social classes and disadvantaged families. In areas where there is a low dentist/population ratio, it may be the only practicable source of treatment.'[3]

These findings were substantiated by the Child Dental Health Survey in 1973[4] and highlight the problems and consequences associated with a shortage of resources in the schools' service. Any attempt to "ration"

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1. *First Report of the Estimates Committee, Session 1962-63*, p. 107 and *Report of the Committee on Child Health Services*, Table E.8.

2. From 7% of all cases in 1949 to 31% (approx. 7.5m. courses) in 1974. See *Report of the Committee on Child Health Services*, para. 13.29.

3. *Ibid.*, para. 13.30.

4. J.E. Todd, *Children's Dental Health in England and Wales, 1973* (London, HMSO, 1975), p. 113 and Tables 12.7 and 12.8.

services affects the school population unevenly: as the level of treatment is reduced not only do the lower social classes tend to be denied the availability of treatment but they also bear the brunt of less desirable forms of treatment that this rationing implies. Thus for example in 1953 the Principal School Dental Officer for Cumberland reported the need for an essentially utilitarian approach:

> 'there is no doubt that a certain amount of ruthlessness has to be cultivated by dental officers under present conditions, otherwise it is liable to become a case of Rome burning while Nero fiddles with elaborate fillings. Such a policy may seem hard on individuals, but the aim of the service must be the greatest good to the greatest number.'[1]

And two years later a dentist in Liverpool wrote that

> 'multiple extractions of the deciduous teeth have to be carried out so that time may be directed to the preservation of the permanent teeth of the older schoolchildren ...'[2]

Such views are less frequently articulated nowadays but nevertheless the Child Dental Health Survey showed that while in 1973, 19% of the fifteen year olds in London and the South East had had some permanent teeth extracted, the figure for the North was 43% and for Wales 50%.[3] However care has to be exercised in relating the dental condition of children to the performance of the Schools' service alone because of course many children have also received treatment from general practitioners. Nevertheless the figures given in the three tables below suggest first, that children as a priority class need substantially more treatment than they are receiving at the present time (Table 7.3); second that the type of treatment given in the general

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1. *The Health of the School Child 1952-53*, p. 44.

2. G.L. Slack, 'Incidence of Dental Caries in Children under Five Years Old', *British Medical Journal*, 1 (29 January 1955) cited in *The Health of the School Child 1954-55*, p. 60.

3. Todd, *Children's Dental Health in England and Wales, 1973*, Table 19.1.

dental services (where the bulk of the treatment on children is carried out) shows huge variations between the regions (Table 7.4) and finally that in terms of tooth loss there was a considerable correlation between the number of fourteen year olds in the different regions with some permanent teeth missing and the figures for edentulous adults found in the 1968 Adult Survey (Table 7.5). It is not of course possible to say to what extent the fourteen year olds surveyed will recreate that pattern, but although the editor of the Child Dental Health Survey noted that the situation at fourteen was not irreparable she nevertheless found the comparison 'worrying'.[1] If nothing else it adds weight to the argument often expressed that the priority service for children should be accorded very much more priority.[2]

TABLE 7.3

PROPORTION OF CHILDREN NEEDING SOME DENTAL ATTENTION AT THE TIME OF EXAMINATION (1973)[3]

Age	Proportion of children with some decay or gum trouble or orthodontic need
five	79%
six	87%
seven	94%
eight	97%
nine	98%
ten	95%
eleven	95%
twelve	94%
thirteen	90%
fourteen	90%
fifteen	88%

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1. *Ibid.*, p. 227.

2. For example see *Report of the Committee on Child Health Services*, para. 13.26.

3. Todd, *Children's Dental Health in England and Wales, 1973*, Table 9.10.

TABLE 7.4

REGIONAL VARIATION IN TREATMENT CARRIED OUT THROUGH THE GENERAL DENTAL SERVICE (1972)[1]

Region	Ratio of filled to extracted permanent teeth for children aged 5-15
North	5.09
North West	5.72
Yorks & Humberside	6.96
West Midlands	6.87
East Midlands	7.38
East Anglia	8.05
Wales	4.25
South West	8.49
Greater London	17.04
South East	11.38

TABLE 7.5

TOOTH LOSS AMONG FOURTEEN YEAR OLDS AND TOOTH LOSS AMONG ADULTS, BY REGION[2]

Region	Proportion of 14 yr olds with some permanent teeth extracted (1973)	Proportion of adults edentulous in 1968
North	37%	48%
Midlands/East Anglia	38%	34%
Wales/South West	34%	43%
London/South East	18%	28%

THE GENERAL DENTAL SERVICE

The figures given in Table 7.1 indicated the overwhelming importance, in terms of employment, of the General Dental Service and they reflect a position that has changed little since early in 1949. It will be remembered that the British Dental Association was the only

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1. Adapted from Table 22.2 in *ibid.*

2. Adapted from Table 22.1 in *ibid.*

professional association to recommend against participation in the new scheme and so at the beginning there was some uncertainty about the prospects for general practice. However 5386 dentists had registered with their local Executive Councils by the end of the first week of the service's operation and within six months the figure had increased to 9272.[1] The expansion since then has been more modest with 12,360 dentists in general practice under the NHS in 1977.[2] But of greater interest has been the increasing amount of work that these practitioners have been able to perform. Table 7.6 gives some indication of this rise in productivity.

TABLE 7.6

NUMBER OF COURSES OF TREATMENT CARRIED OUT PER DENTIST IN THE G.D.S.: SELECTED YEARS 1950-1975[3]

Year	Dentists in G.D.S.	Courses completed (millions)	Courses per dentist
1950	9,657	7.179	743
1955	9,788	7.934	811
1960	10,254	11.539	1,096
1965	10,405	15.867	1,525
1970	10,426	18.539	1,778
1976	11,206	24.477	2,184

Notes: 1. Figures for courses exclude emergency treatment.

2. Figures for England and Wales 1950-1965; England only 1970-1976

The unexpected level of productivity in the first few years of the NHS presented a considerable problem for the government in so far as many more courses of treatment than expected were being completed

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1. Data from MoH, *A/Rep. 1948-49* (Cmnd. 7910), p. 269. This last figure was believed to be out of a possible 10,000 in practice.

2. Royal Commission on the NHS, *Report*, Table 9.4. Figures refer to England and Wales only.

3. Table compiled from data in MoH and DHSS, *A/Reps.* for particular years.

and hence the overall cost quickly escalated past the estimates. In the short term the government responded with cuts in fees to reduce the cost of individual courses of treatment, the imposition of charges in an attempt to dampen demand[1] and the appointment of a working party to consider the whole question of productivity.[2] Following a detailed analysis of the work done by over 250 dentists in NHS practice the Working Party concluded that the dentists were receiving, on average, an income 19% above the figure recommended by the Spens Committee[3] which the government had used as a "target" income. It analysed this excess in two ways: first that 14% could be attributed to work within the NHS and 5% to purely private practice and second that 11% had been gained by working longer hours than the recommended Spens standard and the remaining 8% was attributable to a rate of work that was faster than the initial fee schedule had allowed.[4] However a breakdown of the data derived from the actual sample taken presents a more startling picture. The average figures had been kept down by a number of practitioners who, for reasons of either age or ill-health, were working for less than the Spens recommended figure of 33 chairside hours a week and at the other end of the scale 64% of the sample (who were doing 73% of the total work) were working for over 41 hours a week. With time allowed for administrative tasks this amounted to 'rather more than nine hours a day for a 5½ day week.[5] By way of conclusion and

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1. These actions are considered in detail in chapter ten.

2. MoH, DoH(S), *Report of the Working Party on the Chairside Times taken in carrying out Treatment by General Dental Practitioners in England, Wales and Scotland* (London, HMSO, 1949).

3. Details in chapter ten.

4. *Report of the Working Party on Chairside Times*, para. 63.

5. *Ibid.*, para. 28.

presumably with both the government and media in mind the Working Party expressed the view that:

> 'Most dentists are working longer hours than is comfortable, or than would be good for them if continued for too long a period, and many of them worked more quickly than they would normally. These conditions have been forced upon them by the influx of work which has resulted from the expanded Health Service. As a body, they have been trying to cope with the difficult problem of keeping pace with demand without loss of efficiency and, as a body, the Working Party thinks they should have received more gratitude and less adverse criticism than has actually been the case'.[1]

The essence of the problem was that while the government sought to maintain strict control over the overall cost of the general dental service it placed no real limits on the amount of treatment that the dentists could provide. Thus as productivity increased the government moved to reduce the cost of individual items and hence contain the overall cost. The result has often been referred to as the "treadmill effect" as the dentists, in an attempt to maintain their level of income, endeavoured to increase productivity still further. The phenomenon is important in at least two ways: first because it demonstrates how little interest the government has displayed in how these public monies have been spent (in terms of dental priorities) and second because it implies little concern on the government's part with the levels of dental health being achieved. It reinforces the argument already put that under this particular approach to public supply a policy for dental health consists of little more than securing the public service of a number of dental practitioners. The whole argument was forcefully put in a study of the dental services made by the Office of Health Economics in 1969.

> 'Before the start of the service, during its initial years and even up to the present day, no attempt was, or has

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1. *Ibid.*, para. 29.

> been, made to estimate the likely demands upon the service in relation to defined standards of dental care or of any minimum acceptable targets given the fixed available resources and a limited number of dental practitioners ... [in additon] no attempt has been made to appraise the right level of spending upon the service, and arrangements have been directed to keeping spending within the bounds set in terms of dentists' remuneration'.[1]

The financial and administrative problems raised here will be discussed in more detail in chapters nine and ten.

A second feature of the development of the general dental services has been a significant change in the patterns of treatment provided. There are any number of indices which might be used to illustrate this point and only three will be detailed here: the trend away from prosthetic to conservative work, the reduction in the number of teeth that are extracted and the reduced incidence of emergency treatment. The most outstanding feature of the first years of the service was the number of dentures made and by 1951 it was estimated that over five million had been provided.[2] In that year dentures accounted for 63% of the total fees authorised, including patient contributions,[3] but within four years the figure had dropped to 33%[4] and by 1970 had been further reduced to 22.7% of total costs.[5] The second and related index referring to the number of teeth extracted has shown a similar change. The ratio of fillings to extractions for permanent teeth has improved from 1.3:1 in 1951 through 2.2:1 (1955),

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1. Office of Health Economics, *The Dental Service* (London, OHE, 1969), p. 7.
2. MoH, *A/Rep. 1953* (Cmnd. 9321), p. 78.
3. MoH, *A/Rep. 1952* (Cmnd. 8933), p. 60.
4. MoH, *A/Rep. 1955* (Cmnd. 9857) Table C, p. 213.
5. DHSS, *A/Rep. 1970* (Cmnd. 4714), Table 18, Part 2, p. 178.

3.0:1 (1964) to 4.6:1 in 1970.[1] The change in the third index, the proportion of treatment which is given on an emergency basis can be seen in Table 7.7.

TABLE 7.7

RATIO OF NORMAL TO EMERGENCY COURSES OF TREATMENT IN THE G.D.S.: SELECTED YEARS 1950-1977[2]

Year	Normal courses of treatment (000's)	Emergency courses (000's)	Ratio of normal to emergency courses (000's)
1950	7.179	1.982	3.6:1
1955	7.934	1.988	4.0:1
1960	11.539	2.073	5.6:1
1965	15.867	1.824	8.7:1
1970	18.539	1.404	13.2:1
1975	24.477	1.478	16.6:1
1977	25.899	1.074	24.1:1

Note: Figures for 1950-65 refer to England and Wales, 1970-77 England only.

Taken together these three indices point to a significant change in the type and style of treatment provided under the NHS. Most dental authorities would undoubtedly agree that the change has been for the better in so far as there have been improvements both in the number of teeth conserved rather than extracted or replaced and in the growing proportion of attendance made on a regular basis rather than as a response to pain. The general impression is that the combination of the growth in services and the changing patterns of treatment has led to an improvement in the overall dental health of the nation but the changes are difficult to document. A number of studies have been made but it was not until 1968 that an official

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1. Data from MoH, DHSS, *A/Reps.* for particular years.

2. Source: *ibid.*

national survey took place. A follow up survey ten years later has enabled some preliminary longitudinal assessments of the nation's dental health to be made. Some indication of the improvements is given in the two tables below.

TABLE 7.8

TOTAL TOOTH LOSS FOR DIFFERENT AGE GROUPS, 1968 AND 1978[1]

Age	Proportion of people with no natural teeth 1968	1978
16-24	1%	-
25-34	7%	3%
35-44	22%	12%
45-54	41%	29%
55-64	64%	48%
65-74	79%	74%
75 and over	88%	87%
All ages	37%	29%

TABLE 7.9

MEAN NUMBER OF SOUND, DECAYED, TREATED AND MISSING TEETH AMONG ADULTS WITH SOME NATURAL TEETH, 1968 and 1978[2]

	Average number of teeth in each condition 1968		1978	
Sound and untreated	12.8		13.2	
Crowned or bridged	0.1		0.3	
Filled (otherwise sound)	6.8		7.8	
Filled and decayed	0.7		0.7	
Decayed, not previously treated, but restorable	1.1	2.2	0.9	1.9
Not restorable	0.4		0.3	
Missing	10.1		8.8	
Total	32.0		32.0	

1. Source: J.E. Todd and A.M. Walker, *Adult Dental Health. England and Wales 1968-78* (London, HMSO, 1980), Table 4.1.

2. Source: *ibid.*, Table 6.1.

While these figures give some indication of the gradual improvement in dental health between 1968 and 1978 the two surveys are perhaps most significant for the light they throw on the uneven distribution of this general advance. It can be shown, for example, that age and sex are significant in determining dental health but of much greater importance are the place of residence and social class. Employing the measure of the degree of total tooth loss in the population, Table 7.10 indicates the wide regional and class differences that existed in 1978.

TABLE 7.10

PROPORTION OF PEOPLE WITH NO NATURAL TEETH BY SOCIAL CLASS, REGION AND COUNTRY. GREAT BRITAIN, 1978.[1]

	Social class		
	I, II, IIIa Non-manual	IIIb Manual	IV, V
North	24%	35%	38%
Midlands/E. Anglia	23%	30%	37%
South West	22%	22%	40%
South East	15%	17%	33%
Scotland	32%	38%	45%
Wales	29%	38%	40%

In considering the causes of such differences in dental ill-health the authors of the 1968 Adult Dental Health Survey investigated three main hypotheses: a difference in the level of disease between different parts of the country, a difference in the attitudes of patients to dental health and treatment and a difference in the treatment given by dentists.[2] In respect of the first hypothesis, the authors concluded

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1. Source: Royal Commission on the NHS, *Report*, Table 9.5.

2. P.G. Gray *et al.*, *Adult Dental Health in England and Wales in 1968* (London, HMSO, 1968), Section 4.7.

that:

> 'there was not basically a very great difference in the occurrence of decay in the different regions. Or at least there were other differences which were large enough to mask any variation in disease. It did not appear to be disease that varied but treatment'.[1]

Such a finding puts the possible explanations firmly into the sociological/administrative court and places considerable emphasis on getting the patient to the dentist and on the kind of treatment that is then performed.

The question of whether or not a person attends for dental treatment clearly involves a number of variables which include factors such as attitudes to treatment, the availability of services, the possible costs involved and the importance ascribed to dental fitness. The authors of the 1968 survey reported that:

> 'Two major attendance groups were found to exist, those who said that they attended the dentist for a regular check up and those who said that they did not go for a check up but only attended when they were having trouble with their teeth'.[2]

The two groups were of roughly equal size and the view was put that the division between them was perpetuated by the regulations pertaining to emergency treatment which, in contrast to the arrangements for normal courses of treatment, permitted a dentist to accept patients on a casual basis without any requirement to carry out all the treatment necessary to achieve dental fitness. With dentists paid by item of treatment 'there is a financial disincentive to spending time persuading people to change their dental attitudes'[3] and with no requirement for subsequent attendance the "pain only" syndrome of this

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1. *Ibid.*, p. 144.
2. *Ibid.*, p. 245.
3. *Ibid.*, p. 246.

section of the population is unlikely to be challenged. Such findings tend to support the generally held belief that it is personal attitudes and opinions that determine the rates of attendances for treatment. Certainly this view is used to explain the distribution of practitioners around the country. The situation is seen in essentially market terms with dentists practising in areas of high demand which have normally been associated with concentrations of "middle class" residents. Hence the dentists have been drawn to areas in which there was an established call for their services rather than to those areas where there was a manifest need. Cook and Walker in a study in 1967 (using data from 1962-63) concluded that:

> 'In England and Wales there is clear evidence of an association with the social class structure of the population; the higher the proportion of persons in socio-economic group I (employers, managers and professional workers) ... the higher the proportion of dentists, and the higher the proportion of persons in socio-economic group III (mainly unskilled and semi-skilled workers) the lower the proportion of dentists.'[1]

This position has been supported by Coates and Rawstron using data for 1967-68[2] and has not really been challenged. It can be shown, and one example has already been given in Table 7.10, that standards of dental health are fairly closely related to socio-economic status[3] and that in terms of attendance much the same pattern prevails. Bulman *et al.* found in 1964-65 that:

> 'Sixty-two per cent [of the people interviewed] in Salisbury and 65 per cent in Darlington of Classes I and II said they had been to a dentist within the past two

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1. Cook and Walker, 'The Regional Distribution of Dental Care in the United Kingdom', pp. 445-6.

2. B.E. Coates and E.M. Rawstron, *Regional Variations in Britain* (London, Batsford, 1971).

3. Other evidence can be found in *Adult Dental Health in England and Wales in 1968*, section 4.4.

> years, but only 23 per cent (Salisbury), 31 per cent (Darlington) of Class V made the same claim.'[1]

Thus it appears that those with the greatest need for treatment will not only be the least likely to attend, but will also have the least opportunity of doing so. Bulman *et al.* were unable to explain these phenomena but concluded that

> 'there is clearly a different approach to dental visits in manual and non-manual classes. Thirty three per cent in Salisbury and 35 per cent in Darlington of Classes I and II claimed to have attended regularly compared with no-one in either town in Class V'.[2]

These findings not only support the results of the Adult Dental Health Survey and suggest some basis for the division between "attenders" and "non-attenders" but they also appear to justify the general choice of location made by the dentists. But viewed on a national basis as a public health problem the situation is clearly serious with a considerable proportion of the population facing problems in obtaining dental care. The importance of access to dental health will be discussed below but first some indication of the regional inequalities in the supply of practitioners will be given.

The extent of the differences depends a great deal upon the size of the unit of analysis chose. The British Dental Association, presumably mindful of the need to avoid restrictions on the geographical movement of dentists, presents its analyses in terms of two regions only: the 'South East of England'[3] and the 'Rest of England and Wales'. In both its evidence to the Royal Commission on the NHS[4] and a

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1. J.S. Bulman *et al.*, *Demand and Need for Dental Care* (London, Oxford University Press, 1968), p. 38.

2. *Ibid.*, p. 40.

3. Made up of Greater London, Beds., Berks., Bucks., E. Sussex, Essex, Hants., Herts., IoW., Kent, Oxon., Surrey and W. Sussex.

4. BDA, 'Memorandum to the Royal Commission on the NHS', *BDJ*, 142, 2 (18 January 1977), p. 40.

subsequent research paper on regional distribution[1] this two-part division has been used to show a steadily improving position for the "Rest" both in terms of the absolute number of dentists in practice and in the reduction of what might be called an index of disadvantage (the ratio between the two areas in terms of the number of persons per dentist). Thus between 1965 and 1976 there was a 4% increase in the number of practitioners in the South East against an improvement of 21% for the "Rest", and with figures of 3,234 and 4,923 persons per dentist the index of disadvantage which had been 1.70 in 1965 was reduced to 1.52 ten years later.[2] However if the unit of analysis is reduced in size and the individual health regions of England and Wales are considered then the position is significantly changed. The figures in 1977 for the population per dentist ranged from 2516 in North West Thames to 5456 in the Northern Region, giving an index of 2.16.[3] A further reduction in size to the level of the Area Health Authorities shows a variation from 1118 in Kensington, Chelsea and Westminster to 7213 in Sunderland and an index of 6.45.[4]

In terms of gaining access to dental services it is the figures for the smallest administrative units that are the most significant. A person is unlikely to travel any great distance in pursuit of dental treatment and so it is the availability of services within the immediate locale that is important. The question of access is stressed because recent research has suggested a significant

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1. D.M. Scarrott, 'Changes in the Regional Distribution of General Dental Service's Manpower', *BDJ*, 144, 11 (6 June 1978), pp. 359-63.

2. BDA, 'Memorandum to the Royal Commission on the NHS', Table V.

3. Data from Scarrott, 'Changes in the Regional Distribution of General Dental Service's Manpower', Table II.

4. Data from *ibid.*, Table VI.

correlation between the availability of dental services and attendance patterns, and the importance of regular attendance to dental health has already been noted. The present distribution of dentists in general practice has been premised on the view that the demand for services attracts suppliers. This connection has been supported both by the British Dental Association, which has been conscious of the need to maintain full employment and thus not allow the supply of dentists to exceed the actual demand for work and, apparently, the government which has been unwilling to countenance the more nebulous concept of "need" presumably on the grounds that the active "pursuit" of dental needs would require both increased expenditure and a capacity to direct practitioners to particular areas. As recently as 1978 a Labour Under Secretary of State for Health and Social Security offered implicit support for the laissez-faire position when he noted that

> 'dentists are professional business men. As such, they will have a keen eye for places where they can be fairly confident that their services will be in demand. It seems reasonable to conclude that as their numbers continue to increase there will be a gradual redistribution of dental manpower throughout the country'.[1]

But as the figures for the Area Health Authorities have indicated there is little evidence of this actually taking place. The general consequence of this approach has been the perpetuation of the "two groups" syndrome which was demonstrated in the 1968 Adult Dental Health Survey.[2] The two patterns are illustrated graphically in Figure 7.2.

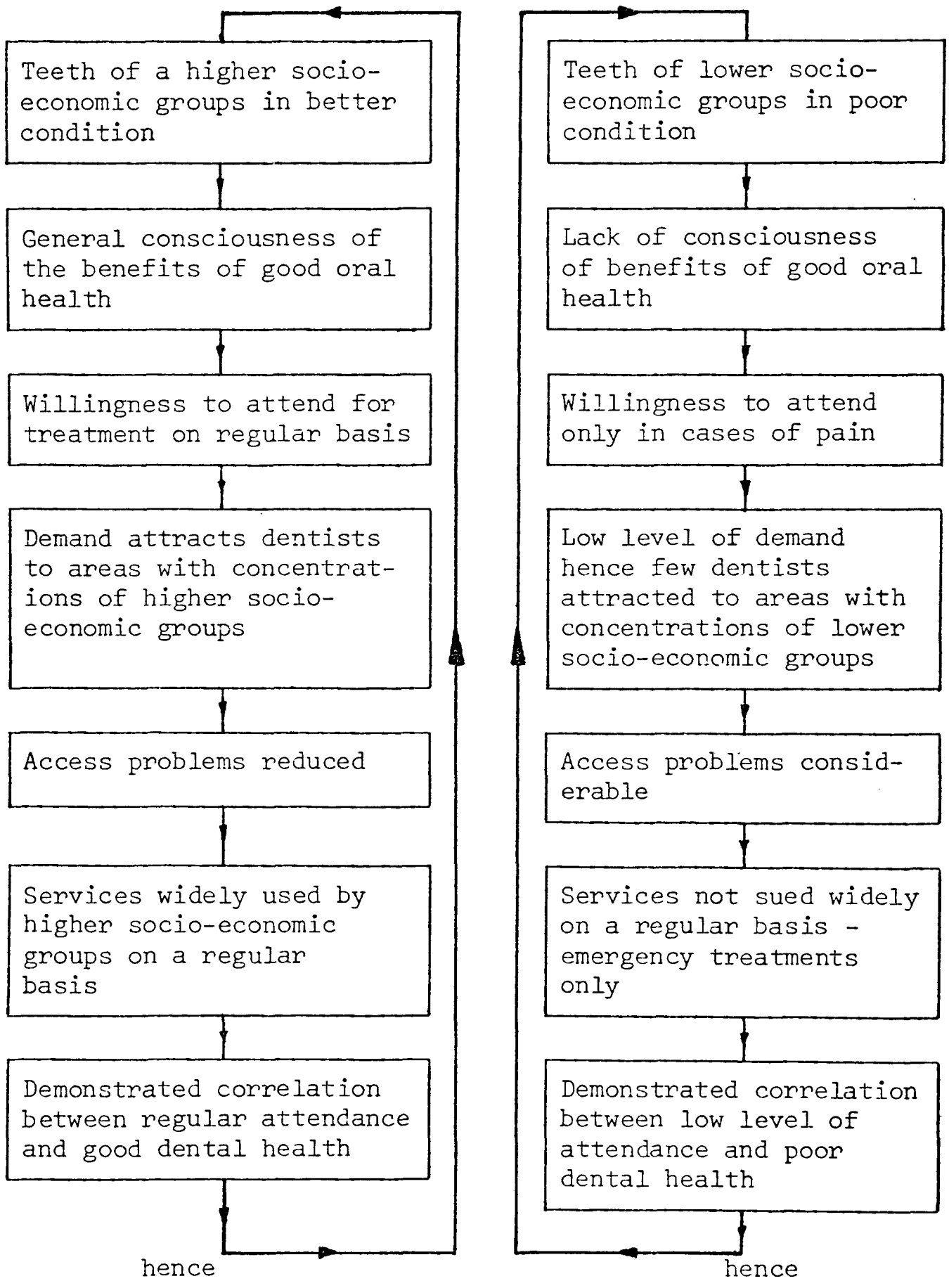
The situation is characterised by two essentially closed loops in which the incidence of demand stimulates the supply of dental

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1. Mr Eric Deakins: 946 H.C. DEB. 5s. Col. 824.

