

# THE HIGH COURT

## COMMERCIAL

[2021] IEHC 737

[2018 No. 10218 P.]

BETWEEN

HEALTH SERVICE EXECUTIVE

PLAINTIFF

AND

LAYA HEALTHCARE LIMITED

DEFENDANT

AND

IRISH LIFE HEALTH DAC

NOTICE PARTY

**JUDGMENT of Mr. Justice Denis McDonald delivered on 25<sup>th</sup> November, 2021**

### **Introduction**

1. In these proceedings, the plaintiff (“*the HSE*”) seeks a declaration as to the proper interpretation of s. 52(3) of the Health Act, 1970 (“*the 1970 Act*”) as amended by s. 9 of the Health (Amendment) Act, 2013 (“*the 2013 Act*”). It will be necessary, in due course, to consider the provisions of s. 52(3) in detail. At this point, it is sufficient to note that, under that sub-s., significant consequences flow from a decision by an in-patient at a public hospital to opt to be treated as a private patient at that hospital notwithstanding that the patient concerned is entitled to be treated as a public patient. Under the sub-s., a patient who so opts is deemed not to be eligible to be treated as a

public patient. Such a decision renders the patient liable under s. 55(1) of the 1970 Act (as amended by s. 6 of the 2013 Act) to make a substantially higher payment for in-patient care than a patient who is treated as a public patient at the hospital even where the accommodation provided to that patient is no different to that provided to a public patient.

2. As formulated in the statement of claim, the HSE originally sought a declaration that the defendant (