2. See above p. 227.

FIGURE 7.2 THE "TWO GROUPS'" ATTITUDE TO DENTAL TREATMENT AND THE CONSEQUENCES FOR DENTAL PRACTICE



services. In view of Mr Deakin's statement and in the absence of evidence to the contrary, the official position for the lower socio-economic groups seems to be that until they can improve their awareness of the benefits of dental care and hence be more prepared to accept treatment then they cannot expect the supply of dentists to be improved. In a structure with an overwhelming concentration on curative services[1] the dentist himself is the most likely person to stimulate such an awareness and again the problem comes back to the importance in improving the levels of attendance. It is in this regard that some of the research in recent years on the significance of the patterns of supply of practitioners should be considered.

This research has suggested a correlation in the opposite direction between demand and supply: that is, if dental services are freely available then this itself is sufficient to stimulate a demand for their use. Cook and Walker found that 'where more facilities are provided demand does more to make use of them'[2] and in more recent research using data from 1974-75 Ashford concluded that:

> 'Virtually all aspects of dental care are found to vary between r.h.a.'s [Regional Health Authorities] in accordance with the *per capita* numbers of dental practitioners. Regions with a relatively high level of supply also tend to have a relatively high rate of use and a corresponding relatively low proportion of emergency treatments.'[3]

In particular Ashford has demonstrated the direct and significant correlation between the supply of dentists and the estimates, treatments and fees paid per person for each Regional Health

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1. See chapter eight below.

2. Cook and Walker, 'The Regional Distribution of Dental Care in the United Kingdom', p. 498.

3. J.R. Ashford, 'Regional Variations in Dental Care in England and Wales', *BDJ*, 145, 9 (7 November 1978), p. 282.

Authority.[1]

In a separate paper using data from the 1968 Adult Dental Health Survey, Lennon has extended this analysis from the region into the separate social groups within the regions and shown that

> 'while each social group in the South East received more treatment than the equivalent group in the North, it was in the lower social groups that differences were greatest. This would suggest that it is the shortage of dentists rather than inherent attitudes to treatment that explained the poor demand for treatment in manual workers in the North.'[2]

However, Lennon recognised that different attitudes could account for the differences noted and turned for support to the survey carried out by Robinson in two adjacent towns in the North-West (Sale and Northwich). Her research showed that in areas with a higher dentist/population ratio the filling/extraction ratio was higher, there was more conservative work done and less emergency treatments carried out than in areas that were less well supplied with practitioners.[3] In addition her findings supported the view that a greater supply of dentists leads to both a greater volume and sophistication of treatment[4] and to greater equality in both use and type of treatment provided for the different social groups.[5] In summary she concluded that

> 'in areas with a favourable dentist to population ratio ... an increase in the amount of conservative treatment was provided to all social groups. It was also observed that in these circumstances the gradient of treatment between

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1. *Ibid.*, p. 277 especially Table II fig. 1.
2. M.A. Lennon, 'An Evaluation of the Adequacy of the General Dental Service', *BDJ*, 141, 7 (5 October 1976), p. 224.
3. M.E. Robinson, 'Dental Manpower Ratios: An Epidemiological Survey of the Effect of Differing Manpower Ratios on the Treatment Provided to Fifteen Year Old Children' (University of Manchester, Faculty of Medicine, M.Sc. Thesis, April 1975), p. 63.
4. *Ibid.*, p. 63.
5. *Ibid.*, pp. 73 and 75.

> the social classes was reduced. This suggests that the difference in treatment usually associated with social class is not related solely to social attitudes.'[1]

The evidence from these research projects is by no means conclusive but nevertheless it does tend to suggest that the resolution of the major problems of social and regional inequalities in the level of treatment provided (with its consequences for the level of dental health achieved) might lie as much in the political/administrative area involving the supply of dentists to particular regions as in the more uncertain field of education, encouragement and socialisation.

In discussing the levels of treatment some evidence has already been given of the second significant variable in determining dental fitness, that is the different types of treatment provided. At a national level it has been shown that measured on indices such as the filling/extraction ratio or the ratio of emergency to normal treatment there has been a steady improvement since the introduction of the NHS. But if changes are analysed on a regional basis then the by now familiar patterns emerge. In 1958, for example, the filling/extraction (F/E) ratio ranged from 3.1:1 in London and the South East to 0.9:1 in the North, while what is perhaps its corollary, the percentage of courses involving full dentures, ranged from 10.8% in the North to 4.7% in London and the South East.[2] In 1974-75 for the 15-19 age groups the F/E ratio varied from 25:1 in North West Thames to 5:1 in Wales and at the same time while one tooth was crowned for every three extracted in N.W. Thames the ratio in Wales was 1:6.[3] The 1968 Adult Dental Health Survey also revealed large differences in the number of fillings provided in different regions[4]

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1. *Ibid.*, p. 79.
2. MoH, *A/Rep. 1959* (Cmnd. 1086), Table F, p. 262.
3. Ashford, 'Regional Variations in Dental Care in Britain', p. 282.
4. *Adult Dental Health in England and Wales in 1968*, section 6.6.

and in the incidence of the use of X-rays as a diagnostic tool. Among those aged 16-34 with some natural teeth the proportion who said that they had an X-ray changed from 34.1% in the North to 74% in London and the South East[1] and, although there had been an overall increase in X-ray usage by 1978, the differences between the regions remained substantially the same.[2]

These figures must of course be considered in conjunction with factors such as attendance patterns because clearly the options open to the dentist will be governed to an extent by the condition of the patient's mouth when they first present for treatment. Nevertheless there can be little doubt that the different approaches taken by the dentists contribute to the regional and social variations in the levels of dental health achieved and that in administrative terms this presents a major problem for the service as a whole. For a number of reasons which include the pressure on a particular dentist's time, the initial condition of a patient's mouth, the dentist's expectations of the patient's future behaviour and the dentists' professional insistence on being the sole arbiter of the appropriate course of action,[3] there is little reason to expect a standard approach to the provision of treatment. Thus there is an obvious tension between the pressure for professional discretion and bureaucratic uniformity whose resolution by administrative means is clearly quite problematical.

To conclude this section on the development of the general dental services under the NHS some consideration must be given to the question of the supply of dentists. The material presented in this chapter has suggested the significance of the supply of dentists for

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1. *Ibid.*, Table 6.4.
2. *Adult Dental Health. England and Wales 1968-78*, pp. 50-2.
3. Within the limits of the prior approval arrangements.

the level of dental health and almost all the official reports and inquiries have expressed disquiet about the shortage of practitioners. The Teviot Committee, for example, felt that they could 'say with confidence that up to a total of about 20,000 in active practice there is no likelihood of securing entrants [to the profession] more quickly than they are needed'[1] and this figure came to achieve an almost infallible status as it was repeated by both the profession and the government alike in the years following the Report's release. The 'temporary exceptions to "comprehensiveness"' expressed in the NHS White Paper were evidence of the official recognition of the problem and if anything the position became worse in the early 1950s when the high age profile of the profession meant that the numbers of dentists being admitted to the Register only marginally exceeded the number removed on the grounds of death or retirement. The situation was compounded not only by the difficulties in effecting a rapid expansion of the facilities for training dentists but also by a shortage of applicants for the available places. The last situation reached such proportions that a Committee chaired by Lord McNair was appointed in 1955 'to ascertain the reasons for the lack of candidates of suitable calibre for training as dentists and to indicate possible directions in which remedies might be sought'.[2]

The Committee's Report was published in 1956 but quickly became dated as the dental schools filled to capacity.[3] Nevertheless it remains of interest for the analysis it provides of the problems of

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1. MoH, DoH(S), *Final Report of the Inter Departmental Committee on Dentistry* (Cmnd. 6727, London, HMSO, 1946), para. 12.

2. *Report of the Committee on Recruitment to the Dental Profession*, para. 1.

3. See report in the *BDJ*, 105, 6 (16 September 1958), p. 219.

the service at that time. The Committee believed that the shortage of recruits stemmed from the low status of the profession and the dissatisfaction expressed by dentists with their terms of service. Status was low compared to the medical profession and this was attributed largely to public attitudes to dental health[1] while the causes of dissatisfaction were seen to be the piece rate form of remuneration, the need to obtain prior approval for certain types of work, the decline in earnings with age, the financial uncertainty about the future and the few opportunities available outside general practice.[2] These problems are dealt with in chapters nine and ten but two significant events might be noted here. First, that the General Dental Council was set up in 1956 following the abolition of the Dental Board under the General Medical Council thus providing the profession with almost complete autonomy in the running of its affairs, and second that in February 1957 the Prime Minister announced the appointment of the Royal Commission on Doctors' and Dentists' Remuneration.[3] No particular causality is claimed between the McNair Report and these developments but of course it can be seen that they went at least some of the way to meeting the reported problems facing the dental services. The status of the profession was undoubtedly enhanced: thirty-five of the thirty-nine member Council were dentists[4]

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1. *Report of the Committee on Recruitment to the Dental Profession*, ss. 29-40.

2. *Ibid.*, ss. 61-71.

3. 565 H.C. DEBS. 5s. Cols. 431-2.

4. See General Dental Council, *Professional Autonomy in Dentistry 1921 to 1971* (Pamphlet issued by the Council. No publication data) and D. Hindley-Smith, 'The General Dental Council. Its Origins Purpose and Functions', *BDJ*, 128, 7 (7 April 1970), pp. 345-9 and 128, 8 (21 April 1970), pp. 411-14.

and the appointment of the Royal Commission portended changes to the system of remuneration which at the time was seen to be almost entirely dependent on the whims of Ministerial fiat.

But more significantly the work of the McNair Committee focussed attention on two issues of critical importance to the dental health services: the number of dentists needed for practice in the NHS and the extent to which the development of the services should be predicated solely on an expansion in the supply and work done by qualified dental practitioners. Some of the complexities and difficulties associated with the relationship of supply and demand in the dental health services have already been noted and in general the government has baulked at making a substantial commitment on the question. Two years after the McNair Committee reported the Minister of Health went some way towards accepting its recommendations (for an increase in the number of students in each year from 650 to 1000)[1] with an announcement of plans to expand the teaching facilities in an attempt to provide an output of 800 practitioners for the U.K. each year.[2] But earlier, in December 1956, Miss Hornsby-Smith, the Parliamentary Secretary to the Ministry of Health, had admitted that this figure would do no more than maintain the existing strength of the profession.[3] In resisting calls for a more substantial expansion she argued in terms of both the actual costs involved and the relative priorities for the health service as a whole. This had been a predominant theme in the Report of the Committee of Enquiry into the cost of the National Health Service which had been presented to Parliament

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1. *Report of the Committee on Recruitment to the Dental Profession* para. 126.
2. 592 H.C. DEB. 5s. Written answers, col. 64.
3. See 562 H.C. DEBS. 5s. Col. 1687.

earlier that year. The Committee believed that it was 'clear that the fundamental problem in the dental service is the acute shortage of trained dental manpower'[1] but added a word of warning about the difficulties involved in meeting the problem:

> 'It is one thing to take steps to prevent the decline in the number of dentists engaged in the Service; but it is quite another matter to secure the expansion of the dental services to meet all the needs. There may be differing views as to what constitutes an "adequate" dental service, but there will be general agreement that the provision now made in the National Health Service falls short of "adequacy" in terms of the dental needs of the whole population. Moreover, as the total resources available to the National Health Service are limited, any large-scale development of the dental services would be made at the expense of some other part of the service.
>
> The shortage of dental manpower makes it the more important to consider every means possible for reducing the amount of dental disease requiring treatment, and making the best use of the trained manpower available."[2]

The question of whether the practice of dentistry should be confined to the work of qualified practitioners will be one of the questions discussed in the next chapter which focusses more closely on the particular shortcomings of the dental health services.

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1. Committee of Enquiry into the Cost of the National Health Service, *Report* (Cmnd. 9663, London, HMSO, 1956), para. 527.

2. *Ibid.*, para. 530.

CHAPTER EIGHT

THE SHORTCOMINGS OF THE DENTAL HEALTH SERVICES

In this chapter an attempt will be made to draw together the evidence presented so far about the development of the dental health services and to summarise the problem areas in thematic form. The six-fold classification of these problems which was suggested in chapter one will be used as the framework for analysis.

The first major area of concern is the poor dental health of the nation as a whole. In some ways it is perhaps an unsatisfactory category with which to begin this summary because clearly the overall dental condition of the population is at least partly dependent upon all the other factors which will be considered here. On the other hand it is useful if for no other reason than the way it stresses the complexities involved and highlights the need for co-ordination among the different arms of the NHS if the incidence of dental disease is to be reduced.

The results of the two major surveys in 1968 and 1978 have demonstrated that some improvement in the nation's dental health has taken place but that progress has been slow. However there are a number of reasons why this modest improvement may not indicate the full extent of the dental health service's performance. The first is the question of the indices of improvement which are used: total tooth loss has been a popular measure (because it reflects a complete breakdown in the care of the natural dentition) but of course the process is irreversible and so once a person becomes edentulous they remain so until death. Nothing done by the dentist can retrieve the situation in statistical terms, though of course the individual patient might be quite happy with a prosthetic replacement, and hence even if the tendency to edentulousness were significantly stemmed it would take many years for this to be reflected in the overall dental

health figures.[1] A second and related factor is that only those people (in 1981) who are under the age of thirty three will have had their total dental experience under the NHS and hence for the bulk of the population the only treatment available during childhood and adolescence was that of the National Health Insurance Scheme which, as it was shown in chapter three, reached only a small minority of the population. Thus, given the importance of treatment received as a child for subsequent oral health, it is going to be some years before the overall impact of NHS dentistry can be fairly judged. It is on these grounds that the dental condition of children assumes considerable importance as an indicator of the achievements of the dental health services and from the evidence which has already been presented[2] it can be seen that the challenge has hardly been met.

A point might also be made about the significance of an overall improvement in dental health as a measure of the success of the public supply of services. *A priori* it is reasonable to suppose that an improvement in overall dental health should follow from the provision of public funds which has enabled treatment to be obtained at below market cost. But clearly the move to public supply was based on a desire to do more than this. In particular it was based on a presumed capacity to relate available resources to dentally determined needs which, with an obvious shortage of dental manpower, also implied some capacity to give priority to the treatment of particular groups. In other words, it is argued, it is not enough to judge (even if this is possible) the success of public provision merely on overall

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1. See J.E. Todd and A.M. Walker, *Adult Dental Health. England and Wales 1968-78* (London, HMSO, 1980), para. 4.1 for a commentary on this.

2. See especially Tables 1.3 and 7.3.

improvements in dental health (which could perhaps have been achieved without the considerable NHS administrative apparatus) but on its capacity to effect significant changes to the patterns of dental care. The consideration given to effecting such changes are discussed in the context of the other five problem areas below.

The fact that only a minority of the population receives NHS dental treatment in any one year is the second obvious problem of the dental health services. Within the existing framework - one in which dental treatment is largely restricted to the curative work of qualified practitioners - a shortage of dentists is the major limitation on expanding the availability of treatment. A witness before a recent Parliamentary Committee hearing estimated that with the present number of dentists in NHS practice in England and Wales, a maximum of 23 million people could in fact receive regular dental treatment.[1] The case for restricting dental treatment to the work of dentists will be considered further below but within the present arrangements the central issue is obviously that of who receives the available treatment? The answer, in so far as it is known and in the absence of excessive waiting lists, appears to be simply those who seek treatment, but that those who seek it regularly, constitute a particular cross-section of the community. The 1968 Adult Dental Health Survey identified two main groups of treatment seekers - the "regulars" and the "irregulars" - and suggested that for a number of reasons the division between the two groups was being reinforced rather than reduced.[2]

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1. House of Commons, *First Report of the Expenditure Committee, Session 1976-77*, 'Preventive Medicine' (London, HMSO), Appendix 38, p. 666.

2. See chapter seven above.

Location in one or other group is a function of a number of factors which have already been discussed but it appears that the major determinants are membership of a particular social class and place of residence.[1] A number of reasons have already been advanced in an attempt to explain this, but the most important point to make at this stage is that there appears to have been little done deliberately to direct resources to areas of defined need and that scarce dental treatment is received in accord with wholly non-dental criteria. Even children, who as a group have been officially accorded priority status, seem to have received little obvious preference. The result of neither significantly increasing the availability of services (by expanding the dental labour force) nor rationing those available on some basis of stated dental need, has led to the third major area of concern, the considerable regional and social iniquities in both the supply of services and the standard of dental health care.

In fact not only are there significant regional and social variations in respect of both the supply of services and the levels of dental health achieved, but on neither count have there been any real signs of improvement. In each case it has been shown that while there has been a general improvement over time the existing relativities continue to be maintained. From the evidence presented it can be seen that this is the case in all three dental arms of the NHS. Also, and this applies to both the local authority and the general dental services, it can be shown that while there have been changes in the types of treatment provided, (for example, from extractions to more conservative work) the differences between the regions remain

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1. See J.S. Bulman *et al.*, *Demand and Need for Dental Care* (London, Oxford University Press, 1968) and chapter seven above.

substantial and in some cases amount to almost completely distinct approaches to dental health care.

The dimensions of the fourth problem area, the shortage of qualified dentists, have been significantly affected by the particular approach adopted for the supply of dental services. Thus the question of the appropriate number of practitioners is related not only to the availability of funds and the "size" of the dental "problem" but also to the emphasis that is given to preventive work and the extent to which curative work is divided between dentists and ancillary personnel. These last two questions will be dealt with at length in the last section of this chapter and here it remains to consider the evidence that has been presented in relation to the appropriate number of qualified practitioners for the NHS.

The most obvious conclusion is that the required number of dentists has never really been determined: figures such as that suggested by the Teviot Committee were oft-quoted, but they hardly represented an authoritative judgement on the problems involved. The committee was aware of this and in fact drew attention to the problems involved in attempting to be more precise.[1] One figure that has assumed obvious importance has been the number of students admitted to the country's dental schools, but there is no evidence that this has been related to any wider conception of overall dental need. Dental migration clearly complicates the picture but the main problems are that there never seems to have been an attempt either to consider the amount of work that needs to be done or to implement a system of dental priorities. Instead the whole approach has been centred on the need

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1. MoH, DoH(S), *Final Report of the Inter Departmental Committee on Dentistry* (Cmnd. 6727, London, HMSO, 1946), para. 12.

for financial control and within the resulting framework the dentists have been substantially free to practise as they like. Hence with little attempt to extend the concept of dental need beyond the sum of the individuals' perceptions of their own needs, consideration of the appropriate level of supply of practitioners has become dominated by its relationship to the manifested level of demand. There are thus two quite distinct positions on the question of supply: the one, held by the British Dental Assocation, that the number of dentists must be related to the exhibited demand for their services, and a second which sees a shortage so long as the available practitioners are unable to meet the dental needs of the community seen as a whole. The evidence suggests that despite the stated intent of basing access to treatment on a professionally determined criterion of need, successive governments have made no attempt to consider the supply of dentists in any other light than the pressures of existing demand.

The fifth problem area concerns the poor priority service. It has been suggested in this summary that if the public supply of the dental health services is to be justified it is to be judged in terms of its capacity, in an environment of scarcity, to allocate resources to areas of special dental need. And in practical terms there has been no real argument with the view that children, who form the bulk of the designated "priority classes", do in fact have such special needs. Yet the evidence presented in the previous chapter suggests that in practice no significant priority has been accorded. Indeed while the problems of the priority service represent a microcosm of the problems of the dental services as a whole, they have also faced additional difficulties in what has been shown to be an unequal competition for the available NHS dental resources. Poor status, poor staffing levels, poor productivity, medical dominance and a lack of leadership are just some

of the problems that have been detailed and given the importance of the dental health of children for the dental health of the population as a whole, the problems of the priority service will constitute a major focus of attention in the remaining three chapters.

Finally, the balance between the curative and preventive dental services must be examined. So far this summary has attempted only to synthesise the evidence raised in consideration of the separate dental arms of the NHS under a number of thematic headings, but in looking at the curative/preventive balance some new material must be introduced. It has already been suggested that a number of the other problem areas of the dental health services derive at least in part from the emphasis on curative work and here consideration will be given to the way in which this approach has come to be predominant in the NHS. The contrast with medicine is instructive. Whereas the doctors represent only a minority of those employed and receive directly only a small percentage of the total funds expended on medically related matters, the dentists occupy a much more monopolistic position within their field. The work of the dentist either as an individual or as a member of a professional group is seen as perhaps the most significant indicator of the performance of this part of the NHS and official pronouncements usually point to data demonstrating the increased number of courses of treatment provided and the increased number of dentists employed as evidence of the success of the dental health services. Thus in many ways dental health policy in Britain has become synonymous with what the dentists do. And while it has been shown that there have been significant changes in the pattern of treatment provided, the focus of the service remains firmly on the dentist in his surgery.

To describe what the dentist does as curative work is to use the term in a rather narrow way but is intended to make the comparison with

preventive work more obvious. Thus the curative work of the dentists (which includes fillings, extractions and prosthetic work) can be contrasted with preventive measures carried out by dentists (topical fluoride treatments, fissure sealants, oral hygiene instruction); by dental ancillaries (plaque control, oral hygiene instruction); by public health authorities (fluoridation of public water supplies); and by means of dental health education or by research into the causes of dental disease. Although the effectiveness of some of these measures has been disputed their potential has long been recognised. The Teviot Committee investigated a number of the approaches mentioned and more recently the Merrison Royal Commission left the readers of its Report in no doubt about the potential of preventive dentistry:

> 'in no other area of health is the way forward so clearly signposted as in the handling of the two major dental diseases. Wholehearted application of known preventive measures would bring treatment needs to manageable proportions. The control of dental caries in children could be a reality in twenty years time and the full effects felt in a generation. Although it is a more difficult area, much can also be done to control periodontal disease.'[1]

Similarly the Committee on Child Health Services investigated the potential of many of the measures and strongly advocated the greater use of many of them.[2] In particular it took exception to the limited use of fluoridation:

> 'If decay is preventible, why is it not being prevented? At present 8% of the people of Britain enjoy the benefits of fluoridation; why then are 92% being deprived? If caries killed, fluoridation would have been mandatory for twenty years. The real obstacles are public apathy, minority prejudice and governmental reluctance to impose a political solution. The cost in unnecessary disease,

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1. Royal Commission on the National Health Service, *Report* (Cmnd. 7615, London, HMSO, 1979), para. 9.17.

2. 'Fit For The Future', *Report of the Committee on Child Health Services* (Cmnd. 6684, London, HMSO, 1976), paras. 13.13-13.23.

> personal pain and discomfort, misuse of professional resources and national expenditure has been immense. *We recommend that immediate steps should be taken to introduce fluoridation on a national scale, if necessary with new legislation'.*[1]

The penultimate sentence of this quotation is the crucial one from a public health perspective: much more could be done at rather less cost if more preventive measures were employed. Again it would be fair to stress that there is nothing like agreement on the efficacy of some of the individual measures listed, but taken as a whole there would be few who would disagree that the overall potential for preventive care was immense. Seen in these terms and given both that the great bulk of the treatment is provided from the public purse and that there has almost always been pressure to reduce expenditure, it is all the more surprising that the dental services remain concentrated on the curative and relatively expensive performance of qualified practitioners. It is not within either the intent or the scope of this thesis to examine each of these preventive measures but rather to consider why the service has been dominated by curative considerations. The explanation, it is suggested, can be found in the particular approach adopted to public supply. Some brief details of the tensions between the curative and preventive approaches will be given in this chapter with the more analytical considerations of finance and administration held over for chapters nine and ten.

The general impression of the development of preventive dental measures under the NHS is one of repeated and purposeful inquiry, official statements of support, but very little substantive action. The example of fluoridation is a good case in point. An official dental mission visited North America in 1952 to study developments in the use

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1. *Ibid.*, para. 13.20.

of fluoridation and the publication of its Report[1] led the government, on the advice of the Standing Dental Advisory Committee and in consultation with the Medical Research Council, to instigate a series of investigations into the use of fluoride as a means of controlling dental decay. The results were published in two reports in 1962 and 1969.[2] Anticipating opposition from organisations such as the National Pure Water Association the steering committee (later known as the Committee on Research into Fluoridation) investigated not only the dentally beneficial effects but also the claims that the addition of fluoride to the water supply might be harmful in other ways. A number of hypotheses had been raised linking fluoridation with mongolism, peptic ulcers and *osteochondritis juvenalis* of the spine but the committee found that there was no evidence whatsoever to support these propositions. It concluded in its 1969 Report that 'the fluoridation of water supplies at the level of 1 p.p.m.F. is a highly effective way of reducing dental decay and is completely safe'.[3] In 1976 the Royal College of Physicians produced a report, *Fluoride, Teeth and Health,*[4] which reviewed research from around the world and confirmed both the safety and the effectiveness of fluoridated water and in 1979 the

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1. MoH, DoH(S), Ministry of Housing and Local Government, *The fluoridation of domestic water supplies in North America as a means of controlling dental caries. Report of the United Kingdom Mission* (London, HMSO, 1953).

2. MoH, Scottish Office and Ministry of Housing and Local Government, 'The Conduct of the Fluoridation Studies in the United Kingdom and the Results Achieved After Five Years', *Reports on Public Health and Medical Subjects*, No. 105 (1962) and 'The Fluoridation Studies in the United Kingdom and the Results Achieved after Eleven Years', *Reports on Public Health and Medical Subjects*, No. 122 (1969).

3. 'The Fluoridation Studies in the United Kingdom and the Results Achieved after Eleven Years', p. 22.

4. Royal College of Physicians, *Fluoride Teeth and Health* (Tunbridge Wells, Pitman, 1976).

Merrison Royal Commission reported that it had been 'impressed by the weight of written evidence in favour of fluoridation'[1] and concluded that:

> 'We are not simply convinced of the wisdom of introducing fluoridation, if necessary compulsorily; we are certain that it is entirely wrong to deprive the most vulnerable section of the population of such an important public health measure for the sake of the views of a small minority of adults for whom its benefits come too late. We recommend that the government introduces legislation to compel water authorities to fluoridate water supplies at the request of health authorities. Otherwise children who cannot choose for themselves will continue to suffer the ravages of a disease which can be substantially reduced by a method that has been shown not to have any deleterious effect.'[2]

In support of this strong advocacy the Commission pointed to the experiences of the community dental services in Birmingham where water had been fluoridated since 1964. The results of their findings are given in Tables 8.1 and 8.2.

TABLE 8.1

EMERGENCY VISITS TO THE DENTIST: BIRMINGHAM CHILDREN 1965-1976[3]

	"Emergency" visits for the relief of pain				
Year	0-4 yrs	5-9 yrs	9-15 yrs	15+ yrs	Total
1965	Not collected	5,978	3,399	891	10,268
1966	722	5,658	3,015	602	10,037
1976	43	994	878	420	2,335

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1. Royal Commission on the NHS, *Report*, para. 9.58.

2. *Ibid.*, para. 9.6.

3. Source: *ibid.*, Table 9.6.

TABLE 8.2

CHILD HEALTH: BIRMINGHAM 1964 and 1977[1]

Year	General anaesthetics given	First teeth extracted	Permanent teeth extracted
1964	22,628	44,410	13,429
1977	3,851	11,487	5,290

Similar support for the measure has come from both the British Dental Association and the government. Since the inception of the NHS the British Dental Association has consistently supported the use of fluoridation through the editorial pages of its journal,[2] through the publication of numerous research reports,[3] through the provision of propaganda sheets (for example, 'Facts and Fantasies on Fluoridation'[4]) to enable individual practitioners to convey the argument to the community, and through its discussion with the government on matters of dental health policy. The government for its part has been equally vocal in support with Minister after Minister affirming the commitment to the fluoridation of public water supplies. The first major initiative came in December 1962 when the Minister of Health announced to the House of Commons his approval for local authorities to adjust the level of fluoride in the water and that he was prepared, in the event of court proceedings on the grounds of lack of power, to indemnify both the local

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1. Source, *ibid.*, Table 9.7.

2. See, for example, *BDJ*, 87, 3 (5 August 1949), p. 74; 96, 8 (20 April 1954), p. 189; 119, 7 (5 October 1965), p. 283 and 140, 5 (2 March 1976), p. 159.

3. See, for example, W. Stewart Ross, 'Fluoridation: The Present Position in Great Britain', *BDJ*, 115, 10 (19 November 1963), pp. 397-405 and J. Murray, 'Fluoridation and Dental Caries: A Review', *BDJ*, 129, 10 (17 November 1970), pp. 467-70.

4. *BDJ*, 100, 2 (17 January 1956), pp. 58-60.

health authority and the water undertaker.[1] But progress in implementing schemes was slow and by 1968 while some 113 local health authorities (covering a population of thirty million) had resolved in favour of fluoridation only two million people were actually receiving fluoridated water.[2] Under the 1974 reorganisation the new Area Health Authorities (AHAs) became responsible for deciding whether fluoridation should be introduced and

> 'the Government indicated that it would expect any Water Authority receiving a request from a Health Authority for fluoridation to give effect to it as soon as it reasonably could, assuming that it was also acceptable to any other Health Authority whose Area would receive supplies of the fluoridated water.'[3]

But despite the fact that estimates suggest that the cost of fluoridation is about 5p per person per year,[4] that the Department of Health and Social Security set aside in 1976 and for the following four years a sum of £500,000 to help AHAs with the capital costs of fluoridation schemes[5] and that 84 of the 90 English AHAs have agreed to the measure, only about 9% of the population receives fluoridated water.[6]

The obvious question remains then, of why, with so much support, so little has been done? Perhaps the most plausible explanation was expressed in the Report of the Expenditure Committee on Preventive Health[7]

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1. MoH, *A/Rep. 1962* (Cmnd. 2067), pp. 61-2.
2. DHSS, *A/Rep. 1968* (Cmnd. 4100), p. 13.
3. DHSS, *On the State of the Public Health, 1974* (London, HMSO), p. 10.
4. BDA, *Fluoridation of Water Supplies* (London, BDA, 1976).
5. DHSS, *A/Rep. 1976* (Cmnd. 3326), para. 101.
6. Royal Commission on the NHS, *Report*, para. 9.58. Four of the eight Welsh AHA's supported fluoridation but only 12% of the population receives treated water.
7. House of Commons, *First Report of the Expenditure Committee, Session 1976-77*, 'Preventive Medicine' (London, HMSO).

in which two factors were stressed: the piece-meal nature of the decisions to fluoridate and the way in which funds for fluoridation are provided. The fact that decisions are made locally has meant that 'the entire resources of a national organisation [the National Pure Water Association] are brought into play each time'[1] and that local supporters have been overwhelmed in their attempts to secure the introduction of fluoridated water. Other research has supported this view and has emphasised the importance of strong local advocacy - particularly by the dental and medical professions - if schemes are to be approved.[2] But the second point - which relates to the sources of supply of funds - is perhaps the more important. The British Association for the Study of Community Dentistry suggested to the Expenditure Committee that as

> 'Area Health Authorities are expected to cover the cost of capital and revenue outlay from their budgets ... many ... have approved fluoridation but cannot afford to implement it in the existing financial climate.'[3]

The Association recommended the allocation of central funds to cover these costs and argued that the cost effectiveness of the measure was beyond doubt. The overall cost of providing dental health services would not be reduced but the number of people able to receive curative treatment would be increased as the dentists would have to spend less time with each patient. Put crudely, the stumbling block, under the existing arrangements, was that the cost of the general dental services

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1. *Ibid.*, para. 214.

2. See Stewart Ross, 'Fluoridation: The Present Position in Great Britain' and B.A. Burt, P.D. Bristow and T.B. Dowell, 'Influencing Community Decisions on Fluoridation', *BDJ*, 135, 2 (17 July 1973), pp. 75-7.

3. *First Report of the Expenditure Committee, Session 1976-77*, Appendix 30, p. 658.

was met by central governemnt but that the modifications necessary to extend the effectiveness of these services would need to be met at the Area level and although some assistance with capital expenditure has been offered, most Authorities have been unwilling to commit themselves to the additional costs. Without central direction and in face of the political sensitivity of the issue of mass-medication,[1] widespread fluoridation of the water supplies is unlikely in the near future.

The second preventive approach, the use of ancillary staff, has proved to be almost as equally contentious as fluoridation, although the battle lines have been rather differently drawn. Several types of ancillary personnel are employed in the NHS - chairside assistants, dental technicians, secretary/receptionists, dental hygienists and dental auxiliaries - but only the last two are permitted to carry out work on the patient without the dentist's direct supervision. In consequence it has been the work of the hygienists and auxiliaries that has met with most opposition.

The possibility of the "dilution" of the profession was a major issue during the implementation stages of the NHS and the perceived threat carried over well past the appointed day. In fact the *Times* suggested in 1953 that the government failed to proceed with the Dentists' Bill (which had passed through the House of Lords and had been read for a first time in the Commons) because of opposition by the British Dental Association which 'feared the experiment with ancillaries more than it wanted autonomy for its profession'.[2] The Association welcomed this tribute to its success and the apparent

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1. The Expenditure Committee, for example, baulked on this issue and was not prepared to recommend the greater fluoridation of public water supplies.

2. *The Times*, 12 January 1953, p. 7.

vindication of its argument that while ancillaries might bring short-term benefits in the long run the only way to improve the dental health of the nation was to train and employ more qualified dentists. The training of ancillaries would, it believed, slow down the pace at which the dental profession might be expected to expand.[1]

Enthusiasm for the employment of ancillaries had come mainly from those with either knowledge of the New Zealand School Dental Nurse scheme or experience of the use of oral hygienists in the Royal Air Force during the war. The Teviot Committee, drawing upon the evidence of these arrangements, advocated a trial scheme with hygienists and this had been carried out by the Oral Hygienists Sub-Committee of the Standing Dental Advisory Committee. Their Final Report was published in 1951 and expressed enthusiasm about both the capabilities and employment of such personnel.[2] A similar response in terms of both training and employment was recorded by the Dental Mission which visited New Zealand in 1950 to make an assessment of use of school dental nurses.[3] But if the British Dental Association had been able to dampen the enthusiasm for the employment of such ancillaries in 1953 it was much less successful with the Dentists' Bill in 1956 which, when enacted, gave the newly created General Dental Council the power to create classes of ancillary workers and authorised the Privy Council, when it saw fit, to require the Council to carry out an experiment in the training and employment of a particular type of ancillary worker to be known as a dental auxiliary. Thus a roll of dental hygienists

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1. Editorial in the *BDJ*, 94, 3 (3 February 1953), p. 72.

2. Central Health Services Council, *A/Rep. 1951*, paras. 22-48.

3. MoH, *New Zealand School Dental Nurses. Report of U.K. Dental Mission* (London, HMSO, 1950).

was established in 1957 and in 1959 the experiment with auxiliaries was commenced. Whereas hygienists were allowed only to scale, clean and polish teeth and administer topical applications of medicaments, the auxiliaries were to be permitted to extract deciduous teeth under local infiltration anaesthesia and undertake simple fillings. However, they were given no diagnostic role[1] and only carried out these treatments under specific instruction from qualified dentists.[2] The General Dental Council reported on the experiment in 1963 and 1966 and concluded that the scheme had

> 'shown that dental auxiliaries can be successfully trained and employed under proper supervision to do, within the limits prescribed, work of great value, particularly among young children.'[3]

This judgement was accepted by the government[4] and rather more grudgingly by the Representative Board of the British Dental Association.[5] Nevertheless despite this agreement with the Council's Report, it is clear that the Association remains unhappy with the employment of auxiliaries and that if the spectre of dilution has been overcome in the case of the hygienists (whose praises the Association has eventually come to sing),[6] it firmly remains in respect of the auxiliaries.[7] The numbers of both types of ancillary has risen slowly (1145 hygienists and

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1. Thus giving them much less independence than the New Zealand Dental Nurses.
2. See G.L. Slack (ed.), *Dental Public Health* (Bristol, John Wright, 1974), ch. 6.
3. *BDJ*, 121, 5 (6 September 1966), p. 236.
4. See MoH, *A/Rep. 1966* (Cmnd. 3326), p. 62.
5. *BDJ*, 121, 11 (6 December 1966), p. 491.
6. See *BDJ*, 137, 10 (19 November 1974), pp. 371-2.
7. See 'The Developing Role of the Dental Ancillary', *BDJ*, 141, 2 (20 July 1976), pp. 51-3.

533 auxiliaries in 1978)[1] and although in 1974 the Working Party on the Dental Services recommended a massive increase in the number of hygienists[2] and the Court Report on Child Health Services suggested the establishment of two new schools for training auxiliaries,[3] there is little evidence of any sense of urgency in the plans to expand the training facilities.

Developments in the other approaches to preventive dentistry are less easy to document. The number of scientific articles in the *British Dental Journal* and elsewhere attests to the volume of research that is now being carried out; the availability of posters, leaflets and films and the holding of "dental weeks" indicates the effort being put into dental health education and clearly many dentists are bringing a much more preventive approach to their practices with the employment of ancillaries, the willingness to undertake (or refer for) orthodontic work and the use of preventive techniques on the individual patient.[4] But the success of the last two approaches, dental health education and preventive practice, obviously depends on either the patient attending at a surgery or at least being exposed to the available propaganda material. Thus to conclude this section it is proposed to consider these preventive measures within the context of the co-ordination of all the available services.

One of the central justifications of the public supply of health services was its presumed capacity to co-ordinate and direct resources to the areas of greatest need. But in the opinion of the Court

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1. Royal Commission on the NHS, *Report*, paras. 9.39-9.40.

2. Working Party on the Dental Services, *Recruitment and Training of Dental Hygienists* (London, HMSO, 1974), para. 16.

3. *Report of the Committee on Child Health Services*, para. 13.44.

4. See W.P. Rock and G. Bradneck, 'Preventive Dentistry in General Practice: A Study of Current Use', *BDJ*, 140, 2 (20 January 1976), pp. 61-4.

Committee on Child Health Services this has hardly been achieved:

> 'widespread disease, official reluctance to prevent, insufficient and unevenly distributed manpower, a divided service. It was put to us that the three parts of the dental health service in the past had often worked with an independence which had done little to ensure that the convenience and clinical needs of children were met: services had sometimes been duplicated, sometimes neglected, and there had been no consideration of the overall cost to the community either socially or economically.'[1]

Under such conditions there are obviously a number of factors which have worked against the development of a comprehensive preventive programme. First, that prevention needs to begin at an early age and involves education both in the importance of oral hygiene and diet and in the need for regular visits to the dentist. However, the inadequate resources of the school dental service have meant that only approximately half of the school children in the country are inspected annually and although others are treated in the general dental service the incompatability of the data collected by the two services means that it is not possible to identify which children are not being seen at all. Furthermore if the attendance patterns for school children are poor, those for pre-school children indicate even greater cause for concern. For example in 1974 the attendance rate for the under fives in the community dental services was only 35/1000[2] and while a million estimates were approved for this group within the general dental services,[3] there is evidence to suggest that because of the way it is administered there is not a lot of incentive for general dental practitioners to undertake preventive treatment. In considering this question the Merrison Royal

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1. *Report of the Committee on Child Health Services*, para. 13.33.
2. *Ibid.*, Table E.8.
3. *Ibid.*, para. 13.6.

Commission reported that:

> 'The general dental services is a treatment service. We doubt whether an item of service system of payment can provide the structure for a fully satisfactory preventive programme. The present fees schedule could be modified to encourage dentists to give preventive advice and individual application of preventive measures'.[1]

However there is evidence to show that despite the problems with fees many dentists do use the available preventive techniques (proportionally higher among more recent graduates) but that almost all believe they should be financially rewarded for so doing.[2]

Outside the immediate location of the surgery, similar problems are found. Resources are scarce and the number of institutions and agencies involved brings formidable co-ordination problems, but perhaps the greatest obstacle is the need to overturn existing patterns of behaviour. If there have been administrative difficulties in effecting the introduction of a preventive approach within the relatively controlled confines of the three dental arms of the NHS these pale alongside the problems faced in the wider, societal context. Some essentially administrative solutions have been offered in pursuit of a more preventive approach - for example a refund of all fees paid if treatment is followed through until the patient is dentally fit and a return for inspection is made within a specified period[3] - but by and large the problems seem to be beyond the scope of bureaucratic practice. They are essentially political problems in the sense that they involve substantial shifts in behavioural patterns and priorities and from the

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1. Royal Commission on the NHS, *Report*, para. 9.66.

2. See *First Report of the Expenditure Committee, Session 1976-77*, Appendix 27.

3. A suggestion made by the BDA to the Committee of Enquiry into the Cost of the National Health Service. See *Report*, para. 579.

available evidence there is little to suggest that the support necessary to invoke such changes will be forthcoming. A good example of the problems involved was given in the exchange between Mr Norman Dodds and the Parliamentary Secretary to the Minister of Education, Mr Kenneth Thompson, in Parliament in 1959. Replying to Mr Dodds' suggestion that there should be greater dissemination of information on the harmful effects of sweet-eating and that the television might be used to promote oral hygiene, Mr Thompson warned that

> 'If the Hon. Member is thinking of starting a campaign to ban sweet eating or lolly sucking or ice cream eating, I wish him well. I do not say that he would not be rendering a great public service, but he would probably be destroying his personal political career, which he might well think worth sacrificing in such a cause; that is not for me to say.'[1]

This unwillingness to disturb the *status quo* has led to little attempt to interfere with dietary patterns, with the content of television advertising or with the rights of individual local authorities to make their own decisions in respect of fluoridation. In consequence the focus of the dental policy has come to the curative services provided by individual dental practitioners and while they have clearly made a fundamental difference to the dental health of the nation, the costs of not pursuing a more preventive approach have been enormous. In a report in 1975 the Director General of the World Health Organisation pointed out that the response to the rapidly increasing problem of dental disease in the developing countries had usually been

> 'to give a high priority to the development of a skilled class of professionals and auxiliaries to restore and replace the decayed teeth and rehabilitate damaged mouths. As a main measure, rather than a support for a mainly preventive service, this type of response is extremely expensive, grossly inefficient and, in the light of today's scientific knowledge, socially undesirable ...

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1. 614 H.C. DEB. 5s. Cols. 169-170.

> The economic advantages of preventing oral disease before it occurs are clear and unmistakable. Not only is the direct cost of restoration and rehabilitation avoided, but the indirect cost to society of developing complex systems of professional education and oral health care is sharply reduced.'[1]

The findings of the Merrison Royal Commission and the Court Committee which have been quoted in this chapter give little reason to doubt the applicability of the Director-General's comments to the situation in Britain and together they suggest that unless more emphasis is laid on the preventive approach to dental health the other problem areas that have just been discussed are unlikely to be resolved.

The evidence thus suggests that the particular development of the dental health services as part of the NHS has made little impact on those problems whose resolution is seen as crucial if the aspirations and objectives of a public dental health policy are to be realised. The arrangements, despite the pressure on practitioners, low attendance rates, and a generally poor standard of dental health, remain overwhelmingly curative in character and the inability to relate access to need, seen in terms of the experiences of the priority service and in the regional and social inequalities, continues to be the most salient feature of the services. With this in mind the next two chapters will examine in some detail the administrative and financial arrangements pertaining to the provision of dental health services.

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1. Cited in the *BDJ*, 140, 10 (20 January 1976), p. 38.

CHAPTER NINE

THE ADMINISTRATIVE ARRANGEMENTS

It was shown in Part Two that the assumption of public responsibility for the health services (including dentistry) was premised on the need for co-ordination and control of the relevant resources and their direction to areas of need and priority and that the identification of such areas was seen as a matter for political decision informed by professional advice. Thus it was argued that a medical definition of need rather than the capacity to pay should determine the availability of treatment and that for dentistry, where the available manpower was clearly insufficient to meet the needs of the whole population, the most dentally "at risk" groups should be afforded priority status. It was widely accepted that the existing distribution of services and patterns of health care were inequitable and inefficient and it was believed that public control of the health services would facilitate the more rational use of the available resources. The organisational capacity in this regard was associated with an ability both to control the public funds committed to the particular area and to influence, by other than financial means, the behaviour of those involved in the service. The government's approach to directing public expenditure in support of dental health policy will be examined in chapter ten while this chapter looks at the other arrangements which have been introduced to promote this end.

The architects of the NHS saw its organisation as a method of achieving control over the available medical and related resources, but clearly the degree of control available in practice has not been as great as has generally been supposed. Chapter five emphasised the tensions between the "pyramid" (command) and "network" (bargaining) models of implementation and highlighted the problems faced by the government in attempting to impose its authority on the developing administrative arrangements. It also gave some indication of the

directions in which compromises were effected: in particular it was argued that dental criteria went largely unconsidered in the haste to achieve an *administratively* coherent system by the appointed day. Here it remains to build on this work and to examine the operation of the administrative arrangements designed to promote the goals of dental health policy. A number of areas will be considered: the government's relationship with the dentists in general practice and in the salaried services; the co-ordination of the three major dental arms of the NHS; the facilities for providing dental advice and involving dentists in administration and decision-making; and finally, the government's relationship with the public as patients. It is clear that in each of these areas the same range of administrative capacities is not available: for example in some situations the government may be able to issue orders backed by legal sanctions, but in others it can do little more than publicise or encourage. The distribution and incidence of these different capacities offers some comment on the particular consequences of the method used to assume public responsibility for the supply of dental health services.

An obvious point from which to begin an examination of the government's relationship with the dentists in general practice is to compare the position of the individual practitioner with the criteria Max Weber established for the behaviour of public officials:[1]

1. The dentists are personally free and not subject to authority (in any sense other than maintaining general standards of behaviour) in respect of their impersonal official obligations

2. They are not organised in a clearly defined hierarchy of offices

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1. See M. Weber, *The Theory of Social and Economic Organization* (New York, Free Press, 1946), pp. 333-4.

3. In a sense their sphere of competence is defined (operations within the oral cavity) but within this limitation their competence is total

4. They are not appointed on a strict contractual basis

5. Although qualifications are required, this is not the basis of their appointment

6. They are not remunerated by salary, although they do have certain pension rights and are free to leave the position if they wish

7. The position is by no means necessarily their sole or primary occupation, as many dentists mix NHS with private practice, often using the former as a means of increasing the latter

8. There is no career structure

9. Consideration of the appropriation of the resources of the office is irrelevant as the dentists own (or at least lease) their equipment

10. Although they are subject to certain controls it is not possible to say that the dentist is subject to strict and systematic discipline in the conduct of his office.

In sum, the dentists' position denies, at least in part, every one of the specifications that Weber saw as likely to attach to a person in a bureaucratic relationship. This in itself has no intrinsic significance but it obviously casts some light on the difficulties faced by the government in attempting to direct resources to areas of perceived need. In administrative terms there is no direct line of authority from the Minister to the dentist and by and large the individual practitioner is a free agent. The capacity to practice in the NHS is restricted only by the need to be registered with the General Dental Council and there are no barriers to the choice of geographical location. In practice the dentist may work as much or as little as he likes, refuse to accept patients for treatment and undertake "private" as well as NHS work. He is free to move or terminate his practice, subject only to a requirement to complete outstanding

treatment, and to go into partnership or employ associates, assistants or hygienists.[1]

In respect of individual patients the dentist is largely free to determine the appropriate course of treatment although some courses may only be undertaken with the prior approval of the Dental Estimates Board. However, while this gives some control over dental behaviour, especially in regard to the more expensive items of treatment, the proportion of courses requiring prior approval has steadily declined. This can be explained partly by the reduction in the amount of denture work carried out and partly by changes to the Regulations which have reduced the number of items requiring the Estimates Board's sanction. In its evidence to the Merrison Royal Commission the BDA recorded its satisfaction with this development.

> 'Over the years, the prior approval rules - severely restrictive in the early days of the NHS - have been progressively eased as a result of BDA/DHSS negotiations, and now give rise to no significant difficulty.'[2]

But of course 'no significant difficulty' for the dentist also means little opportunity for the government, through the Dental Estimates Board, to influence behaviour.

Similarly, the government has little control over the quality of work done. Complaints by patients are investigated by Regional Dental Officers who are also responsible for routine examinations of a very small sample of the courses of treatment completed by general dental practitioners. In 1977, for example, a total of 16,545 inspections were made (0.06% of the total courses of treatment) but

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1. Essentially these are what are termed the dentist's "Terms of Service". For a full summary see R. Ormrod and H. Walker, *The National Health Service* (London, Butterworths, 1950), pp. 65-73.

2. *Memorandum to the Royal Commission on the NHS* reprinted in *BDJ*, 142, 2 (18 January 1977), pp. 53-63, para. 46.

only 50 were deemed to be "entirely unsatisfactory".[1] But despite this low figure it is clear that quality control remains something of a problem and that the appropriate solution is elusive. The Royal Commission suggested five possible approaches: greater attention to defining quality; assistance with the transition from student to practitioner; continuing education; greater emphasis on forms of peer review and the extension of the existing policing arrangements.[2] Of these only the last is generally available to a bureaucratic organisation and is probably the least effective. It is an *ex post facto* arrangement and to cover a significant proportion of the work done it would require the development of a cadre of policing dentists in a situation of acute manpower shortage.[3] The other techniques - essentially manifestations of the concept of control by ideas - are probably much more persuasive but remain in the hands of the profession. This is not to challenge the role of professional control of standards but only to point out the difficulties faced by the government in influencing these matters.

But in a situation where the government has little capacity to influence the behaviour of those for whose services it is paying, there is one area in which the capacity to control is considerable: that is in the arrangements for paying the individual practitioner. It is argued in the next chapter that the government has largely abrogated its capacity to control the financial resources available to the dental health services, but this is clearly not true of the specific

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1. DHSS, *A/Rep. 1977* (Cmnd. 7394), para. 105.
2. Royal Commission on the National Health Service, *Report* (Cmnd. 7615, London, HMSO, 1979), para. 9.27.
3. But note also Rudolf Klein's comments about the absence of such staff in the NHS generally. See R. Klein, 'The Political Economy of National Health', *Public Interest*, 26 (Winter 1972), p. 123.

structures designed to ensure that each dentist received only what he is due and that he doesn't abuse the remuneration regulations. Central to this process of control is the Dental Estimates Board which, under the NHS Regulations, is empowered to 'consider all dental estimate forms ... and may give or withhold approval as it sees fit.'[1] The Board is made up of seven dentists and two lay members and employs over 1500 staff, including 37 dentists, at its Eastbourne headquarters.[2] For each course of treatment a dentist submits a dental estimate form to the Board where it is processed and, if found to be in order, forms the basis of the payment made through the dentist's Family Practitioner Committee. Processing involves a number of procedures designed not only to calculate payments but also to detect both failures by dentists to comply with their terms of service and cases of excessive treatment. The operation - the Board receives about 100,000 estimates a day - has been computerised since 1960 and involves a number of tests including one in which the estimate is reconciled against a "dental history file" tape to establish that it is compatible with the Regulations. If approved the estimate is further processed to determine the fee entitlement and patient charges. Those estimates rejected by the computer are examined individually with, if necessary, reference to the particular practitioner.[3]

The arrangements are both complex and comprehensive and provide the government with a strict method of control over the distribution of the public funds expended in respect of dental treatment. In fact

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1. See Dental Estimates Board, *Dental Estimates Board in England and Wales* (Eastbourne, November 1978), p. 1.

2. A separate Dental Estimates Board for Scotland is located in Edinburgh.

3. For details see *Dental Estimates Board in England and Wales, passim.*

the whole item-of-service form of remuneration lends itself to this form of control. The British Dental Association in its evidence to the Merrison Royal Commission summarised the position succinctly:

> 'Because the State is committed to pay the dentist only for work satisfactorily completed, the Government needs to impose few rules beyond the minimum needed to regulate the dentist's dealings with the patients actually under treatment. The dentist will not be paid unless he works; he cannot work unless he attracts and keeps patients; he cannot attract and keep patients unless his standards are acceptable and his behaviour reasonable. So he works well and behaves reasonably, and the State is spared the need for a monstrous administrative edifice to service and supervise him ... The system has been under continual study within the profession since the earliest days of the N.H.S. but, so far, no acceptable alternative has been found which would not cause more problems than it would cure.'[1]

But while the system may be acceptable to the profession in so far as most of the dentists' income derives from the public purse with only marginal encroachment on the jealously guarded area of professional independence, and it is acceptable to the government in so far as all expenditure is rigorously accounted for, the whole structure is little more than a system of paying dentists for what they do. The administrative arrangements relating the government to the individual general dental practitioner include no capacity for the promotion of dental health objectives which conflict with the established patterns of behaviour and they amount to little more than a method of policing the Regulations and more specifically the dentists' terms of service. Should a dentist fail to comply with these a wide range of administrative responses have been provided, including the imposition of fines, the need to submit *all* estimates for prior approval and possible prohibition from NHS practice,[2] but so long as the obligations

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1. BDA, *Memorandum to the Royal Commission on the National Health Service*, para. 42.

2. Full details given in BDA, *Ethics and Legal Obligations of Dental Practitioners* (London, BDA, 1972), pp. 22-3 and 26-32.

are met the government has little or no capacity to influence the performance of the dentist in general practice.

In respect of the salaried practitioners a greater degree of control is available although again there are a number of obvious constraints. The most significant of these is the relative autonomy enjoyed by the local employing authorities (originally the local health and education committees and Regional Hospital Boards but now the Area Health Authorities). Within each authority there exists some capacity to direct dental resources to areas of particular need but the central government is generally bereft of the power to see that dental manpower is distributed among the local authorities on the basis of either equality or priority and need. Within each authority dentistry must compete with other health care areas for the available resources and the result, demonstrated by the figures given in chapter seven, is a very great variation in the availability of salaried dental services. The central government, particularly the Ministry of Education, was severely chided by the Estimates Committee for its failure to exercise more leadership and direction in this area, but its formal capacities are clearly limited and confined largely to the use of Circulars to advise and to publicise the experiences of individual authorities.

This lack of capacity to direct resources is emphasised if the problems associated with co-ordinating the three dental arms of the NHS are considered. Despite the fact that the need for co-ordination was a major impetus to the setting up of the NHS it is clear that it has remained an elusive goal. In respect of dentistry the Estimates Committee was particularly concerned by the failure to co-ordinate the treatment of children,[1] the McNair Committee was critical of the

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1. House of Commons, *Estimates Committee, First Report Session 1962-63*, 'Dental Services' (London, HMSO, 1963), paras. 69-72.

efforts to co-ordinate a programme of dental health education[1] and more recently it has been suggested that the problems of co-ordination were a major stimulus for the 1974 reorganisation.[2] The new administrative structure clearly includes a commitment to a much greater degree of co-ordination but if the specific arrangements for dentistry are examined it is by no means clear how it is to be achieved. Between 1948 and 1974 the three arms of the dental services were almost wholly distinct and while the hospital and general dental services were both eventually responsible to the Minister for Health, the school service came under the jurisdiction of the minister of Education.[3] The 1974 reforms brought the three arms under the jurisdiction of a single minister and the management arrangements laid great stress on the role of the Area Health Authority (AHA):

> 'The AHA will be the central management point for dentistry:
> a. providing directly the salaried school dental service, priority dental services, etc.;
> b. contracting with general practitioners, via the FPC;
> c. holding contracts of specialists ...'[4]

Central to the AHA's performance of these roles was the newly created position of Area Dental Officer (ADO) whose role, *inter alia*, included

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1. MoH, DoH(S), *Report of the Committee on Recruitment to the Dental Profession* (Cmnd. 9861, London, HMSO, 1956), para. 80.

2. See R. Levitt, *The Reorganised National Health Service* (London, Croom Helm, 1976), ch. 1.

3. In 1963 the Government specifically rejected a suggestion that the school service should come within the jurisdiction of the Ministry of Health. See House of Commons, *Estimates Committee, Ninth Special Report, Session 1962-63*, 'Dental Services' (London, HMSO, 1963), p. 9.

4. DHSS, *Management Arrangements for the Reorganised National Health Service* (London, HMSO, 1972), para. 5.5.

> 'd. monitoring and seeking to co-ordinate the overall dental service provided to the Area, both by his own staff and by general dental practitioners and the hospital service;
> e. preparing plans for improving the service and seeking the agreement of the independent clinicians to put them into practice.'[1]

However, it was admitted that the 'ADO will not have powers of direction in clinical matters over the hospital or general dental practitioners in the area'[2] but it was believed that

> 'by his position as adviser to the AHA and by the knowledge and experience that he can acquire as an administrator in touch with the profession, he will be able to exercise an effective co-ordinating and guiding influence over the profession as a whole and thereby generally provide the improvement of the dental service in the area.'[3]

The result of the reorganisation represents something of a paradox: the capacity for central control and direction (however limited) has been largely eliminated in favour of Area co-ordination - although great stress remains on the lines of responsibility leading to the Secretary of State - yet in the case of the dental services few formal means of achieving this co-ordination have been provided.[4] Similarly, while the financial arrangements of the new structure 'will be designed progressively to reduce the disparities between the resources available to different regions'[5] the inclusion of dentistry in the wider health budget for the purposes of this allocation gives

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1. *Ibid.*, para. 5.6.
2. *Ibid.*, para. 5.7.
3. *Ibid.*
4. See D.T.E. Williams and R.J. Anderson, 'The Role of the Area Dental Officer', *BDJ*, 148, 1 (1 January 1980), p. 19. 'The a.d.o. [Area Dental Officer] can offer few of the inducements to co-operate that are available to his counterparts in medical administration.'
5. *National Health Service Reorganisation: England* (Cmnd. 5055, London, HMSO, 1972), para. 160.

the central government little capacity to control the distribution of salaried dental officers around the country. Thus despite the fact that a 'national service calls for a national strategy, with national objectives, standards and priorities',[1] for dentistry at least, there appear to be few arrangements to see that there is any consistency between the services in different health authorities or that the different services within a single authority are complementary. In addition, since the general dental practitioners are still financed directly by the central government (through the Dental Estimates Board) there is little reason to suppose that any sort of balance should be achieved between these and the salaried practitioners.

A good indication of the problem can be found in the difficulties experienced in co-ordinating the treatment given to children. The Estimates Committee believed that the basis of the problem was essentially one of information:

> 'it should be possible to devise a system of documentation covering all the dental services which will make it possible to draw up statistics showing the number of school children who are known to be dentally fit'[2]

and recommended that

> 'the Health Departments should devise a system of documentation which will make comprehensive statistics available showing the dental treatment given to school children in whatever service they are treated.'[3]

But despite the government's acceptance 'in principle' of this recommendation and its undertaking to carry out pilot feasibility studies,[4] little substantive change appears to have taken place and in

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1. *Ibid.*, para. 1.

2. *First Report of the Estimates Committee, Session 1962-63*, para. 83.

3. *Ibid.*

4. *Ninth Special Report of the Estimates Committee, Session 1962-63*, p. 10.

1976 the Court Committee on Child Health Services reported upon the difficulties which still existed in estimating the number of children needing treatment.[1] The nub of the problem is first, that the records of the general dental service are based on courses of treatment provided[2] while the school service has always recorded the number of children treated and second that the school service has no means of identifying the particular children who are being treated in general practice. Thus, for example, a school dentist may expend considerable time inspecting children who have recently received treatment elsewhere while at the same time, because of the lack of resources in the salaried service, a considerable number of children do not see a dentist at all.

Under the existing arrangements few mechanisms are available to overcome this problem and at best co-operation and co-ordination have been achieved only on a voluntary basis. The Estimates Committee pointed to areas where successful experiments had been carried out[3] and clearly the definition of the duties of the Area Dental Officer in the 1974 re-organisation was informed by the need for such co-ordination, but as yet there is little evidence of its successful achievement.[4]

The fourth aspect of the organisational structure to be considered are the arrangements for providing dental advice and for

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1. 'Fit for the Future', *Report of the Committee on Child Health Services* (Cmnd. 6684, London, HMSO, 1976), para. 13.24.

2. Of course any one child may have more than one course in a year.

3. *First Report of the Estimates Committee, Session 1962-63*, para. 70.

4. Though see G.O. Taylor, 'Co-operation between School Dental Service and General Dental Service', *BDJ*, 141, 2 (20 July 1976), p. 59 for brief details of a scheme operating in Thameside.

involving dentists in the decision making and administrative processes. Such involvement has come in three main ways: as members of the professional staff of the central department; as holders of the office of Area Dental Officer (which in most cases involves rather more administration than clinical practice)[1] or as members of dental advisory committees.

A majority of the dentists within the Department of Health and Social Security are employed as Regional Dental officers who are responsible, as has been shown, for investigating complaints and providing an inspection service for the Dental Estimates Board. The Chief Dental Officer at DHSS is responsible for advising the Secretary of State on clinical and other professional dental matters but he remains subordinate to the Chief Medical Officer who enjoys responsibility for the whole range of public health care provision. The number of dental officers employed is relatively small and shows little increase from the position found by the Estimates Committee in 1962.[2] But in view of the relatively small number of control mechanisms available to the central department and the high degree of both delegation (to Area Health Authorities) and hiving off (to bodies such as the Dental Estimates Board) there seems little justification for any larger dental staff. However, the importance of these staff members is, as MacKenzie notes in the case of DHSS's medical officers, difficult to determine.[3] The authority of the office of Chief Medical Officer has been built more on the qualities and personalities of the

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1. Details of a recent survey in 'The Role of the Area Dental Officer', Table 1.

2. *First Report of the Estimates Committee, Session 1962-63*, especially QQ. 118-20.

3. W.J.M. MacKenzie, *Power and Responsibility in Health Care* (Oxford, Oxford University Press, 1979), ch. 9.

incumbents than its statutory powers[1] and as yet there has been little time to see whether the Chief Dental Officer will attract the same degree of respect.

The position of Area Dental Officer, introduced in 1974, has not been without its problems. The Merrison Royal Commission noted that the appointment of such officers had been viewed with suspicion but that they were needed 'to represent and interpret the interests of the profession within the NHS management structure, and the priorities of the NHS to the profession.'[2] The ADO thus sits in an invidious position between the profession and administration and his position has not been helped either by the limited administrative capacity to fulfil the duties of the office or the hostility which greeted the establishment of the position. The *British Dental Journal* noted in 1978 that the ADOs

> 'have either received the grudging support of their colleagues or at times met undisguised hostility that has occasionally reached the borders of ethical propriety.'[3]

The editorial went on to suggest that the basis of the hostility lay in the professional background of many of the ADOs (employment in the school dental service) but that the overall implications of the problem should not be underestimated. It was the ADO's role to attempt to raise the priority afforded to dentistry in the individual areas and thus in the absence of support from DHSS 'it will be for the profession to decide whether it wishes to have a dental voice readily available at area level.'[4] The present position is that the ADO enjoys neither

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1. Since 1919 the office has had permanent head status.
2. Royal Commission on the NHS, *Report*, para. 9.44.
3. *BDJ*, 145, 12 (19 December 1978), p. 351.
4. *Ibid.*

the wholesale support of the practitioners in his area nor the status of a member of the Area Team of Officers and is thus ill-equipped to provide any substantial input into the administration of the dental services at the Area level.

The use of professional advisory bodies was a natural corollary of the public assumption of responsibility for supply in which the neutral and widely applicable bureaucratic techniques would need to be informed on the content of the policy area in question. But in addition, as was suggested in chapter five, the statutory provisions for such advice were perceived by the dentists as a necessary counter to bureaucratic hegemony and an important pre-condition of their involvement in any public dental service. Thus under both the original and post-1974 arrangements statutory provision was made for the tendering of professional advice at both the national and local levels. Nationally the Minister was initially advised by the Central Health Services Council (CHSC) which had three dental members (out of forty-one) and the Standing Dental Advisory Committee which was composed largely of dentists. These arrangements survived the 1974 re-organisation although the membership and basis of appointment to the CHSC was changed. At the local level the arrangement whereby a Local Dental Committee was elected by practitioners to advise the Executive Council on matters affecting general practice was supplemented by the appointment of Area and Regional Dental Committees in 1974. These comprise dentists from all parts of the Service and are required to advise the relevant authority on all matters pertaining to dental health.[1]

It is by no means easy to determine the degree to which these

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1. *Management Arrangements for the Reorganised National Health Service*, para. 5.12.

bodies have been influential in the administration of the dental health services but on the available evidence it is difficult to believe that they have made much of an impact. The Annual Reports of the Central Health Services Council contain few references to dental matters and the Standing Dental Advisory Committee seems to confine itself almost wholly to fairly narrow dental issues.[1] There is practically no evidence about the operation of the advisory bodies at the local level, but again it seems likely that they have little capacity to make a significant contribution. This can be explained in at least two ways: first that the authorities to which they report have little capacity to effect significant changes to the administrative process and second that since the system has been organised on a national basis most decisions of substance affecting its operation are made at the national level where, in so far as the dentists' case is heard, it is made by the British Dental Association. In this regard it is important to note that the Local Dental Committees (the advisory committees on general practice at the Area level) elect a substantial part of the membership of the General Dental Services Committee,[2] perhaps the most "political" committee of the British Dental Association;[3] that the hospital dentists elect a Central Committee for Hospital Dental Services and that the Community dentists elect a

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1. For example in 1975 it met three times and considered dental radiological protection, the use and restriction of barbiturates, hepatitis B infections, the use of general anaesthetics in dentistry, the need for an inquiry into dental anaesthetic deaths, the presence of fluorescers in dental porcelains and NHS finances. See Central Health Services Council, *A/Rep. 1975*, paras. 71-9.

2. See A.G. Green, 'The General Practitioner: His Representation and Political Lines of Communication in England', *BDJ*, 136, 7 (2 April 1974), pp. 285-8.

3. See 'The General Dental Services Committee', *BDJ*, 131, 7 (5 October 1971), pp. 319-21 for details.

Central Committee for Community Dental Services.[1]

Thus the general conclusion about professional involvement in NHS administration and decision making is that it is exercised primarily by the British Dental Association through the nexus of the employer/employee relationship. In a study of NHS doctors Mechanic and Faich argue that dissatisfaction with matters other than money was expressed through conflicts over remuneration since payment issues were a regularised means of dealing with doctors' grievances[2] and in view of the evidence presented both here and in the following chapter, it appears that the dental situation is little different. Thus the statutory advisory committees and dentists within the administration appear to play an insignificant role in comparison to the performance of the British Dental Association which through its various committees[3] presents the dentists' case at all formalised hearings. Two further points might be made in support of this conclusion about the role of the BDA: first that the two major committees appointed in recent years to look at the planning and administration of the dental services - The Working Party on Dental Services and the Dental Strategy Review Group - are essentially bilateral arrangements between the Health Departments and the BDA, and second that in evidence to the Expenditure Committee, officials of the Department of Health and Social Security blamed the Association for failing to apply sufficient pressure to secure the introduction of topical fluorides into general

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1. See *BDJ*, 141, 8 (19 October 1976), p. 229 for details of election arrangements for this Committee.

2. See D. Mechanic and R.G. Faich, 'Doctors in Revolt: The Crisis in the English National Health Service', *Medical Care* VIII, 6, (November-December 1970), pp. 442-455.

3. See BDA, *BDA: The British Dental Association* (London, BDA, n.d.), pp. 8-9 for full details.

dental practice in the NHS.[1] Under these arrangements the dental contribution to matters of administration seems to be confined to what can be accommodated within the basic employer/employee dialogue.

The final area of administration to be considered concerns the part played by the public in the dental health services. Clearly the major role is that of patient but since 1974 members of the public have also been formally involved in the administrative structure as members of the Community Health Councils. The Councils have no special significance for the dental services beyond their NHS-wide role which involves the right to seek information from and make representations to, the Area Health Authorities, to visit hospitals and other institutions and to be consulted about development plans,[2] but they are mentioned because of the way they reflect the change in emphasis that the 1974 re-organisation introduced. In so far as "consumers" were represented before that date it was by lay members of the Regional Hospital Boards but under Sir Keith Joseph's proposal great stress was laid on the separation of managerial and representational functions.[3] Thus the latter was taken out of the main managerial structure and lodged with a distinct body, the Community Health Council. In this way just as direct dental involvement in the administration has tended to be replaced by dental involvement through the professional organisation, so the representation of the dental

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1. House of Commons, *First Report of the Expenditure Committee, Session 1976-77*, 'Preventive Medicine' (London, HMSO, 1977), Q. 1856.

2. See R.G.S. Brown, *Reorganising the National Health Service* (Oxford, Blackwell and Martin Robertson, 1979), pp. 29-30 for a discussion of the role of the Community Health Councils.

3. See B. Watkin, *The National Health Service: The First Phase* (London, Allen and Unwin, 1978), pp. 122-5 for the development of this approach.

patient (as a consumer of dental services) has been moved to a separate body with the administration of the dental services being left almost totally in bureaucratic hands.

But of more significance for this chapter are the relationships between the public (as patients) and the dentists (as the providers of services) and the public and the government (as the provider of most of the funds involved). In general practice, unlike the arrangements for the doctors, the dentists do not have a "list" of patients and hence each course of treatment is done under a separate contractual arrangement. Once a dentist has accepted someone as a patient he is required to provide all the treatment necessary for dental fitness that the patient is willing to undergo, but when this is completed his obligations end. He may refuse to undertake subsequent treatment and hence a patient might receive attention from a number of dentists in a given time. However, it is clearly in the dentist's interests to build up a continuing relationship with as many patients as possible and in practice this is what has occurred although it should be remembered that still only a minority of the population is involved in this way.[1]

The evidence considered in chapter seven pointed to the relationship between regular care and good oral health, but the present arrangements do little to encourage the development of the dentist-patient relationship. Indeed, as was shown in that chapter, the regulations governing emergency treatment in fact militate against it. The particular form of the dentist-patient relationship was

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1. For example the 1978 survey showed that only 46% of the population attended for regular check ups. See J.E. Todd and A.M. Walker, *Adult Dental Health. England and Wales 1968-1978* (London, HMSO, 1980), Table 8.1.

justified initially on the grounds that there were insufficient practitioners to meet the needs of the whole population and since then the retention of the basic fee-for-service form of remuneration has prevented any change. However the Committee on Child Health Services recommended in 1976 that experiments in the dental care of children should take place in the general dental services involving different forms of payment. 'Such a change in remuneration' it noted, 'either to a capitation fee as in medicine, or to an annual fee for maintaining a child dentally fit, should encourage the practice of preventive as well as reparative dentistry for children.'[1] As yet such experimentation has not occurred[2] but the recommendations highlight the fact that responsibility for securing dental care remains almost entirely in the hands of the individual and that there are no arrangements for ensuring that those with a need for dental treatment do in fact receive it.

In the salaried services the relationships are much the same. With school children the potential exists, through comprehensive school inspections, to reach almost the entire school population, but a lack of dental manpower and a lack of co-ordination with the general dental services in treating those found to require attention, has made this an unattainable target. For nursing and expectant mothers the attendance rates at the priority clinics are very low although of course many seek treatment from general practitioners. But again the dentists with a responsibility for the priority group have no way of ensuring that those entitled and in need of treatment are in fact

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1. *Report of the Committee on Child Health Services*, para. 13.39.

2. Although the General Dental Services Committee expressed its support for the measure in 1980. See *BDA News*, 7 October 1980, p. 1.

receiving it.

Thus in its relationship with the public in the role of potential dental patients the government has a very limited capacity to promote its dental health goals. It has no power to compel attendance and has had to resort to the use of financial incentives (considered in the next chapter) and attempts at dental health education in seeking to increase attendance rates. The success of the latter, which has taken many forms including posters, school projects, dental "weeks" and television advertising, is difficult to determine but it remains a popular approach to the improvement of oral health if for no other reason than the paucity of alternatives. And in fact a wide range of interested organisations (including the manufacturers of dental materials) have become involved.

To this point the administrative structure has been considered largely in terms of the formal arrangements for achieving dental health policy ends. In this regard there can be little question that the administrative capacities to control, to co-ordinate, to direct and to allocate, on which the moves to public supply were premised, are largely absent from the NHS organisation. However some consideration must also be given to the concept of co-ordination or control by "ideas" rather than by the more formal administrative means. In his work *Control in a Bureaucracy* Andrew Dunsire suggests that there is underlying agreement among writers on three main modes of superior-subordinate relationship in an organisation: 'duress' (achieving compliance by threat or use of penal sanctions); 'exchange' (winning co-operation by the mutual recognition of contribution and obligation); and 'identification':

> 'The assuring of collaboration by the spontaneous sharing of values, purposes and outlook, or by the long-term inculcation in the subordinate of the values, etc., of

> the superior.'[1]

The examples given thus far in this chapter fall mainly into the first two of Dunsire's 'modes' and to conclude some consideration will be given to this idea of 'identification'.

Dunsire's third categorisation draws its inspiration from Luther Gulick's understanding of 'co-ordination by ideas' which involves

> 'the development of intelligent singleness of purpose in the minds and wills of those who are working together as a group, so that each worker will of his own accord fit his task into the whole with skill and enthusiasm.'[2]

There is now a considerable amount of literature on both the methods of achieving this identification of interests between the individual and the values and aims of the organisation and on the consequences of this symbiosis. Much of the latter is critical: for example the attacks on the encouragement of elitism in the higher echelons of the Civil Service,[3] but whatever the merits of the individual complaints, there is little doubt that the technique is seen as an effective form of control. Whether or not the values or goals it promotes are desired is a logically distinct question. To an extent the concept was implicit in the understanding of civil service loyalty with which many in the Labour Party approached the problems of public supply, for experience had shown the capacity of the bureaucracy, *en masse*, to move behind the position of a new government and identify with its

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1. A. Dunsire, *Control in a Bureaucracy* (Oxford, Martin Robertson, 1978), p. 35.

2. L. Gulick and L.F. Urwick (eds.), *Papers on the Science of Administration* (New York, Institute of Public Administration, 1937), p. 6.

3. For example see P. Kellner and Lord Crowther-Hunt, *The Civil Servants. An Inquiry into Britain's Ruling Class* (London, Macdonald, 1980), esp. ch. 6.

aspirations. At a superficial level there is little doubt that the organisational arrangements of the traditional civil service encouraged this belief, but for one or two writers the issue was clearly more problematical. As was shown in chapter four the Webbs, Tawney and T.H. Marshall all addressed themselves to the behaviour of the public administrators and pointed not only to the need to bring professionalism to the public service but also to socialise the professions with a respect for the needs of the community as a whole instead of the pursuit of mere personal gain. But beyond Marshall's observation that such a process was already occurring little advice was tendered on how such community and professional needs could be reconciled. And more to the point the administrative arrangements of the dental health services did little to attempt to bridge the gap.

There is little doubt that the dentists' primary loyalty is to their profession rather than the State as their employer. In fact it is argued that far from socialising the profession the advent of the NHS has in fact strengthened the professional ties of the dental practitioners and has contributed significantly to the development of a relatively strong and united professional organisation from the weak and divided arrangements which were a feature of the pre-NHS situation. With a single employer the dentists have come to look to their central organisation to promote and protect their interests and hence the importance of this professional affiliation has been increased. This question will be pursued in greater detail in the concluding chapter but its importance here lies in the fact that dentists appear to see themselves as dentists first and only incidentally as public employees. Thus in so far as they are guided by dominant ideas, these derive from the profession itself rather than the government. This is not of course to suggest that the profession has been oblivious to community

needs but only that there is no *necessary* conjunction between professional and community priorities. In many areas there may be no conflict at all but in others there clearly is and in this respect it is important to note the virtual professional monopoly over the education and training of dental practitioners. The choice of entrants to the profession, the design of the training syllabus and the establishment of criteria for inclusion on the Dental Register (the necessary prerequisite for practice) are almost entirely in professional hands. The major source of dental information for the individual practitioner is the professional journal[1] which contains a mixture of scientific and dento-political material, and continuing education, particularly at the local level, is organised by the profession itself. Again the purpose is not to challenge these arrangements but to point out the way in which the government, as the major employer is almost wholly excluded from the professional education of its employees and how, in terms of developing ideas about the style and purpose of dental practice, the professional organisation plays a key role.

Although such arrangements are commonplace among the professions the position of the dentists differs markedly, for example, from the doctors in the NHS. As a group the doctors have a great deal more contact, within their working day, with other employees and aspects of the NHS. Over 53% of the doctors work in the hospitals (where there are career structures) and the 41% who are in general practice[2] have fairly frequent contact, because of the structural organisation of

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1. The *British Dental Journal*.

2. These figures from Royal Commission on the NHS, *Report*, Table 14.1. The remainder work in the school and community services.

health care, with hospitals, specialists and the plethora of ancillary health workers. This is not to argue that the doctors *have* become more committed to the ideas and aspirations of the NHS, but it is to suggest that the apparatus for socialisation is much more readily apparent. The dentist, by contrast, is a solitary figure, mainly employed in relatively small general practices which employ only a limited number of ancillary personnel. Under these arrangements the majority of dentists have very little contact with their peers in the course of their work and it has been shown that only a small number play any significant role in the administration of the service. Hence the opportunities for the government to secure co-ordination and control by the spread and acceptance of ideas is limited and it is hardly surprising that the dentist should identify more readily with their professional organisation rather than their employer. They have not in any real sense been "brought into" the organisation which is the NHS and their terms of service do little to foster a sense of commitment to the well-being of the population as a whole.[1] Under these conditions it is understandable that they should concentrate, through the British Dental Association, on maintaining what they perceive to be their professional status and standard of living.

The government's capacity to develop a particular ethos among its dental employees seems to be no greater than its ability to influence their behaviour by more obvious means and hence by way of preliminary conclusion it is suggested that in administrative terms at least, the capacities to control, co-ordinate and direct, on which

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1. However this is not to deny that a great many dentists do have such a commitment, but only to make the point that the administrative arrangements *per se* have done little to foster this view.

the move to public supply was premised, are largely absent in the resulting organisational structure. However this conclusion and its implications for the shortcomings of the dental health services will be discussed in more detail in the final chapter after the services' financial arrangements have been examined.

CHAPTER TEN

THE FINANCIAL ARRANGEMENTS

On the appointed day[1] the government possessed few dental resources: it had run and of course continued to run, through the local authorities, the relatively small service for children and nursing mothers. But in contrast to what was done in the case of the hospitals and their staffs, the dental clauses of the *National Health Service Act* made no provision for a large scale takeover of buildings, equipment or contracts. The dentists with their facilities maintained their independence and were under no obligation to take part in the new service. Thus, as the government would have to purchase any dental treatment it promised to provide, an examination of the way in which it approached the use of the financial resources set aside for this purpose is of obvious importance in understanding the problems that have arisen. In respect of the general dental service there are three main ways in which the government can control the money it expends on dentistry. These are the arrangements for setting patient charges, the methods used to pay the dentists and the system for determining the fees payable in respect of each course of treatment undertaken. Each of these will be considered in turn.

CHARGES

Charges for dentures were announced in the budget in April 1951[2] and charges for other types of treatment were foreshadowed in a statement by the Chancellor of the Exchequer on "the financial and economic situation" to the House of Commons in January 1952.[3] The charges have remained and have been steadily increased since that

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1. 5 July 1948.
2. 486 H.C. DEB. 5s. Col. 852.
3. 495 H.C. DEB. 5s. Cols 54-5.

date. This section will examine the reasons behind the introduction of the charges and the manner in which they have been employed.

Although in its 1951 Report the Standing Dental Advisory Committee had advocated consideration of measures to limit the number of dentures supplied[1] and the Minister of Health had emphasised the need to safeguard children's teeth and promote conservative work where possible,[2] there is little evidence to suggest that such factors played much part in the decision to introduce denture charges. In fact the charges were an integral part of an overall budgetary strategy in which the escalating cost of re-armament had put great pressure on the other areas of public expenditure, of which the NHS was an obvious candidate for economies. Its expenditure had repeatedly exceeded the estimates, the Cabinet had set up a committee to keep a weekly check on the Minister, Aneurin Bevan,[3] and in the previous budget the Chancellor, Sir Stafford Cripps, had warned that the period of initiation has passed and that

> 'there is no excuse for exceeding the estimates ... Any expansion in one part of the Service must in future be met by economies or, if necessary, by contraction in others. In exercising this essential control over total expenditure, regard will of course be had to priorities.'[4]

Seen in this light Gaitskell's action in introducing charges for dentures was merely the logical extension of a developing approach. But the question remains of why dentures (and spectacles) were chosen as the first line of saving?

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1. Central Health Services Council, *A/Rep. 1951*, para. 14.

2. See *BDJ*, 90, 10 (15 May 1951), p. 273.

3. Private correspondence (24 July 1981) with Philip Williams, editor of the Gaitskell Diaries which are to be published in 1982.

4. 474 H.C. DEB. 5s. Cols. 59-60.

It was perhaps at this point, with the decision to effect economies already made, that the recommendations of the Standing Dental Advisory Committee and the arguments of the Minister of Health assumed some importance and provided the justification for the measures adopted. By 1951 the priority services had reached something of a nadir having lost about 25% of their staff in the previous two years and in the financial year 1950/51 payments in respect of dentures accounted for 63% of the total fees authorised in the general dental service.[1] Hence a measure which afforded the possibility of both a reduction in expenditure on dentures and a movement of resources in favour of the priority patients, was obviously attractive. But there is no evidence to suggest that the arguments influenced the Chancellor who, according to his biographer, believed health charges to be 'right and not just a sad necessity'[2] and who was adamant, in face of the Prime Minister's desire to stress the abuses that had taken place, that the economic importance of the measure should be emphasised.[3] It is more likely that the probable consequences of the action made the reductions in the NHS budget more palatable to the Minister of Health who could at least argue that in contrast to say prescriptions, personal expenditure on dentures would only be occasional and would not generally involve those for whom priority was sought. And perhaps more to the point it was infinitely preferable to the proposal, raised by the Chancellor at one stage, to eliminate entirely the free dental service.[4]

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1. MoH, *A/Rep. 1952* (Cmnd. 8933), Table 13, p. 58.
2. P. Williams, *Hugh Gaitskell* (London, Cape, 1979), p. 262.
3. *Ibid.*, pp. 262-3.
4. *Ibid.*, p. 249.

The measure did not, of course, find much favour with the former Health Minister, Aneurin Bevan, whose opposition to the charges and continual threats to resign introduced considerable tension to the pre-budget discussions and whose eventual resignation, along with Harold Wilson and John Freeman, brought rather more notoriety to the decision than it would otherwise have received. Even the King was reported as feeling that Bevan 'must be mad to resign over a thing like that. I really don't see why people should have free false teeth anymore than they have shoes free'.[1] But the former Minister of Health saw the issue in wider terms. In his resignation speech to the House of Commons he complained that

> '... you have been saying ... that I have been quarrelling about a triviality - spectacles and dentures. You may call it a triviality. I remember the triviality that started an avalanche in 1931 ... What will he [the Chancellor] do next year? Or are you going to take your stand on the upper denture? The lower half apparently does not matter, but the top half is sacrosanct. Is that right?'[2]

The Chancellor, he continued

> 'is putting a ceiling on the Health Service. With rising prices the Health Service is squeezed between the artificial figure and the rising prices. What is to be squeezed next year? ... Where do you stop?'[3]

In the end Gaitskell's position prevailed, the charges were introduced, and the cost to the public purse of supplying dentures noticeably declined, although it is not perhaps possible to attribute this solely to the Chancellor's action.[4] But in a sense the political differences between the two men masked, to an extent, their commitment to the same

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1. Gaitskell's diary 30 April 1951 cited in *ibid.*, p. 251.

2. 487 H.C. DEB. 5s. Col. 41.

3. *Ibid.*

4. See below p. 299.

organisational principle: that is political control over administrative actions. The whole Fabian approach which was discussed in chapter four and to which Gaitskell was an obvious heir, premised its support for the assumption of public responsibility for supply on the provisions made for political control and hence the Chancellor, in this instance, was merely seeking to allocate resources on the basis of political judgements about priorities. This was a position to which Bevan was also clearly committed. The whole force of his argument about the administrative structure of the NHS centred on the necessity of political control and in fact bodies such as the Regional Hospital Boards and Executive Councils were, in law, only agents of the Minister. On this view Bevan's claim[1] that the Service was new and that the actual cost could not be estimated until the behavioural patterns of the public were known, cannot be sustained. Experience has shown that, at least in the case of the dentists, spending patterns are largely determined by the providers of the services and that to accept the actual pattern as the required pattern is to alienate the capacity for political control. Clearly importance must be attached to professional judgements but it must be remembered that in most cases the doctor or dentist is primarily concerned with the individual patient in his surgery whereas the Minister has a much wider remit. Tension between the two is probably unavoidable but unless political control can be exercised there is little prospect of realising the goals of a system of public supply especially in an area like dentistry where the manifest shortage of professional resources meant that there was no prospect in the forseeable future of treatment being available for all. In fact the case was clearly put by Bevan less than two years

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1. See M. Foot, *Aneurin Bevan* (St. Albans, Granada, 1975), ii, p. 289.

later. Speaking in the debate following the appointment of the Guilleband Committee[1] he enquired

> 'how such a committee could come to the conclusion that it is in the best interests of the country that there should be a reduction in the expenditure on the pharmaceutical side of the service or an increase on the dental side. That is not a matter for specialist knowledge. Priorities of expenditure within the Health Service itself are a matter of political opinion and judgement. If we are to seek the consequences and the therapeutical value of spending money on this or that it is a professional question; but if we are to decide who is to be the beneficiary, whether it is a person who wants dental care or a person who wants hospital care, that is not a professional question at all but a question of social priorities.'[2]

Thus the imposition of charges, however imperfect the mechanism of selection, can be defended on the grounds of both maintaining political control over public expenditure and attempting to allocate resources in a way which supported the stated priorities within the dental services. Even the British Dental Association, which has always opposed the imposition of charges on the grounds that they deter people from seeking treatment, agreed that if a reduction in expenditure was needed then 'this is the right item on which to economise'.[3]

The decision, in 1952, to introduce charges for treatment followed a similar pattern although in this case there was rather more debate about the dental consequences of the action. The Minister of Health spoke of 'the need to rectify obvious abuses and improve the public health by pruning or rearranging some of the present services or, indeed, by getting the emphasis altered in the right direction',[4] and

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1. The Committee of Enquiry into the Cost of the National Health Service.
2. 515 H.C. DEB. 5s. Cols. 1706-7.
3. *BDJ*, 90, 8 (17 April 1951), p. 220.
4. 498 H.C. DEB. 5s. Col. 841.

implied that the measure would directly benefit the priority classes who were exempt from the impost. However there can be little doubt that the overwhelming attraction was again the promised saving which at this time was estimated at £7½m. The *Times* leader, for example, commented that:

> 'The Estimates contain more financial tactics than medical or social strategy. Their preoccupation is more with the imposition of an arbitrary, though necessary, limit on expenditure, than with a distribution of the budget, according to a clear pattern of priorities.'[1]

But this comment notwithstanding, it is perhaps fair to say that in respect of dentistry the government showed some consideration for its dental priorities even if its understanding of the consequences of making the charge were widely disputed. In fact the measure was strongly contested both in the Parliament and by the British Dental Association whose objections were essentially threefold. First, that the charges would

> 'penalise those patients who seek regular treatment, and will encourage the neglect of oral health by the public and will result in a lamentable increase of dental disease, with a consequent ultimate rise in the cost of the Service.'[2]

Second, that the measure would particularly effect young adolescents 'whose earnings are not sufficient to make a recurring charge for dental treatment a matter for little moment',[3] and finally that

> 'the absence of any special provision for exemption from payments of those who require emergency treatment for the relief of pain will result in much unnecessary hardship and suffering'.[4]

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1. *The Times*, 27 March 1952, p. 7.

2. Resolution of the Council of the BDA, 9 February 1952, reported in *BDJ*, 92, 4 (19 February 1952), p. 103.

3. *Ibid.*, p. 99.

4. *Ibid.*, p. 103.

These arguments were repeated and extended in the debate on the legislation where particular stress was laid on the penalties which would be imposed on those who sought regular treatment:[1] that is, the likelihood that they would pay a high percentage of the cost each time whereas the irregular attender would only pay £1 whatever the condition of his mouth. For his part the Minister moved amendments in the Committee stage to extend the age of exemption from 16 to 21 and to provide for free initial examinations,[2] but he was unwilling to countenance possible alternative approaches to charges on the ground that they would bring an element of uncertainty to the anticipated level of yield from patient sources. Another Government Member, Mr Macleod, admitted that there was some doubt about the consequences of the action but believed that the charges could be supported

> 'either because they are economically essential or because I believe - I freely grant that one could be wrong on this - it is possible to get a list of priorities. If that be so, then these charges are going to be justified if the health of the children is better looked after ... it is becoming increasingly possible to get appointments for the dental treatment of one's children ... The reason for this is that less dentures are being made and dentists have more time.'[3]

Implicit in the government's argument was the assumption that charges would in fact deter people from using the general dental services and that either as Mr Macleod suggested, the time could be filled by children or as the Minister hoped, more dentists would make their services available to the school dental service on a sessional basis.[4] But at the same time the opponents of the measure sought to

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1. For example see 499 H.C. DEB. 5s. Col. 781.

2. 499 H.C. DEB. 5s. Cols. 778-9.

3. *Ibid.*, col. 789.

4. 498 H.C. DEB. 5s. Col. 848.

emphasise that the charges were more likely to dissuade regular attenders and to deter would-be attenders from seeking treatment except when in pain. The two positions are of course quite compatible and the issue resolved largely into the question of whether the government should positively discriminate in favour of a particular group. In the way that the charges for dentures demonstrated the fundamental difficulties in maintaining political control over expenditure, this issue of charges for treatment highlighted the problems that followed from this in attempting to ration services in a bureaucratic system.

The tension again lay between the position of the dentist with his primary concern for individual patients and that of the Minister with his wider, community responsibility, and the central issue comprised the basis on which decisions should be made in the absence of market-type forces. In a sense, although it wasn't seen in these terms at the time, the particular dispute put the whole issue of public responsibility for supply on the line in so far as its justification lay in the capacity to promote national priorities even when these contradicted the existing patterns of behaviour. In this instance, despite the considerable opposition from the profession, the Ministerial view on priorities prevailed, but in the next few years it proved increasingly difficult to sustain. In respect of the charges issue the *Report of the Committee of Enquiry into the Cost of the National Health Service* gives some indication of the attractions of the competing approaches. The Guillebaud Committee, as its title implied, was primarily concerned with the costs of providing health services although in passing judgement on the imposition of dental charges it did take notice of some wider considerations. The Committee was particularly conscious of the problems caused by the shortage of dental

manpower[1] but it was also at pains to point out the general financial constraints on the NHS and to stress that any large scale expansion of the dental services could only take place at the expense of another area.[2] Hence 'the aim for the present must be to make the best use of the available resources within the annual budgets approved by Parliament'.[3] Within this framework the Committee accepted the view that it would be unwise to abolish denture charges because it would lead to more denture work at the expense of conservation and attention to the priority classes. But on the issue of charges for treatment it demonstrated more ambivalence, reporting that

> 'we would regard the reduction of the incidence of these charges as having the highest priority when additional resources become available'.[4]

Behind this recommendation was an acceptance of the British Dental Association's argument that charges deterred people from seeking treatment and a belief that the arrangements in fact added to the overall cost of the service. That, in other words, the person who didn't attend for treatment until pain was experienced required a great deal more treatment at much greater cost than the regular attender.[5] This conclusion attracted the Committee to the Association's proposal on charges, which

> 'would enable those people who are prepared to keep themselves dentally fit to contract as it were into a free service for dental treatment. It would overcome many of the objections to the existing charge and would

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1. Committee of Enquiry into the Cost of the National Health Service, *Report*, para. 527.
2. *Ibid.*, para. 530.
3. *Ibid.*, para. 545.
4. *Ibid.*, para. 580.
5. *Ibid.*, para. 578.

> at the same time make an effective contribution to preventive health'.[1]

However, to be fair to the Committee, it did add that should the priority service be shown to be suffering the measure could be reconsidered.[2] Nevertheless the proposal represented a radical change of approach in which the instrumental intent of the charge was directed away from the priority classes towards a more general encouragement of regular dental treatment. In the event the recommendation was not accepted but at the same time little more was done, by the use of charges, to promote the needs of the priority classes. They remained exempt from the impact but as it was only increased once, from £1 to £1.50, in the period 1952-1971, its success as a deterrent obviously declined.

In 1970 the Chancellor of the Exchequer in the new Conservative Administration announced the intention of the Government to 'establish more sensible priorities'[3] which in respect of dentistry involved the retention of the free initial examination but the imposition of a charge equivalent to approximately half the cost of the treatment actually provided and the lowering of the age of exemption from twenty-one to eighteen.[4] The Minister of Health (Sir Keith Joseph) claimed that:

> 'The new system of dental charges will giva a financial incentive to patients to look after their teeth ... and should, therefore, have a beneficial effect on dental

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1. *Ibid.*, para. 581.
2. *Ibid.*, para. 582.
3. Based on the principle that 'where the user can afford it, he should bear more of the cost and the taxpayer less'. See 805 H.C. DEB. 5s. Col. 42.
4. *Ibid.*, col. 43.

> health'[1]

and was later

> 'glad to acknowledge that although the British Dental Association disagreed with what the Government proposed, once it was persuaded that the Government intended to go ahead the Association undertook to advise its members on an approach to dental patients to explain exactly the new system ... The BDA explains that this system should be a great encouragement to people to attend their dentists regularly ... Instead of a standard charge for all non-exempt patients of £1.50 or the cost, whichever was the lesser, as up to 1 April, there is now a clear economic advantage to the patient to have regular and relatively small treatment because he will pay only half the cost.'[2]

But in tendering this advice, the BDA was making the most of what it perceived as a bad job. The Association's own view was that 'the increased charges and the proposed method of relating them to the amount of treatment required should be condemned,[3] but as the government showed no indication of backing down it felt obliged to move to minimise its members' losses.

Thus while it can be argued that the government moved to assert its control over priorities with this measure it must also be noted how these priorities were being radically redefined.[4] In so far as the government sought to use the financial incentives associated with charges it was not to promote the claims of those whom it had been agreed, on dental criteria, should have priority, but rather to reward those willing to attend for regular treatment. But the 1968 Adult Dental Health Survey which was considered in chapter seven and whose conclusions were available to the government at this time, showed

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1. 810 H.C. DEB. 5s. Col. 1447.
2. 816 H.C. DEB. 5s. Cols. 278-9.
3. *BDJ*, 129, 10 (17 November 1970), p. 447.
4. See the debate on this issue at 816 H.C. DEB. 5s. Cols. 262-310.

quite clearly that there were basically two types of dental patient: those who attended regularly and those whose attendance was only induced by the experience of pain and that socio-economic and regional factors played an important part in defining this distinction.

Hence the Minister's action, in introducing this type of charge, did little but consolidate the existing attendance patterns in which people in the higher socio-economic groups made much greater use of the available services than those in the lower socio-economic groups, with a similar imbalance being shown between different areas of the country. Thus although the structure of the charges offered some financial incentive for the "irregulars" to seek more frequent treatment, the evidence suggests that the migration to the "regular" category is a complex process which depends particularly on the availability of services, which the measure did nothing to change. In fact it tended to entrench the existing distribution. The work in chapter seven showed that dentists tended to practice in areas with substantial middle class populations - populations which were already heavily over-represented in the "regulars" category - and hence the additional financial incentive to seek regular treatment was likely only to increase the demand for treatment and hence the attractiveness of practice, in these areas. There was little to encourage dentists to move to the numerous relatively deprived areas.

Subsequently, in 1976, the charging system was revised, with the patient being required to pay up to a maximum of £3.50 for ordinary treatment and £12.00 for dentures.[1] Since then the charges have been regularly revised in support of expenditure cuts and since 1979 they have been raised in line with general rise in prices. At

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1. SI (1975), No. 1945.

1 April 1981 the maximum charges were £9 for routine treatment and £58 for complex dentures.[1] As a proportion of the total expanditure on the General Dental Service, charges have risen from 15.5% in 1975/76 to a projected 25.9% in 1981/82.[2]

REMUNERATION

The second main area of financial control relates to the remuneration of dental practitioners. Dentists in general practice are paid on a fee-for-service principle which had been operational in both National Health Insurance and private practice between the wars and which survived the transition to the NHS despite the dentists' attempts to secure the introduction of a grant-in-aid scheme.[3] Under such an arrangement the level of the scale of fees (dealt with separately below) assumes an obvious importance although in practice, as will be shown, it has been largely subordinated to the calculation of what has become known as the dentists' "target income". In the determination of this figure there have been three distinct phases of operation. The first comprised the initial determination by the Spens Committee, the second was a period of largely Ministerial control and the third, since 1962, has been dominated by the operation of the Review Body on Doctors' and Dentists' Remuneration.

In respect of the initial determination, Bevan had outlined his plans to Cabinet as early as December 1945:

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1. *BDA News*. Supplement to the *BDJ*, 150, 7 (7 April 1981), p. 1.

2. Sources: *CSO Annual Abstract of Statistics 1981* (London, HMSO), Table 3.3 and *BDA News*, 7 April 1981. These last figures are drawn from the White Paper on Public Supply (Cmnd. 8175), 1980.

3. See ch. 5 above.

> 'All remuneration of dentists, by salary or under scale of fees, will be fixed by national regulations and will have regard to national standards recommended by a body analogous to the Spens Committee for doctors, or other body set up for the purpose'.[1]

That such a Committee should become involved was a logical consequence of the general approach to public supply: the determination of the incomes was to be divorced from the market place and the government - a newcomer to this type of employment - sought advice and guidance on setting appropriate levels of remuneration. That it was done nationally was justified by the need for uniformity and the promotion of equal treatment for employee and patient alike. This in turn was seen to depend on central control and direction. The arguments in support of these two main propositions have already been considered and it should just be reiterated that the appointment of the Spens Committee in September 1946 was a natural corollary of both the stress on central planning, co-ordination and control and the belief in the possibility of rationally determining priorities and needs. As such the Committee and its successors afford an excellent opportunity to analyse the functioning of the system of public supply in this important aspect of the dental health services.

The Committee was appointed to make recommendations about 'what ought to be the range of total professional incomes of a registered dental practitioner in any publicly organised service of general dental practice'.[2] But in so doing its deliberations were to be informed by three factors: the financial expectations of dental practice in the

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1. Cabinet Papaers: CAB 129/5, CP(45)339, 13 December 1945. *Proposals for a National Health Service.* Memorandum by the Minister of Health.

2. MoH, DoH(S), *Report of the Inter Departmental Committee on the Remuneration of General Dental Practitioners* (Cmnd. 7402, London, HMSO, 1948), para. 1.

past; the desirability of maintaining the 'proper social and economic status of general dental practice';[1] and the capacity of the profession to attract suitable types of recruits.[2] The Committee imposed further restrictions on itself by dealing only with net incomes (thus avoiding the thorny question of the appropriate level of practice expenses) and by making its recommendations in 1939 values without suggesting what adjustments should be made to convert these to 1948 prices.

The Committee followed a fairly standard pattern of inquiry: it received written evidence and examined witnesses,[3] but of more significance was the research it sponsored into pre-war dental incomes. This took the form of a questionnaire to each dentist on the Register[4] which sought details of their net incomes for the years 1936, 1937 and 1938. A total of 11,898 questionnaires were set out but the response, despite strong support for the project from the dental organisations,[5] was not impressive. In the end only 3,999 returns (33.6%) were found to be suitable for analysis but nevertheless the Committee, with the support of the Government Actuary, concluded that this was a sufficient basis for a reliable estimation of the range of dental incomes for the years in question.[6]

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1. *Ibid.*
2. *Ibid.*
3. All were either dentists or representatives of the government.
4. In contrast to the sampling technique used for the doctors.
5. See editorial in the *BDJ*, 82, 2 (17 January 1947), pp. 48-9.
6. Full details given in BDA, *Interdepartmental Committee on the Remuneration of Dental Practitioners: Memorandum of Evidence submitted on behalf of the Dental Profession by the British Dental Association, Incorporated Dental Society and Public Dental Service Association* (July 1947).

Of the considerations which the Committee was required to take note (past income, status and recruitment) there can be little doubt that the first, based on the results of the survey just described, was the most significant. The data and particularly their comparison with the equivalent figures for the medical profession,[1] brought a note of objectivity to the Committee's work, whereas the justification for income changes on the grounds of status and recruitment potential was based largely on very subjective material.

Nevertheless, if the Committee was unable to accept a lot of the dentists' arguments about status it remains true that their determination of a suitable range of dental incomes was based on a largely subjective assessment of both dentistry as a middle class profession and of the contribution of middle class professionals to the life of the community [2] Thus having discovered that in the years of the survey 25% of the dentists had an income of less than £450, 50% less than £700 and 75% less than £1100,[3] the Committee determined on the basis of its assessment of the importance of dentistry that the figures for these quartiles in NHS practice should be increased to £850, £1100 and £1400 respectively. But in providing these figures the Committee was conscious of the fact that they could only be justified 'if the supply of dentists is so related to demand as to produce a spread of incomes comparable to that in 1938'.[4] As such a distribution was unlikely they decided to express their recommendation in terms of a target income for 'a single handed practitioner making full use of

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1. But note that the Committee was not prepared to make a direct comparison.

2. For example see *Report of the Inter Departmental Committee on the Remuneration of General Dental Practitioners*, para. 15.

3. *Ibid.*, para. 16.

4. *Ibid.*, para. 17.

all appropriate assistance and working efficiently for 1500 hours a year at the chairside ...'[1] In 1939 values this was calculated to be £1600.

In their determination of this figure the Committee made no attempt to relate it (except perhaps in the most vague way in respect of recruitment) to the promotion of oral health. The figure derived entirely from a largely unstated understanding of a "proper" income for a dental practitioner and assumed, in a way which has been noted elsewhere, that the public funding of dental practice would lead to greater dental health. To a degree of course this has proved to be correct: the initial rush for treatment (particularly for the supply of dentures) and the gradual increase in the number of people receiving regular treatment are obvious indicators, yet it is also clear that problems associated with overall levels of attendance do not constitute the limits of the dental health service's shortcomings.

To be fair to the Committee it must be admitted that it extended its consideration beyond a target income to include recommendations on a number of other items and most particularly the question of differential incomes. Differentiation in the past, the Committee noted, had been effected by variation in fees, but they viewed this as an option unlikely to be available in a publicly organised service.[2] Instead they discussed three possibilities for extending the range of dental incomes: the use of partnerships or the employment of assistants, working in excess of the recommended number of hours and the use of specialists whose remuneration should be approximately twice that of

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1. *Ibid.*, para. 32.

2. *Ibid.*, para. 20.

a general practitioner.[1] But again it should be stressed that such differentials were supported not on the grounds of their relevance to dental health but on their ability to increase dental incomes. In fact only two recommendations, those pertaining to special provisions for income maintenance in sparsely populated areas and the need to induce practitioners to unattractive areas,[2] could be held to relate the question of remuneration directly to the problems facing the supply of dental services. And on these topics the Committee offered no guidance on possible strategies and, as will be seen, they subsequently failed to make the agenda of later considerations.

The Spens Report was clearly of great practical importance not only because it was responsible for setting the initial target income but also because of its part in influencing both the tone and techniques of subsequent work in the area. In analysing the work of the Committee, and indeed that of its successors, from the perspective of their contribution to a publicly sponsored dental service, there are two obvious points of interest: the type and sources of information that the decision making bodies have seen fit or in fact have been able to entertain and the methods by which they have arrived at their conclusions.

In terms of information the Committee's sources were two-fold: the profession and the Government, and if the Report is compared with the evidence provided there can be little doubt that the dentists' submission carried the most weight. This can be explained at least in part by the Government's attitude: the Ministry of Health was clearly embarrassed at being asked to submit evidence and the

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1. *Ibid.*, paras. 21-25.

2. *Ibid.*, para. 26.

internal memoranda on the subject express considerable doubt as to whether they would be able to contribute anything of significance.[1] In the end they agreed to attend and answer questions from the Committee and did in fact assemble some data on comparative medical and dental salaries in the public health system and the armed forces.[2] In many ways the Ministry's diffidence on this matter reflects the general level of uncertainty with which it approached the supply of dental services and by avoiding any commitment on the factors which should contribute to the determination of dental incomes the initiative, in providing the Committee with information, passed to the profession.

Evidence was sought from a range of dentists but the major contribution was received from the Dental Consultative Committee[3] whose submission comprised three major parts: an extremely subjective assessment of the proper economic and social status of the dentist; some more factual material on factors which were held to influence the dentist's capacity to work and the survey of pre-war dental incomes. For anything beyond this the Committee seems to have relied on the dentists in its own ranks and the two Reports of the Teviot Committee which had been published by this time. The most obvious feature of these arrangements was the narrow range of information available to the Committee at the time of its determination. It was, to say the least, dentist-centred, and this was a result of both the

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1. MoH, *Inter Departmental Committee on the Remuneration of General Dental Practitioners: Evidence from the Ministry of Health and the Department of Health for Scotland.* PRO. MH77/170. File No. 93285/10/9.

2. *Ibid.*

3. Which represented the British Dental Association, the Incorporated Dental Society and the Public Dental Service Association.

Government's instructions to the Committee and its own chosen mode of operation. For despite instructions to obtain 'whatever information and evidence ... thought fit'[1] the Committee stuck fairly rigidly to its remit to take cognisance of past incomes, the social and economic status of dentists and the capacity to attract recruits in recommending the appropriate range of incomes for registered dental practitioners. Dentistry in these circumstances consisted in little more than the behaviour and aspirations of dentists and only information pertaining to these factors was deemed relevant for consideration.

The most striking feature of this pattern of information was its partial nature: partial in the sense that it included only certain factors pertaining to dentistry and the supply of dental services (in particular those relating to the status of dentistry as a profession) and partial also in so far as it considered only those practitioners in the general dental services and almost completely avoided the salaried dental officers.[2] The Committee sought no information on variations in dental practice around the country; it undertook no study of the likely impact its recommendations might make and made no attempt to relate remuneration to factors affecting either the supply of services or their utilization by the public. Dental remuneration was to be determined from a limited range of criteria which directly impinged upon the dentists' well-being and no effort was made to examine it in a wider context. It is often quite difficult to ascribe relative significance to the factors involved

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1. *Report of the Inter Departmental Committee on the Remuneration of General Dental Practitioners*, para. 1.

2. Except specialists.

in decision making but with such limited background information the behaviour of the Spens Committee is relatively transparent. The basic determination derived almost entirely from some understanding of the appropriate level of income for a middle class professional and the only deviations considered related to additional rewards for particular experience or expertise. Not only was the determination a partial one in the sense described but it was also an extremely simple one with, for example, the wide range of results from its survey being reduced to a single "target" figure.

The major point to be made from this determination procedure is how small brooked consideration of dental needs and priorities. The level and the form of dental incomes were decided by a process in which only the Government and the profession were involved and where the Government's priorities, far from being concerned with the place of the consumer and say the promotion of the equal availability of services, were overwhelmingly directed at securing the participation of a majority of dentists on the appointed day. The implications of this strategy (seen for example in the effect these conditions in the general dental services would have on the schools dental service) went unconsidered as the Government with its huge resources (most particularly the capacity to pay for a large volume of dental treatment) bargained with the profession over the conditions governing the release of those resources. Nowhere in that aspect of this initial dialogue governing overall levels of remuneration were the consequences for the consumer discussed.

The second phase in the evolution of the system of remuneration for general dental practitioners ran from the beginning of the Service in 1948 until the appointment, in 1962, of the first Review Body, following the recommendations of the Royal Commission on Doctors' and

Dentists' Remuneration. Its central feature was the exercise of Ministerial fiat in the adjustment of dental earnings. The number of changes was so great that in its evidence to the Royal Commission the British Dental Association felt it

> 'highly improbable that any other wage, salary or fee-earning section of the community has had to endure within the space of nine years the effects of eleven Government measures, introduced either by legislation or by regulation, directly influencing their standard of living and the pursuit of their profession, trade or occupation.'[1]

In looking at this period attention will be focussed primarily on the measures taken in the first two years of the service's operation, when the estimates were wildly exceeded, and only a brief comment will be made on the subsequent and rather less radical adjustments. With the exception of the changes made on 1 February 1949, Ministerial control over dental incomes was effected by wholesale adjustments to the level of fees.

The major stimulus for the changes made in 1949, was undoubtedly the evidence of the burgeoning cost of providing dental treatment in face of a demand that was far greater than expected. 'Shortly after the 5th July' reported the Ministry of Health, 'it soon became apparent that contrary to public belief it had been fee and not fear which had hitherto governed the demand rate',[2] and the Government moved quickly to reduce their financial commitment which for a period represented almost 10% of total NHS expenditure.[3] In so doing it sought to emphasise the benefits that were accruing to the dentists:

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1. BDA, *Memorandum to the Royal Commission on the Remuneration of National Health Service Doctors and Dentists* (London, BDA, 1957), para. 85.

2. MoH, *A/Rep. 1948-49* (Cmnd. 7910), p. 152.

3. See, for example, Office of Health Economics, *The Dental Service* (London, OHE, 1969), p. 8.

> 'During October and November evidence was coming to light which showed that a number of dentists were earning sums very much higher than had been foreseen and out of all proportion with the recommendations in the Spens Report; and regulations were accordingly made on 23rd December and 17th January, the effect of which was to halve all dentists' earnings in excess of £4,800 gross in a full year, with effect from 1st February. These regulations were an emergency measure, designed to impose a check on excessive earnings in advance of a review of the scale of fees, a possibility which had been foreseen when the original scale was brought out in June, 1948. With this in mind, towards the end of the period under review, a Working Party was appointed under the Chairmanship of Mr. W. Penman, M.B.E., F.I.A., a past President of the Institute of Actuaries, to investigate and report upon the timings of dental operations.'[1]

However, before the Penman Working Party had been able to conclude its investigation, the Minister decided

> 'in the light of information furnished by the Dental Estimates Board about the amounts already authorised for payment to dentists, that a general reduction of the scale of fees was called for ... Accordingly, on 18th May, 1949, regulations (S.I. 1949, No. 955) were made providing for a reduced scale of fees (representing approximately a 20 per cent. reduction from the previous scale) in respect of applications for treatment accepted on or after 1st June, 1949; at the same time the regulations providing for the 50 per cent. reduction of gross earnings in excess of an annual rate of £4,800 were repealed (apart from a minor provision) with effect from 31st July, 1949.'[2]

The Penman Committee finally reported[3] on 15 August 1949 and discussion between the Government and the profession on its implications began in October. However the Official Report again recorded how dentists' earnings continued to be substantially above the levels recommended by the Spens Committee and thus how,

> 'in view of this, and of the national economic situation

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1. MoH, *A/Rep. 1948-49*, p. 269.

2. MoH, *A/Rep. 1949-50*, (Cmnd. 8342), p. 36.

3. MoH, DoH(S), *Report of the Working Party on the Chairside Times taken in carrying out treatment by General Dental Practitioners in England, Wales and Scotland* (London, HMSO, 1949).

> the Minister decided that it was necessary to take immediate steps to secure a further interim reduction in the amount being paid to dentists, without waiting for the outcome of the enquiries mentioned in the preceding paragraph. Discussions were accordingly opened with the profession on 1st April, 1950, and the Minister finally decided that the further reduction should be of the order of 10 per cent.'[1]

Each of the changes was resisted by the profession and the resentment generated led, eventually, to a breakdown in communication between the two sides. In fact the heat generated by the dispute, which led to the public disclosure of letters between the two parties and accusations that the Minister had misled the House of Commons,[2] tended to obscure some of the more important issues.

In so far as it is possible to ascertain what information was available to the Minister at the time the changes were made it seems probable that the overwhelming concern was the overall cost of the NHS. In December 1948 the Minister reported to Parliament that the cost of the general dental services up to 30 November had been £5,541,658[3] and on 1 February 1949 it was calculated that the running costs were £900,000 per week.[4] Much was made of the way expenditure was running far in excess of the estimates (which had been calculated as £7 15 million for England and Wales in 1948-49) but it is instructive at this stage to consider the way in which this original figure was compiled. Two points should be noted. First that in the opinion of the Accountant-General of the Ministry of Health, the calculation of

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1. MoH, *A/Rep. 1949-50*, p. 36. The decision was given effect in SI (1950), No. 663.

2. *BDJ*, 87, 1 (1 July 1949), p. 21.

3. 459 H.C. DEB. 5s. Q. 62.

4. *Seventh Report of the Estimates Committee, Session 1948-9.* 'The Administration of the National Health Service', para. 29.

of the initial estimates was little more than '... a speculation if you like'[1] due to the lack of knowledge about the future demand for services, the level of remuneration to be paid and the number of dentists who would in fact contract into the Service[2] and second that in the debate on the Supplementary Estimates the Minister of Health had advanced the argument that:

> 'Suppose I [had] put into the Estimates assumptions that could have formed the basis of a negotiation by these professions, I should immediately have been helpless. If these figures ... had been put into the Estimates by me, my negotiations would have been hopelessly destroyed from the very beginning ... I think every man who has had any experience of negotiations knows very well that if they could read in the Estimates what I estimated I was going to spend upon those services they would know at once what to ask for and what to expect.'[3]

These problems with the estimates are stressed because of the way in which they indicate the level of uncertainty which characterised the early administration of the dental health services. Not only were the three variables mentioned by the Accountant General underestimated but also a further two assumptions quickly proved unreliable: most dentists worked longer than the thirty-three chairside hours on which the Spens Committee recommendations were based and many dentists completed individual operations in rather less time than the initial fee schedule had assumed. The result, with demand being much higher than expected, was that dental incomes quickly surpassed the recommended figures and consequently that the overall cost was much greater than had been anticipated. Thus the Minister became heavily pre-occupied with ways of reducing the level of dental expenditure

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1. *Ibid.*, Q. 309.
2. *Ibid.*, QQ. 309-16 and para. 29.
3. 461 H.C. DEB. 5s. Col. 1452.

and hence rectifying the perceived imbalance which had been produced between the dental and other areas of the health services.

But in the Government's view the remedial action, the withholding of 50 per cent of all gross earnings above £400 per month, quickly proved inadequate and hence the two free cuts were authorised. At the time of the first, of approximately 20%, the findings of the Penman Working Party on Chairside Times were unavailable and the Minister, despite earlier assurances that changes would not be made until Penman had reported, was

> 'forced to the conclusion that the present rate of dental earnings, as revealed in the analysis already forwarded to the dental organisations and in the further analysis enclosed with this letter ... cannot be allowed to continue.'[1]

The analysis referred to showed that without taking account of purely private practice, 50% of all dentists were earning incomes in excess of the recommended figure.[2] Thus in the circumstances,

> 'the Minister felt that he could not allow the present unjustifiable drain on the Exchequer to continue and he has decided to amend the Regulations to provide for a reduced scale of fees in respect of work undertaken after May 31.'[3]

The cuts were made up of a reduction of approximately 10% on prosthetic items and 25% on conservative and surgical treatment.

In justifying the second round of "cuts" the Government reiterated its arguments about overall costs and individual incomes but added a third factor in the probable reduction in overheads that would result from a high volume of work. In a letter to the Secretary

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1. *BDJ*, 86, 11 (3 June 1949), p. 284. Letter to the Association from Miss Russell-Smith, Ministry of Health.

2. *Ibid.*, p. 285.

3. *Ibid.*

of the British Dental Association, Miss Russell-Smith suggested that:

> 'The Association will be aware that in the Debate on the Supplementary Estimates on 14th March, the Chancellor of the Exchequer emphasised the necessity for justifying mounting expenditure and announced that the National Health Service would be thoroughly examined in all its incidence to make sure that money was not being wasted or ill-spent. This examination is now taking place, and among the questions to which consideration is being given, the Minister has felt compelled to have regard to the fact that, notwithstanding the reduction made last summer, very large sums of money - far higher than either the Minister or (as he believes) the dental organisations contemplated when the original scale of fees was discussed - are still being paid in respect of general dental services.'[1]

The dentists protested about the iniquities of such a cut and advocated a system where the brunt of the reductions would be met by those with higher earnings. However a second letter from Miss Russell-Smith claimed that there were

> 'serious difficulties in working out a scheme for a sliding scale of reductions, which involves problems likely to take some time to solve. In the meantime the need for reducing the very large sums of money now being paid in respect of general dental services is becoming increasingly urgent, and the Minister does not consider that it would be justifiable to wait until a scheme for a sliding scale of reductions could be worked out and brought into operation.'[2]

Faced with this decision the editor of the *British Dental Journal* could only conclude that the

> 'arbitrary decision ... had been forced upon the Minister by the overriding authority of the Treasury. The Health Service is costing more than the Government expected it would. The Minister has, therefore, been driven to look for the readiest means of effecting economies ...'[3]

The conflict over these decisions again highlighted the two problems for public supply raised earlier in the chapter, of

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1. Letter dated 30 March 1950 reproduced in *BDJ*, 88, 8 (21 April 1950), p. 225.

2. *Ibid.*

3. *BDJ*, 88, 9 (5 May 1950), p. 248.

maintaining political control over priorities and making decisions which accorded with those priorities. Difficulties with the first led, in this case, to very considerable opposition from the profession which, combined with pressure from the doctors, eventually resulted in the Government largely abdicating control of remuneration in favour of the Review Body. The second proved almost impossible to implement because of the communication problem resulting from the attempts at political control, the need for swift action in face of mounting costs and difficulties in working out an appropriate methodology. These matters will be considered in more detail in Part Five and to conclude this section on the period of Ministerial control the changes made after 1950 will be briefly examined.

By and large the decisions exhibit a similar pattern although there is perhaps a hint that they were used in support of the dental policy. In fact the central issue became the government's unwillingness, in face of intense pressure from the British Dental Association, to restore the 10% cut in fees which had been implemented in 1950. It was finally granted only after intense lobbying by the profession, the undertaking of a sample survey on incomes by the Association, some twenty-four meetings between Ministry of Health officials and members of the Association's Remuneration Sub-Committee and two large and separate inquiries by the Inland Revenue and the Association into past remuneration and present earnings and expenses.[1] Interpretations of this apparent delay in raising the level of fees varied considerably. In his oral evidence to the Royal Commission on Doctors' and Dentists' Remuneration the Chairman of the Council of the British Dental Association, Mr Lionel Balding, was under no illusions about the

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1. For full details see *BDJ*, 98, 9 (3 May 1955), p. 329.

intent:

> 'We were kept waiting for five years for that cut to be restored, and we have little doubt - and I think I can produce evidence to show it - that it was Government policy to hold down dental remuneration during this time so that the School Dental service, administered by the local authorities, could be carried on.'[1]

Mr. Balding found the strategy extraordinary, and attempted to substantiate his claim by reference to official statements. However, he was of course at pains to emphasise that the Association supported the strengthening of the school service, but not by 'depressing the remuneration of the people in another service. The normal method would be to raise the salaries offered in the School Dental Service.'[2] But of course the Government was in no position to do this especially in so far as salaries in local authorities had to be considered alongside those paid to other employees such as engineers or town clerks.[3]

The Government, for its part, showed reluctance to claim responsibility for a financial strategy which showed some capacity to effect a relocation of resources in line with the stated policy objectives. An official of the Ministry of Education suggested to the Estimates Committee that the introduction of charges in 1951 and 1952 had made some contribution to the increase in staffing levels[4] and in a similar vein the Chief Medical Officer of the Ministry of Education attributed at least part of the decline in numbers in 1957 to the restoration of the 10% "cut" in 1955 and the introduction of a revised scale of fees in April 1957.[5]

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1. *BDJ*, 104, 9 (6 May 1958), p. 326.
2. *Ibid.*
3. See *First Report of the Estimates Committee, Session 1962-63*, QQ. 2265-9 for a discussion of this limitation.
4. *Ibid.*, Q. 855.
5. DES, *The Health of the School Child 1956-57*, p. 59.

If the above represents at least a modest attempt to relate administrative action to policy goals, the approach was changed radically by the Report, and subsequent acceptance of the recommendations, of the Royal Commission on Doctors' and Dentists' Remuneration. The Commission itself appears to have largely accepted the evidence of the British Dental Association on the financial uncertainty caused by ministerial control over remuneration and advocated what was essentially a return to the Spens principle in which a "proper" target income was to be objectively set. However, mindful of the problems that had occurred, it also recommended 'arrangements which we consider necessary in future for ensuring that dentists' actual incomes correspond with intended incomes.'[1] Thus the Commission advocated two new pieces of machinery: a Review Body[2] to advise the government on appropriate levels of remuneration and a Dental Rates Study Group[3] which would attempt, after inquiring into the detailed timing of individual operations and the overall hours worked, to set a scale of fees which would produce the desired income. The operation of the Study Group is examined under the heading of "Fees" later in the chapter while the Review Body, whose work has been the central feature of the third phase of remuneration decision making, is considered here.

The Royal Commission wasted no time in its Report in suggesting that the problems of the past had 'been caused by the absence of any machinery to ensure that general dental practitioners earned broadly

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1. Royal Commission on Doctors' and Dentists' Remuneration, *Report* (Cmnd. 939, London, HMSO, 1960), para. 382.

2. *Ibid.*, paras. 426-50.

3. *Ibid.*, paras. 385-8.

what it was intended they should earn.'[1] It believed that the basic problem with the existing arrangements was that remuneration was related only to the number of items of treatment carried out and hence if a dentist worked either longer hours or at greater speed his income would obviously rise.[2] The entire thrust of the Commission's recommendations was aimed at increasing the sophistication of the calculation so that these factors would be included. The motivation for this approach can perhaps be gleaned from the comments of Professor Jewkes which, although they appear as a Memorandum of Dissent, probably capture the Commission's interpretation and attitude to the treatment of the dentists in the early 1950s. He wrote that:

> 'It would be difficult, even by searching the records of periods of violent economic upheaval, to find a parallel case where the standard of living of a whole occupation has swung about so wildly as it has for the dentists in this decade. The manner in which one Government after another has run strangely counter to the spiral of the times: for since the war ... increasing emphasis has been placed upon the improvement of industrial relations and amicable settlement of earnings and working condition by discussion and mutual agreement ... The responsibility for this melancholy episode must, in my view, rest on the Government side.'[3]

The Commission was particularly keen to stress that the determination of remuneration should be brought "out of politics": the recommended Review Body would report not to the Minister of Health but the Prime Minister[4] and although of course the government would not be bound to accept its advice,

> 'we believe that seven people such as we have in mind will make recommendations of such weight and authority that the

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1. *Ibid.*, para. 381.
2. *Ibid.*
3. *Ibid.*, paras. 58-9. 'Memorandum of Dissent'.
4. *Ibid.*, para. 431.

> Government will be able, and indeed feel bound, to accept them. This procedure will in fact, therefore, give the profession a valuable safeguard. Their remuneration will be determined, in practice, by a group of independent persons of standing and authority not committed to the Government's point of view.'[1]

Thus with the exception of a single paragraph which dealt with inducement payments to attract dentists to remote areas,[2] the Commission moved to divorce the levels of remuneration from both wider policy questions and, in so far as the Review Body's recommendations would "have" to be accepted, from government control. In fact on those occasions when the government has declined to accept, in view, for example of its wider policy on pay restraint, the future of the services has been put in jeopardy.[3] In other words, the Commission moved largely to deny the government the capacity to control, in the positive sense of being able to direct, in support of policy objectives, the allocation of the bulk of the financial resources available to the dental health services, although of course the more negative controls, covering malpractices and mismanagement of funds, remained. Thus it was suggested that the remuneration of most of the health service's dentists should be determined in isolation from any consideration of dental health policy objectives.

The government accepted the recommendations: in fact it had offered no evidence at all to the Commission on the way in which general dental practitioners should be paid,[4] and it was presumably content with arrangements which, if they gave little scope for

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1. *Ibid.*, para. 436.
2. *Ibid.*, para. 392.
3. See, for example p. 328 below.
4. See Royal Commission on Doctors' and Dentists' Remuneration, *Report*, para. 380.

modifying the system's defects, at least offered the probability that having accepted the Review Body's figures, the overall costs could be contained at a known level.[1] This move to institutionalisation also appealed to the profession. An editorial in the *British Dental Journal* noted that the Minister of Health in accepting the Report, had 'surrendered his right to make arbitrary changes in the level of remuneration' and expressed the hope that 'this new arrangement will establish a greater sense of security within the profession than has been possible during the last twelve years when remuneration has been entirely at the whim of the government of the day'.[2] But in reaching a consensus on a system which offered predictability to both major parties, the particular demands of a public dental health policy received little consideration.

In order to understand the subsequent behaviour of the Review Body it is not necessary to undertake a full history because in terms of its principles of operation little has changed in the years since 1962. In its First Report the Committee gave notice of its intention to

> 'give further thought to the basis of remuneration of general dental practitioners and to possible alternatives to the present system, so that if we can find a more satisfactory system we should be able to consider recommending it at a subsequent review.'[3]

In response the Dental Association appointed an *ad hoc* Committee under Mr Tattersall to review possible alternative arrangements. However

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1. This had been a complaint about the previous system. See the Treasury witness before the Royal Commission reported in *BDJ*, 104, 10 (20 May 1958), p. 372.

2. *BDJ*, 110, 6 (21 March 1961), p. 183.

3. *Official Report, House of Commons* (25 March 1963) cited in *BDJ*, 114, 7 (2 April 1963), p. 267.

following publication of his report[1] a questionnaire sent by the Association to the 12,000 dentists who provided general dental services elicited an overwhelming response in favour of the existing system, whatever its shortcomings, in face of the offered alternatives.[2] Thus in its Seventh Report the Review Body appears to have accepted this judgement (as did the Health Departments) and agreed that 'payment by item of service is the only feasible method of payment in the present circumstances.'[3]

Within this framework the Review Body has endeavoured to implement the recommendations of the Royal Commission. At the general level these included the need to avoid the 'recurrent disputes about remuneration which had bedevilled relations between the medical and dental professions and the Government for many years';[4] the need to bring some assurance to the professions that 'their standard of living will not be depressed by arbitrary Government action'[5] and finally the need to 'avoid a situation in which the tax payer has to pay more than he should towards the remuneration of doctors and dentists'.[6] More specifically, in respect of general dental practitioners it was recommended that income should cease to be linked only with the number of items of treatment and be more 'broadly linked to the hours

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1. BDA, *General Dental Services Committee, Report of the Ad Hoc Sub-Committee on Methods of Remuneration* (London, BDA, 1964).

2. Full details in BDA, *Third Memorandum to the Review Body* (London, BDA, 1965).

3. Review Body on Doctors' and Dentists' Remuneration, *Seventh Report* (Cmnd. 2992, London, HMSO, 1966), para. 235.

4. Royal Commission on Doctors' and Dentists' Remuneration, *Report*, para. 404.

5. *Ibid.*

6. *Ibid.*, para. 405.

worked by the average practitioner'.[1] However, while the Commission did not

> 'think it desirable to define exactly the factors of which the Review Body should take account in making its recommendations ... it should be left to them to decide which factors might be relevant at any particular time and the weight to be attached to them.'

It did expect that

> 'three factors which would always be relevant would be changes in the cost of living, the improvement of earnings in other professions and the quantity and quality of recruitment in all professions.'[2]

These three factors, along with questions relating to productivity have come to dominate the work of the Review Body.

Once the decision was made to increase the number of relevant variables the necessary calculations became infinitely more complex. And by and large the whole process *is* just a calculation for although values are implicit in the weightings given to different factors and in decisions about relevance, great stress has been laid on the ability to "prove" the validity of the figures determined. For example the editor of the *British Dental Journal* noted in 1975 that it was

> 'significant that the only major government interference with a review body award occurred in 1970 when the 12th Kindersley report recommended a 30 per cent pay increase based, apparently, to a large extent on confidential and unpublished evidence. The case, valid though it was, was not well argued enough by the Review Body and the Government's refusal to implement the report was, therefore, easier to justify.
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> Since then the Review Body has not made the same mistake ... Each report includes an appendix showing the precise calculation on which the recommendations are based - hence the astonishing precision of, for example, not £7,640 or £7,650 but £7,643 for the average dentist in

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1. *Ibid.*, para. 384.

2. *Ibid.*, para. 431.

1975/76.'[1]

The pursuit of proof and precision has led to an emphasis on quantification and a premium on supportive evidence. This in turn has led to something of a bias against arguments that cannot be adequately documented and a tendency to over-simplify concepts in order to accommodate them. What is an *average* dentist? Is he in single handed practice? in practice as a principle with one or more associates? or in partnership with other principals? On what type of practice should the calculation of justifiable expenses be based? A comment in the *British Dental Journal* following the publication of the Review Body's First Report drew attention to the problem:

> 'Whatever argument may be raised against accepting the fact that as the majority of dentists work single handed they are therefore entitled to a scale of fees which recognises it, nothing can excuse a system which accepts the contribution of dental treatment given by assistants, takes into consideration the fees they earn, and then establishes a scale which ignores the hours they work.'[2]

Clearly the possible permutations of variables were enormous but gradually through its continued operation and more particularly through its role of sponsor of an on-going dialogue between the Association and the Health Departments, the Review Body established definitional criteria which were acceptable to all parties. However, greater difficulty has been experienced with some of the other factors against which it had been decided to assess dental incomes. Rises in the cost of living were easy to document but the Review Body felt itself constrained in at least two ways in applying them to the dentists. The first, in line with the recommendations of the Royal Commission, has been the desire to avoid making too frequent adjustments to the

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1. *BDJ*, 138, 9 (6 May 1975), pp. 325-6.

2. *BDJ*, 114, 7 (2 April 1963), p. 238.

target income and the second has been the pressure applied by the pay policies of successive governments.

The Review Body began by intending to deliver triennial judgements but under pressure of inflation this was reduced to periods of two years and since the appointment of the new Review Body in 1971 the determinations have been made annually.[1] The issue that led to this new appointment was the publication, in 1970, of the Twelfth Report in which the second major factor in determining dental incomes, their comparability with those of other professions, also played a significant part. The major problem in this respect centred upon the collection of the necessary information. The Royal Commission had undertaken a major survey on the remuneration of doctors, dentists and other professional groups, but resources on this scale were unavailable to the Review Body. In fact it was not until 1966 that it could report the collection of a significant amount of information on comparative earnings but even then it was noted that 'it must be recognised that there is no hope of securing figures of the same breadth and authority as those obtained by the Royal Commission.'[2] In this instance the research led only to the conclusion that it could not be established that medical and dental earnings were substantially lower than they should be.[3] Some further information was gathered in time for its Ninth Report (1968) but it was only in 1970 that the Review Body felt itself able to make an authoritative statement on comparative earnings.[4] 'For the first time', it reported,

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1. See *First Report* (Cmnd. 4825, 1971), para. 19.
2. Review Body, *Seventh Report*, para. 41.
3. *Ibid.*
4. Review Body, *Twelfth Report* (Cmnd. 4352), para. 90.

> 'we have conclusive evidence that the increase in doctors' and dentists' remuneration since the Pilkington Commission's recommendations has - despite our efforts in our previous general surveys to extract relevant guidance from inadequate statistics - lagged somewhat behind the increase for other comparable groups. Clearly an adjustment must be made to close the gap which had developed by October 1967.'[1]

When the recommended adjustment was combined with the cost of living component for the two years of the period under review, the 'calculation would justify an increase of between 29.5 and 31 per cent'.[2]

Faced with such a proposal in an election year the Government considered a number of strategies, including postponing a decision until after the poll,[3] before announcing, under a threat from the doctors to break off all contact, that it would agree to a partial acceptance of the recommendations but that the Report would be referred to the National Board for Prices and Incomes for 'a second opinion'.[4] At this, the Chairman Lord Kindersley and the rest of the Review Body (adjudged by the Secretary of State to be 'completely reactionary economists and vice-chancellors, whom we haven't bothered to replace')[5] resigned *en bloc*. But just two weeks later the Government was defeated at the polls and the incoming Secretary of State both withdrew the references to the Prices and Incomes Board and set in train negotiations to secure the appointment of a new Review

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1. *Ibid.*, para. 84.

2. *Ibid.*, para. 88.

3. See R.H.S. Crossman, *The Diaries of a Cabinet Minister. Volume III Secretary of State for Social Services* (London, Hamish Hamilton and Jonathan Cape, 1973), pp. 925-6.

4. Press conference given by the Secretary of State: reported in *BDJ*, 129, 1 (7 July 1970), p. 2.

5. Crossman, *The Diaries of a Cabinet Minister*, iii, p. 937.

Body.[1] Almost identical in structure to its predecessor the new body issued its first report in December 1971[2] and since then its operation, as has been suggested already, has been characterised by annual reports and close attention to the arithmetic of indexation and comparability.

The third factor that the Royal Commission commended to the Review Body's attention, the influence of remuneration on the quantity and quality of recruitment, has been frequently considered but has at no point served as a basis for significant change. The Review Body has repeatedly affirmed its general satisfaction with recruitment to the profession[3] and only in 1972 did it concede that the relative unattractiveness of dentistry in comparison to medicine should be some part of the reason for recommending that 'dentists' remuneration should be such as to bring about a modest amount of improvement in their income compared with that of most other groups.'[4]

The fourth and final factor which has informed the Review Body's work has been the manner in which increased productivity should be rewarded. Such increases have resulted from longer hours, technical advances, better organisation of practices and the larger numbers of younger dentists in practice. The Royal Commission argued that income should be related to hours worked but that the benefits of technological advances should not automatically accrue wholly to the

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1. Details, including Sir Keith Joseph's correspondence, in *BDJ*, 130, 3 (2 February 1971), pp. 119-21.

2. Cmnd. 4825.

3. See, for example, Review Body, *Seventh Report*, para. 226; *Ninth Report* (Cmnd. 3600, paras. 163-4; *Twelfth Report*, paras. 64-74 and *Third Report* [of the new Body], (Cmnd. 5353), para. 35.

4. Review Body, *Second Report* (Cmnd. 5010), paras. 91-2.

practitioner.[1] In general the Review Body has followed this lead but the translation of the idea into practice has presented a number of problems. For example at the beginning of a particular period the fees might be set to realise a specified target income, but because of the increasing number of younger dentists who are familiar, through their training, with the more recent technological developments and who are perhaps prepared to use more ancillary personnel, output is increased, incomes rise, and the fees have to be cut if the target is not to be exceeded. Thus the older dentist, probably more set in his ways and anyway physically incapable of working at the rate of his younger colleagues, finds his income dropping even though he maintains a steady output. In relation to this specific point the profession and the Health Departments have agreed to seniority payments for older dentists[2] but the more general question of productivity remains problematical. In its Ninth Report the Review Body suggested this compromise:

> '(a) Dentists should receive the full financial benefit of additional output arising from extra hours worked, i.e. any excess over target average net income due to this factor should result in an upward revision of the target net income and not a reduction in fees.
> (b) the benefit of increased productivity, i.e. greater output per dentist hour, should be shared between the dentist and the community with due regard to the best analysis that can be made of the reasons for the increase We recognise that no precise analysis is possible and that, even if it were, there are no objective criteria by which to decide how the share should be apportioned. But clearly there is a difference between greater productivity due to more intensive and sustained effort by the dentist and that which is due, for example, to improved equipment or to changes in practice organisation (although we are aware that even here some additional effort may be required or extra strain imposed).

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1. Royal Commission on Doctors' and Dentists' Remuneration, *Report*, para. 384.

2. DHSS, *A/Rep. 1969* (Cmnd. 4462), p. 11.

> (c) In our view it is the benefits arising from increased productivity not directly related to greater effort by the dentist, which it would be particularly appropriate to share with the community, although we recognise that in practice it will usually be necessary to make a largely arbitrary assumption about an appropriate allocation of benefits due to increased productivity as a whole.'[1]

But the results of its implementation were not encouraging. The Twelfth Report detailed the claims and counter claims of the profession and the government in respect of productivity but yielded only the conclusion that:

> 'None of this information puts us in any better position to quantify accurately the extent to which we should assign responsibility for productivity improvements to greater personal efforts by general dental practitioners.'[2]

And again in 1972 it was reported that 'it will be apparent from what we have said in this chapter that in general we have little to go by except qualitative information and general impressions.'[3]

Thus the problem of relating pay to productivity remains largely unresolved. The Dental Rates Study Group attempted to distinguish between those productivity changes arising from new equipment or improved techniques and those that arise from direct and measurable contribution from practitioners, but found inherent difficulties in attempting to draw such a distinction. The Review Body for its part reported that without such information it was 'not in a position to assess the full implications of the survey of working hours nor the part, if any, of the increase in output in recent years that is due to increased personal effort by the practitioners.'[4] There remains no

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1. Review Body, *Ninth Report*, para. 173.
2. Review Body, *Twelfth Report*, para. 40.
3. Review Body, *Second Report*, para. 27.
4. Review Body, *Fifth Report* (Cmnd. 6032), para. 58.

little irony in the fact that the only factor regularly used by the Review Body which attempts to relate income to the amount of treatment given and received, has been largely unworkable due to the bureaucratic complications inherent in collecting the required information.

The four factors discussed, cost of living, comparability, recruitment and productivity, have dominated the work of the Review Body and it remains only to emphasise the almost total exclusion of other factors which might be considered relevant to the promotion of a dental health policy. The only reference (apart from the question of recruitment which has been discussed and from which no action followed) has been to the unequal regional distribution of manpower, and again the Review Body has done nothing other than note the problem and express some gratification that the matter was being considered by the profession and the government.[1] This aside, the Review Body (as well it might under its terms of reference) has remained aloof from the more obvious shortcomings of the dental health services.

To complete this section on remuneration some consideration must be given to the systems of payment used in the other parts of the public dental service. Thus far, on the premise that it provides the bulk of the treatment as well as costing the most money, attention has been focussed on the general dental service, but each of the other areas also has its own pay machinery.

Following the recommendations of the Spens Committee that:

> 'In so far, although of course only in so far as, dental specialists have had a professional training comparable to that of medical specialists and have obtained a higher qualification comparable to those obtained by medical specialists, they ought in our opinion to be remunerated

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1. For brief details see DHSS, *A/Rep. 1977* (Cmnd. 7394), para. 10.1.

within the same range as medical specialists.'[1]

dentists in the hospital service have shared the same scales of remuneration as the doctors. Since 1962 these scales have been set by the Review Body which has apparently seen no reason to separate the two. Indeed by arrangement with the British Dental Assocation, a wholly medical body, the Joint Evidence Committee,[2] represents hospital dentists at the Body's hearings.

The remuneration of the second group, the local authority dental officers (now called community health dental staff) was decided by the Dental Whitley Council (local authorities) until in 1974, when responsibility for these services passed to the Area Health Authorities, it was brought within the jurisdiction of the Review Body.

Dentists in the universities and the armed forces also have their pay determined independently: university teachers by the University Grants Committee and the forces by the Review Body on Armed Forces Pay. However the Grants Committee follows the policy that 'there should be comparability of remuneration between academic clinicians and their colleagues in the NHS'[3] and the Review Body, which has been in operation since 1971, also operates on the principle of parity with remuneration in the NHS.[4] It is not proposed to consider the workings of these bodies but only to note how there has

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1. *Report of the Inter Departmental Committee on the Remuneration of General Dental Practitioners*, para. 23.

2. This committee also represents the Central Committee for Hospital Medical Services, the Hospital Junior Staff Group Council and the General Medical Services Committee.

3. University Grants Commission, *Annual Survey 1974-75* (Cmnd. 6435, London, HMSO, 1976), para. 45.

4. See Review Body on Armed Forces Pay, *Supplement to the Fifth Report* (Cmnd. 6515, London, HMSO, 1976).

been a tendency to standardise the remuneration of all publicly employed dentists and how since 1974, the Review Body on Doctors' and Dentists' Remuneration has become virtually the sole arbiter in the determination of the levels of income to be earned.

FEES

Under the arrangements that have been used in the general dental service to determine dental remuneration, the scale of fees plays a most significant part. The arithmetic of the arrangements is deceptively simple: the total income of the individual dentist is the product of the number of courses of treatment completed and the fee that each course attracts. Thus the initial scale of fees was a direct cause of the high level of incomes earned in the first few months of operation and since then it has been used as a regulatory mechanism to enable a predetermined income to be attained.

In the period before the appointment of the Dental Rates Study Group the fees were set by the government, sometimes with and at other times without, consultation with the profession. Representatives of the three dental associations were involved in negotiations over the initial scale,[1] but the cuts in 1949 and 1950 were largely unilateral and resulted in a breakdown in communication between the two sides. However, the dialogue was gradually re-established over the next few years and a "Contact Committee"[2] comprising representatives of the profession and the Health Departments met regularly in an effort to

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1. See discussion over scale of fees in paper dated 9 March 1948 in MoH, *National Health Services. Dental Services Policy: January 1946 - October 1948.* PRO. MH77/125. File No. 93285/10/1B.

2. Details in *BDJ*, 101, 8 (16 October 1956), pp. 281-2.

produce 'a scale which will be clear and will be equitable in its allocation of fees to each item of treatment'.[1] The ten per cent reduction in fees was restored in 1955[2] and on 1 April 1957 a revised schedule of fees was introduced. The aim of the revision

> 'was to achieve a better balanced scale, reflecting more closely than did the previous fees the average time spent on the various types of treatment ... the fees for conservative dentistry have been altered, particular emphasis being placed on treatment to conserve the teeth of children. In place of the previous fee of 7s.6d. applying to any conservative treatment to a deciduous tooth, varying amounts ranging from 7s.6d. to £1 11s.6d are now payable ... These changes were designed to give further encouragement to the treatment of children.'[3]

The dentists' remuneration was supplemented by an additional payment of 2.6% on gross fees from 1 May 1957[4] and this was increased to 4.7% from 1 January 1959.[5]

Thus despite considerable movements in the level of fees in this period, only one attempt was made to revise the relative weightings of the different types of treatment. Even this was motivated by the desire to relate payment to time taken although of course it did provide a considerable incentive to give priority to the treatment of children. Since 1961 the compilation of the fee schedule has been the responsibility of the Dental Rates Study Group which appears to have maintained the primacy of time in undertaking its task. Little is known about the operation of the Group which is made up of representatives of the profession and the government, work study

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1. MoH, *A/Rep. 1954* (Cmnd. 9566), p. 75.
2. SI (1955), No. 604.
3. MoH, *A/Rep. 1957* (Cmnd. 495), p. 77.
4. SI (1957), No. 729.
5. SI (1958), No. 2169.

experts, and an independent chairman, especially as it does not publish the material on which its calculations are based. The author of the only paper of substance on the group characterises its behaviour as essentially technical:

> 'The group's task is to implement someone else's valuation of dentists rather than to make value judgements of its own ... The D.R.S.G. is not a negotiating body in the normal sense of the word. The group has a technical problem to solve ...'[1]

and this impression is borne out by the tenor of its reports.

The primary concern of the Group has been to establish an accurate figure for the practice expenses which account for the difference between net and gross remuneration and then, after inquiry into both working hours and the timing of individual operations, to set a schedule which will realise the gross amount. But in determining the fee levels the Group has shown a reluctance to consider the dental merits of the different kinds of operation: that is, it has baulked at rewarding say preventive treatment or perhaps encouraging conservative rather than prosthetic work. In fact the Group has reported 'that the patterns of fees should not give financial advantage to one form of treatment or another'[2] and in consequence it endeavours to

> 'make all treatments approximately equally remunerative, on a time basis, after any laboratory costs: in other words it seeks to remove financial considerations from choice of treatment, so far as is possible.'[3]

In this way its work is wholly responsive and

> 'descriptive rather than prescriptive. Estimates are made

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1. D.M. Scarrott, 'The Dental Rates Study Group: A Review of Methods', *BDJ*, 146, 5 (6 March 1979), pp. 151 and 158.

2. Dental Rates Study Group, *Seventh Report*, published in *BDJ*, 120, 12 (21 June 1966), p. 608.

3. Scarrott, 'The Dental Rates Study Group', p. 158.

> of what dentists will themselves choose to do, rather than what the group feels they ought to do.'[1]

Hence the fees reflect, essentially, the established behavioural patterns of the profession and the Group has made no attempt to take the consideration of fee relativities out of a framework that is dominated by concern for the income of individual practitioners.

CONCLUSION

The major conclusion that can be drawn from the evidence presented in this and the previous chapter is that the particular capacities on which the assumption of public responsibility for supply was premised have not been realised in respect of the dental health services. The evidence suggests that in practice neither the expected level of administrative capacity nor the expected degree of political control have been available, and consequently it has not proved possible either to meet the specific shortcomings of the dental health services or to realise the more general ambitions of health care reform.

The organisational arrangements have proved quite adequate for administering the provision of dental services by a large number of practitioners but this is not of course the same thing as saying that they represent adequate arrangements for the administration of a policy for dental health on a national scale. The distinction between the two is rarely admitted but is nevertheless most significant. Adequacy on the one hand refers to characteristics such as financial accountability and the arrangements for dealing with complaints. On the other it is extended to incorporate such factors as responsiveness to

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1. *Ibid.*

perceived defects in performance, the ability to direct scarce resources in support of stated priorities and needs, and the capacity to focus the efforts of those involved in the dental health services on the particular problems associated with the improvement of oral health on a national basis.

The difference between the two approaches cannot simply be reduced to a question of the level of available resources. It also involves both the commitment and the ability to ensure that the available resources are used in a particular way and from the evidence presented in the last few chapters it would appear that such an ability has largely been absent from the arrangements pertaining to the dental health services. The explanation of the absence of this ability is the subject of the last chapter in which it is held that the inadequacies of the dental health services can be directly attributed to the particular approach adopted to the assumption of public responsibility for their supply.

PART FIVE

CONCLUSION

CHAPTER ELEVEN

THE LIMITS OF BUREAUCRATIZATION

It remains, in this last chapter, to review the evidence presented about the implementation and operation of the dental health services and to give some consideration to the relationship between the aspirations which informed the assumption of public responsibility for supply and the subsequent policy performance. It has already been noted that considerable difficulty has been experienced in overcoming the particular shortcomings of the services. There can be no doubt that in aggregate terms the oral health of the nation has been significantly improved and that the rate of attendance for treatment has shown a substantial increase, but in relation to any of the indices based either on equality or the relationship between the receipt of treatment and a dental determination of need, the services have enjoyed only marginal success. The point is crucial because clearly the public provision of dental health care was based on something more than the hope of an aggregate improvement in dental well-being. Indeed, it was shown in chapter two that a determination to separate access to health care from social or economic status was behind much of the pressure for reform and if such intentions were not expressed quite so explicitly in relation to dentistry, this owed more to the dominance of medical and hospital matters in this period than to any attempt to deny such a principle to the operation of dental health services.

Each of the major reports recognised that the realisation of this principle would require a substantial change to the combination of charity and market forces which characterised the availability of health services before the second world war and although they gave little space to the particular issues that this change would involve, there was general agreement on the need for public involvement both as a means of effecting the co-ordination of the many services involved

in health care and of providing the financial backing which a comprehensive and universally available service would require. But if the medical reports gave such matters little consideration, the issue of the form and the approach to public supply generated quite a deal of debate and disagreement within the Labour movement which resulted in the establishment, by the late 'thirties, of a fairly dominant position on the question. This position is of central importance to this thesis in so far as it defined the specific means by which it was believed that the goals and aspirations of health care reform would be realised. The main conclusion of the thesis is that most of the shortcomings in policy achievement can be traced to limitations associated with the particular approach to public supply and more specifically that they can be linked to inadequacies in the assumptions which underpinned the approach and which informed its institutional arrangements.

Of the four major assumptions discussed in chapter four, the first two - the beliefs in administrative capability and in the capacity to maintain political control - clearly depended on the second two - the absence, in public organisations of problems associated with power and the essentially neutral and technical character of the administrative process. In this last chapter it is proposed to review the adequacy of these assumptions in terms of the experiences of the dental health services and to argue that the shortfalls in administrative capacity and political control which have been evidenced in the previous chapters can be explained in terms both of the power of those involved in the particular policy area and the values and processes of the administrative system. The last four chapters yielded numerous practical examples of the consequences for the dental health services of these limitations in administrative capacity and political

control and here it is proposed only to give a thematic summary of the way in which problems associated with power and the values of public administration have limited the scope of policy achievement.

ADMINISTRATIVE CAPACITY

Much was made in the reports of the medical reformers of the requirements for the co-ordination of services and the direction of resources to areas of identified need. A number of schemes were suggested by which such goals might be achieved and although none of them was fully worked out, an underlying implication was the need for a considerable administrative capacity on behalf of the appropriate public authorities. In a similar way the Fabian approach came to assume not only the need for such administrative competence to pursue policy goals but also the fact that it would be available under the kind of arrangements it proposed. Yet a most obvious point which has emerged from the evidence in Part Four of the thesis is that such capacities and competence have been conspicuous by their absence. The various authorities charged with the administration of the dental health services have exhibited little ability to co-ordinate services, to direct dentists to areas of need, to ensure that people with dental problems receive treatment or to ensure that, in a situation of scarcity, agreed priorities are met first. Without such capacities the realisation of the type of ambitions that first informed the public assumption of responsibility for supply has become extremely problematical and hence it is of obvious importance to understand why this has been the case. The question will be answered in terms of the assumptions made about power and the nature of the administrative process.

The issue of power in relation to the administration of the dental health services has centred on the capacity of those involved

to resist particular courses of action which could be seen to be crucial to policy fulfilment. Such power has been exercised by the dentists in resisting both a salaried service and the imposition of restrictions on the areas where they might practice; by the public, in the role of patients, in resisting compulsory attendance for treatment; and by some of the involved public authorities in resisting, for example, the pressure to fluoridate water supplies. Power in this sense has been manifested in a number of ways: in respect of the issue of the salaried service it was fairly visible and was associated with the possible sanction of professional non-involvement, but in the case of compulsory attendance it was much less obvious and in fact the issue was never really explored. The "freedom of the patient" was a theme raised in relation to a number of issues including the choice of practitioner and the requirement that all treatment necessary for complete dental fitness should be undergone once an initial examination had been made, and its potency derived almost entirely from a widely accepted, but largely unstated, understanding of the kinds of freedoms enjoyed by the individual in British society.

But whether it has been exercised in a positive or negative way the point must be made that a number of the most important actors in the dental health services have had the power to resist the imposition of particular administrative arrangements and that in consequence many of the kinds of linkages which the approach to public supply presumed, have in fact been unavailable in practice. The general point is, of course, that issues associated with power have not disappeared because the policy has become a public responsibility and that conflicts over competing ambitions have not simply evaporated in face of the electoral mandate of those in power. Indeed it will be

argued in the next section that the undertaking of public supply has actually increased the capacity of those involved to pursue their own ends and to resist subordination to the dictates of administrative rationality. Chapter nine included details of the administrative lacunae which have followed from this and both chapters seven and eight provided many examples of the contributions these have made to the shortcomings of the dental health services.

But if the power of those involved has been significant in limiting administrative achievement, this has been overshadowed by the problems associated with the particular assumption about the nature of administration and the administrative process. Much was made in chapter four of the Fabian belief in the essentially technical and instrumental nature of public administration which was seen to be a neutral process of universal application and as such quite suitable for undertaking the public provision of dental health services. In practice administration has proved to be far from value free and in fact the particular values of the administrative process greatly influenced both the implementation and subsequent operation of the services. They have been responsible, above all, for the specific organisational arrangements chosen and for the fact that considerations pertaining to the immediate problems of dentistry made little impact on these arrangements. A number of illustrations of the way in which the particular values of public administration have affected administrative capacity can be seen in the process of implementation.

The first might be termed the question of timetabling and relates primarily to the speed with which the dental health services were introduced. Constraints imposed by pressures of time were manifested in a number of ways but perhaps the most obvious example can be seen in the contrast between the approaches taken by the profession and the

government to the possibility of the public supply of dental services. The dentists clearly hoped to use the political interest in the subject to raise the status of the profession, to increase public awareness of the virtues of oral health and to resolve some of the profession's intrinsic concerns, most particularly the issues of medical dominance and the continued use of the repair shops for dentures. The government, for its part, had a wholly different approach and sought not to enlarge but to narrow the consideration of dental matters, to confine them to essentially practical problems of public supply, and to isolate and identify any particular issues that might hinder the rapid introduction of such a supply.

The central problem for the government consisted in making dental services available on the appointed day and to secure this availability any problems had to be reduced to administratively manageable proportions within the given time. Thus the demands of administration with its basis in legislation and regulation immediately imposed a particular timetable on events leading to the introduction of dental health services. On the government side the initial consideration (conducted by the committee on Post War Dental Policy) was almost entirely administrative in character and was undertaken secretly by a group of civil servants. Only when the essential basis of supply had been determined was the topic opened up for wider public debate with the appointment of the Teviot Committee and direct consultation with the profession. In other words the speed with which it was believed to be necessary to proceed largely precluded consideration of the possible problems associated with improving dental health. Instead the debate was concerned only with the determination of how the provision of dental health services could be incorporated, with a minimum of dislocation, within the general organisational framework. In this way

the pressure of time left little room, especially in view of the much greater political significance accorded to the medical and hospital services, for the consideration of matters that were peculiar to dentistry and because of this virtually no attempt was made to relate the administrative apparatus to the particular problems that were imminent.

The second issue arising from the values associated with administration was the way it predisposed the participants to view the problems faced in a specific way. If the constraints of time reduced the scope of the debate then there can also be little doubt that adherence to the particular approach imposed a fairly rigid framework on the consideration of the issues involved. A number of factors contributed to this framework including the provision made for annual budgeting and estimates and what are usually termed constitutional conventions such as ministerial responsibility and financial accountability. Some hint of the difficulties with the initial estimates has already been given and in face of the general uncertainties which surrounded the introduction of dental services, the overwhelming concern of the government came to be to ensure that all expenditure could be rigorously accounted for and that no money was spent unnecessarily. The only specifically dental construct in the administrative arrangements of the NHS, the Dental Estimates Board, was provided in an endeavour to promote such controls, and in all stages of the implementation process the issues on which the government was most intransigent related to matters of financial control.

In some ways this emphasis on financial control can be seen as the seeking out of a familiar port in a storm which involved a mixture of ignorance about both the demand and supply side of the dental services, a largely open-ended financial commitment and hostility from

the would-be providers. Nevertheless its ramifications can hardly be ignored. Under this approach a policy for dental health became in practical terms the physical provision of dental health services and in fact in so far as there was a policy for the provision of dental health services, it was reduced to the assessment of factors involved in negotiating acceptable terms of service with the representatives of the dental organisations. This in turn was characterised, as has been shown, by conflict between the professional desire to maintain clinical autonomy and the government's insistence that money should be expended on dental treatment only in accord with specific procedures. The heat generated and the time taken by the negotiations over this specific problem dominated the final stages of the implementation proceedings to the exclusion of almost any other issue related to the supply of dental services and hence matters such as the pattern of distribution of dentists around the country or the problems of providing an effective priority service either went undiscussed or else were afforded only the most superficial attention.

Thus while a considerable number of arrangements were made to see that the traditionally high standards of public financial probity were applied to the new service and that the necessary command and authority links were forged, this consideration did not flow over into other aspects of the dental health services so as to ensure, for example, that resources could be directed to areas of identified need, that co-ordination could be achieved between the different services in a single locality or that people with manifest dental problems did in fact receive treatment.

The third point about the way in which administrative values affected the implementation of the dental health services can be made fairly quickly and consists in the preference for the use of the

existing administrative arrangements as the basis for the expansion of the health services. That the new developments should make use of the established structures and practices was never really challenged and the National Health Service White Paper gave clear expression to the perceived advantages of the approach:

> 'There are two possible ways of approaching the task. One, with all the attraction of simplicity, would be to disregard the past and the present entirely and to invent *ad hoc* a completely new organisation for all health requirements. The other is to use and absorb the experience of the past and present, building it into the wider service. The Government have adopted the latter methods, as more in accord with native preference in this country.'[1]

But again the point should be made that from the start dentistry was to be adapted to the demands of the existing administrative arrangements and few concessions would be made. However, the issue of central control over resources remained contentious for some time. Bevan's approach to the organisation of the NHS, which he outlined to Cabinet in October 1945, rested squarely on the belief that resources must be centrally allocated:

> 'For the first time we shall be promising the whole population a full service - every kind of hospital and specialist care planned over the entire country ... and we have got to achieve as nearly as possible a uniform standard of service for all.'

But, he continued

> 'Under any local government system - even if modified by Joint Boards or otherwise - there will tend to be a better service for the richer areas, a worse service for the poorer.'[2]

The position was challenged by the Lord President of the Council

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1. MoH, DoH(S), *A National Health Service* (Cmnd. 6502, London, HMSO, 1944), p. 8.

2. Cabinet Papers: CAB 129/3 C.P.(45)205, *NHS. Future of the Hospital Services.* Memo by the Minister of Health (5 October 1945).

(Herbert Morrison)[1] who argued the case for a much more significant role for the local authorities, but following Bevan's subsequent rejoinder[2] the issue was not again raised and the Minister was authorised to negotiate with those who would be involved in the service.[3]

But if the argument for central control was won, its triumph was considerably undermined by the commitment to use, where possible, the existing administrative arrangements. The two were by no means compatible and a number of examples were given in chapter seven of the problems of control and direction that arose either from geographical limits to responsibility or jurisdiction, or from the presence of more than one type of service within a single area. In other words, the commitment to incrementalism, to build on the existing administrative arrangements, had an immediate and obvious impact on the capacity to direct and control. The general practitioner services were organised nationally, the hospital services were based on the Regional Hospital Boards while the school and priority services were run by the local authorities. Thus in addition to the difficulties experienced within each service, their differences (seen in terms of area, clientele, remuneration, responsibility and so on) clearly added a very considerable extra dimension to the problems of control and direction. There were, as the White Paper suggested, obvious advantages in using the

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1. Cabinet Papers: CAB 129/3 C.P.(45)227, *NHS. Future of the Hospital Services*. Memo by the Lord President of the Council (12 October 1945).

2. Cabinet Papers: CAB 129/3 C.P.(45)231, *NHS. Hospital Services*. Memo. by the Minister of Health (16 October 1945).

3. Cabinet Minutes: CAB 129/5 C.M.(45) Cabinet 65(45). *Cabinet discussion following Minister of Health's proposals for the NHS* (20 December 1945).

"tried" rather than the "untried" forms of organisation, but at the same time the process of adapting the new policy area to the existing arrangements had obvious implications for the administration of that policy. It led, above all, to the subordination of dental matters to other considerations: in this case the framework imposed by the established organisational forms and the politically more significant medical and hospital services. The result, as in the case with the other characteristics discussed in this section, was that the particular capacities to direct and control which might be required to promote a policy for dental health, were never seriously considered.

These three illustrations give some indication both of the particular values associated with public administration and of the consequences for a particular policy area of its subordination to such administrative norms. More importantly they illustrate the point that in being administered within the public realm, dentistry and the dental health services, were given little opportunity to be considered on their merits. Public administration did not prove to be neutral and instrumental, as had been expected, but rather value-laden and tradition-bound. With little or no allowance for these phenomena the possibility of exercising administrative rationality in regard to the supply of dental health services quickly evaporated in face of the demands for organisational coherence and the dominance of the traditional norms of bureaucratic behaviour.

But the inherent values of adminstration acted not only to shape the way in which the problems of the dental health services were approached but also to deny or restrict the use of a number of potential solutions to specific problems. Hence whatever the merits of a particular course of action, in practice, its utilisation has been required to be compatible with the established administrative practices.

A good example has been the case of preventive dentistry whose potential in public health terms has never been denied but whose incorporation into the NHS has never really been achieved. A number of explanations have already been discussed, particularly in regard to the fluoridation of water supplies, but the use of topical fluoride applications and preventive measures such as oral hygiene instruction might also be considered. At present these applications are not available under the NHS while no fee is payable in respect of preventive instruction, and although the British Dental Association has argued that payment for topical fluorides 'would be throwing away money which could be better spent elsewhere'[1] it appears that the major reason why they are not provided is the administrative difficulty in supervising their use. A witness before the Expenditure Committee noted that:

> 'If you fit a denture or put a filling in a tooth then it is perfectly possible for a dental officer of the Department of Health to come along and check and he can actually see there is a filling or a denture. If you apply topical fluoride, there is no way he can say, yes, there is evidence that topical fluoride has been applied.'[2]

The point is perhaps an obvious one but its implications have nevertheless been considerable in so far as the rationality and capacity of the administrative arrangements have been concerned. Administration has proved to be far from value free and under these circumstances it has not been possible to meet the problems of the dental health services in isolation. Solutions have had not only to be compatible with the norms of administrative practice but also to complement and supplement other related services and consequently the

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1. House of Commons, *First Report of the Expenditure Committee, Session 1976-77*. 'Preventive Medicine' (London, HMSO, 1977), Q. 1106. But for another view see para. 220 in the main report.

2. *Ibid.*, Q. 1105.

kind of administrative responsiveness which the whole approach presumed has just not been available.

More generally it may be concluded that in practice the assumptions about administrative competence have proved to be untenable in the face of both the power of those involved to resist the imposition of particular administrative arrangements and the complications caused by the adaption of the problems of dental health to the traditional norms of administrative behaviour. This shortfall in administrative competence has seriously undermined the capacity of the particular approach to public supply to meet the shortcomings of the dental health services and thus realise the kind of performance on which it was premised. But perhaps of greater significance for the policy as a whole has been the failure to maintain political control which is discussed in the next section below.

POLITICAL CONTROL

The second major assumption behind the particular approach to public supply was the belief in the capacity to maintain political control over the policy in question. It was a position which derived from a close identification of power with the possession of public office and one which raised the expectation that behaviour and performance could be continually related to policy intention. More specifically it included the beliefs that needs could be identified, priorities defined, inequalities recognised and that the full weight of public commitment could be moved behind the resolution of the problems faced. In practice it has been shown that there have been significant problems in maintaining this type of control and again it is suggested that they can be explained in terms of the power of those involved and and the particular character of the administrative process. The issue

of power in this context has centred not only on the profession but also on the recipients of the services provided.

The power of the profession has been manifested in two important ways in relation to the issue of political control. The first has involved its capacity to resist the kinds of direction and control which had been seen as essential prerequisites for policy achievement and the second has been the development of a high degree of autonomy amongst the agencies involved in dental health administration which has effectively moved a number of issues beyond the competence of public control. Each factor can be attributed to the growth in the power of the profession which was undoubtedly stimulated by its employment within the public domain.

Considerable coverage was given, in chapter three, to the history of the profession as a means of emphasising both its general lack of organisation and its poor public standing in the years prior to the introduction of the NHS. These features assumed considerable significance during the period of implementation and led, as was shown in chapter five, to a number of problems for the dentists in dealing with the government. The British Dental Association, for example, experienced considerable difficulty in both establishing what might be called the "dentists' position" on the number of significant issues and agreeing on their degree of commitment to particular objectives. A second problem confronting a divided profession was the distribution of representatives on negotiating and other contact committees and a third and more serious difficulty lay in the fact that none of the negotiating committees drawn from the dental organisations had the authority to commit the individual organisations to particular agreements with the government. After each meeting the representatives of each group had to report back to their parent body and further

inter-organisational talks had to be held before any substantial position could be established. Thus the machinery of negotiation on the dentists' side was extremely cumbersome and generally unable to make quick decisions.

The issue of unity - of amalgamation with the other dental organisations - had been a regular topic on the agenda of the British Dental Assocaation Representative Board meetings throughout the 1930s. A special Advisory Committee had been set up in 1933[1] and in 1937 a motion was carried to the effect that

> 'the Council should be instructed to consider in what ways unity of the profession could be achieved, so as to strengthen the political powers of the profession as a whole, improve its status and protect it from exploitation'.[2]

But if the issue made the Association's agenda, no substantial action was forthcoming. The major stumbling block was the *Dentists' Act* of 1921 which had admitted to the Register almost all of those in *bona fide* practice at the time and which in turn had led to something of a division between those with and without qualifications. The British Dental Association had subsequently voted to admit to its ranks only those practitioners with a university or Royal College qualification[3] and, although the evidence is essentially inferential, there also appears to have developed significant social and status divisions within the profession. A good example of the type of attitudes involved was given in the Association's Presidential Address in 1930. In a part of his speech which has already been quoted, Sir Norman Bennett argued that

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1. BDA, *Minutes of the Representative Board*, (1 April 1933).
2. *Ibid.*, (30 October 1937).
3. See p. 67 above.

> 'professional education is expensive, and for this and other social reasons it is right and natural that the professionally qualified dental surgeon should expect to enjoy a higher scale of living than those who have not equipped themselves so thoroughly. *Ceteris paribus* he should be the better man.'[1]

In view of such attitudes it is not surprising that the various motions which were intended to stimulate an interest in unification should come to nought and that the dentists should remain organisationally divided throughout the implementation period of the NHS. Yet within a few months of the government having become the major provider of dental treatment, the dental associations had been amalgamated and the foundations of a strong professional organisation had been laid. There can be little doubt that the two events were connected and that the experiences of the profession in the years leading up to the introduction of the NHS provided a significant stimulus for the formation of a combined organisation capable of representing the views of the profession to the government.

The amalgamation, in which the title of the British Dental Association was adopted even though the event was seen as a merger between three equal partners,[2] not only strengthened the profession organisationally at both branch and central office levels but also contributed to a rapid growth in the development of a consciousness, amongst the dentists, of being members of a single profession. In contrast to the pre-war situation where both attendances and incomes were generally low and hence competition for the available patients was considerable, the introduction of public funding brought, at least

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1. N.G. Bennett, 'The British Dental Association: Its Origin, Progress and Advance', *BDJ*, 51, 11 (2 June 1930), p. 581.

2. See British Dental Association, Incorporated Dental Society, Public Dental Service Association, *Report of the Amalgamation Drafting Committee* (London, March 1949).

initially, a virtually unlimited "pool" of patients which reduced the need for competition and instead focussed attention upon the terms of service for treating the individual patient. The British Dental Association soon began to claim, with some justification, that it was the legitimate spokesman for the profession and it went to some considerable lengths to demonstrate its capacity to do this.

In seeking to promote the profession's cause at every possible opportunity it sought to establish itself as the major party with whom the government should negotiate and liaise on dental matters. In practice it has been shown that this was at the expense of a wider range of formal contacts through professional involvement in administration and it is something of an irony that the particular approach to public supply which was premised, among other things, on an assumption about political control, should in fact have provided a major stimulus to professional integration and organisation which in turn has led to a position whereby the dentists have remained largely "outside" the NHS and communicate with the government only through their elected representatives. In support of this arrangement the Association has developed a network of committees covering all aspects of the profession's relationship with its major employer which enables it to provide quick, co-ordinated and comprehensive responses to any important issues that arise.

The result of this development has been not only the capacity to resist, in an industrial relations sense, particular government approaches to dental health, but also that the profession itself has become identified as the major figure of authority in the dental field and that instead of this authority being channelled into the administration at all levels it has become located in a visibly separate body. The development of separate authority structures - bureaucratic and

professional - which tend to meet only at their apices has led not only to a concentration on the employer/employee relationship but also to difficulties in undertaking the kind of professional assessment of needs that the approach to public supply had presumed. The dentists have gone onto the public pay roll, but for the most part they have remained independent contractors, jealous of their professional status and with a monopoly over the supply of services. Consequently questions relating to the needs and organisation of the dental health services have become inseparable from questions pertaining to the practitioners' terms of service with the resolution of the first becoming dependent upon the satisfactory conclusion of negotiations over the second. Dental policy has thus become inextricably bound up with employer/employee relationship between the government and the dentists who, with their monopoly over the supply of services and growth in status under the NHS, have been able to influence events in a manner which has largely denied the validity of the assumption about political control on which the whole approach was premised.

If the scope for political control has been restricted by the fact that questions relating to dental health have become inseparable from questions relating to the dentists' terms of service, a second area of constraint should be noted in the growth of autonomy of a number of the agencies involved in the administration of the NHS. The major consequence of this has been that a number of the authority linkages on which the ability to exercise political control had been seen to depend were just not established.

The developments leading to the appointment of the Review Body on Doctors' and Dentists' Remuneration, which were discussed at some length in chapter ten, are instructive in this regard. If war "was too serious a business to be left to the generals" then the catch-cry in

the NHS has been just the opposite and that health care "is too serious a business to be left to the politicians". The need to take health matters "out of politics" has been a theme regularly evoked since 1948 and one which has been ably fuelled by the professions who have managed to extend the principle of political non-interference from the immediate arena of doctor/dentist-patient relationship to cover almost all aspects of their relationship with their employer, the state. In the dentists' case this has meant that the government now has little opportunity to influence the determination of incomes, the setting of fees, the control of registration, the control of the registration of ancillary personnel, the supervision of dental schools' curricula or the disciplinary procedures. Consequently, as has been shown in Part Four, the government lacks the capacity to exercise the kind of political control which would be necessary for a more rigorous prosecution of its dental health policy goals. The legislation governing these matters could of course be amended and thus it is not strictly true to say that the government has completely alienated its capacities in these areas, but developed practice, seen for example in the response to the governments' non-acceptance of the pay recommendations in 1970, has put them largely beyond its competence.

There can be little doubt that the growth of this autonomy has followed from the powerful position developed by the dentists by their participation in the NHS and if, on the issue of remuneration, they benefitted from moving on the coat-tails of the doctors, then the appointment of the General Dental Council in 1956 indicated the extent to which they had become a force in their own right. The appointment meant the grant of self-government to the profession which, according to a former and long standing Registrar of the council, 'is regarded as a privilege, restricted to the leading professions and coveted by

others and by professions in other countries; it is conferred by Parliament and dependent on public opinion'.[1] But, continued Hindley-Smith:

> 'The value of professional self-government depends on certain assumptions: first, that those who seek professional advice are rarely able to assess its value before they commit themselves; secondly, that only the members of the profession have a sufficiently intimate acquaintance with progress in the advancement of knowledge and the standards of practice within that profession to assess the standards of education and conduct required of practitioners in the triple context of national need, public demand and available resources; thirdly, that the governing bodies of the profession are alone able to provide the requisite expertise in a form which is uncoloured by professional self-interest or by political expediency, because they owe allegiance neither to government on the one hand nor to their profession on the other, but only to the public will as expressed in Parliament'.[2]

Beneath the rhetoric the implications of the statement are clear: that the dental profession had established itself in a position of sufficient strength to enjoy a detachment from public control denied to the majority of public employees. This privilege, which was in marked contrast to the pre-war experience, undoubtedly resulted from the growth in prestige associated with the profession's participation in the NHS, but of more importance to this thesis have been its consequences in restricting the capacity for political control and with it the ability to meet the particular shortcomings of the dental health services.

The third issue in considering the problems for political control of the power of those involved in the policy area concerns the position of the public as the recipients of services. That the great majority

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1. D. Hindley-Smith, 'The General Dental Council. Twenty Five Years On', *BDJ*, 151, 1 (7 July 1981), p. 31.

2. *Ibid.*

of people are satisfied with the treatment they receive under the NHS has been often documented,[1] and there can be little doubt that the provision of particular services such as dentistry has raised the expectation that they will continue to be available. The problem this presents in a situation of scarcity of supply is that if priorities are to be met in line with a professional determination of need, then it is likely that this will be possible only if services are denied to other sections of the community which may have become used to their provision. The political implications of the situation are obvious and even if it is extremely difficult to document the kinds of influence that this sort of situation has on decision making, two factors stand out from the experience of the dental health services.

First, that there has been very little movement of resources towards specific areas of identified need and second, as was shown in chapter ten, there has been a gradual movement away from using the control over dental charges as a means of directly promoting dental priorities to a system prejudiced towards the regular attender. As the regular attenders as a group are generally those with the fewest dental problems, the action makes little dental sense as the dichotomy between the two groups of attenders is reinforced, but politically the action is much more easily understood. Those already apprised of the benefits of treatment, who would be the most likely to object if it were withdrawn, can keep their costs low by regular attendance while those with the greatest need, whose use and expectation of the service is minimal, will be deterred from seeking treatment by the high cost involved in undertaking all the work required to achieve dental fitness.

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1. See, for example, G. Forsyth, 'Is The Health Service Doing Its Job?', *New Society* (19 October 1967), p. 545.

The extent of the influence of the public as receivers of dental treatment is of course impossible to quantify, but nevertheless there is sufficient evidence to make the general point about the limitations on political control, with its ramifications for policy achievement, which have resulted from a concern with consumer response.

Thus, all in all, the power of those involved has had a considerable impact on the ability to maintain and exercise political control over the policy for dental health. Neither the consumers nor the providers of services have proved as passive as the advocates of the particular approach had assumed and consequently very great difficulty has been experienced in resolving the particular shortcomings of the dental health services. However, before moving to more detailed conclusions, the effect of the nature and values of the administrative process on the capacity to exercise political control must also be considered.

There are a number of ways in which the character of public administration has acted to restrict the scope of political control and two major themes have emerged most strongly from the evidence presented. The first is that in attempting to assess needs, priorities and so forth there have been considerable limitations on the kinds of information with which the administration has been able to deal with the result that some matters have just not been considered. The second is that on a large number of issues, faced with a wide range of information, the administrative process has just not yielded the kind of clear-cut conclusions that the particular approach to public supply had anticipated.

The central point to be made about the kind of information available to decision makers in the dental health services is that it has been partial and that the nature of this partiality has derived

from the particular character of the administrative apparatus which has collected and processed it. The best example can be found in the information relating to the dental condition of the nation as a whole: two national surveys have given some indication of the overall dimensions of the problem but more precise information, of a type necessary for assessing the needs of a particular area, is just not available. The major problem is that while a considerable amount is known about those who attend for treatment, little or nothing is known about those who do not. In the first case data collection is a relatively straightforward exercise, and indeed a necessary one with a fee-for-service system of payment. But in the case of the non-attenders, data collection is both expensive and administratively complex and is not a necessary pre-requisite for the day to day functioning of the administrative system. The differences in the data available in the general and school dental services serves to emphasise the point about the relationship between administrative needs and the data collected: in general practice the information deals exclusively with the number of courses of treatment undertaken while in the school services, where remuneration is by salary rather than piece-work, the data collected relates to the number of people treated. The different requirements of the separate administrative systems have led, most obviously in this case, to significant problems in co-ordinating the provision of dental health care.

But not only has the administrative process been important in determining which information has been collected but it also affected the type of information that is considered. Most significantly, and this was brought out most clearly in reference to the remuneration of general practitioners, the system has shown an obvious bias in favour of quantitative data at the expense of more qualitative material. Those

factors which cannot be expressed numerically (examples include the quality of work done and value preferences such as support for preventive rather than curative treatment) thus tend to play little part in overall policy considerations. Thus for instance, with pressure for financial control and efficiency within the public sector, expenditure on conservative dentistry, in which the amount of treatment done can be calculated and the work physically checked, is likely to be preferred, irrespective of the dental considerations, to preventive work which often manifests no indication of its application and whose use is premised on some probable future benefit.

Finally, the point must also be made that on a number of issues the administrative process has not yielded the kinds of clear cut conclusion on which the exercise of political control was seen to depend. Many of the factors already discussed have obviously had a bearing on this and here only the issue of complexity will be considered. Put plainly the argument is that the administrative procedures introduced in the attempt to realise the goals and aspirations of a public dental health policy, have proved unequal to the task of sorting out the information with which they have been confronted. A number of issues have been involved. The first has involved the problem of institution building: how do you develop administrative arrangements which, say, "reward" activity 'a' while "penalising" 'b' without affecting 'c'? The point relates to the close proximity of dentistry to other areas of health care and to the fact that administrative action in support of policy goals cannot be made in isolation from those other services. Secondly, there have been difficulties, in administrative terms, in resolving tensions between competing claims within the area of dental health care. The stated values and aspirations of the policy backed by a professional determination of needs

and priorities have undoubtedly helped the adjudication of a number of difficult issues, but there have been occasions where this has not proved enough. How, for example, should the compensation made to a dentist whose age has reduced his work capacity compare with that of a dentist who operates in a sparsely populated area and whose appointment book is rarely full?

Although they are not central to policy achievement issues like this have nevertheless been important, especially in view of the significance that has become attached to the dentists' terms of service. Yet they are questions which lead to no logical conclusion. In consequence, as with the matters relating to institution building and complementing the other health services, the complexities of administration have had a considerable impact on the ability to maintain political control. And if this conclusion is linked to those pertaining to the particular treatment of information and to the power of those involved in the administration of the dental health services, the more general conclusion can be stated that the assumptions about political control, which informed the particular approach to public supply, have been found quite untenable in practice with the result that the ability to fulfil the policy's ambitions has been very much limited. This issue will be considered in more detail in the final section below.

CONCLUSION

The particular approach adopted to the public provision of dental health services contained a number of assumptions which in practice have been shown to be ill-founded. They have not permitted the degree of administrative effectiveness and political control that had been postulated and consequently the aspirations which first

informed the assumption of public responsibility for supply have remained largely elusive. Policy achievement has been limited and it is the central conclusion of this thesis that the principal limitation derives from the failure of the approach to consider either the power of those involved in the policy area or the consequences of subjecting it to public administration.

The approach significantly underestimated both the political nature of the changes it envisaged and the complexities which their administration would involve. Consequently its limitations have arisen largely from a tendency to simplify both political and administrative problems by their subordination to traditional organisational norms. The institutional arrangements which resulted have been ill-equipped to deal either with the kinds of tension which have developed between competing interests or the particular problems associated with the attempt to improve oral health. As a result there has been practically no attempt at conflict resolution and an almost complete separation of professional and administrative matters. Consequently the policy for dental health has been reduced to arrangements on the one hand for paying dentists for what they do and on the other for rewarding those patients whose familiarity with the benefits of dental health has already been proved. Under these conditions considerations other than dental need and equity have governed both the supply of, and access to, the available treatment.

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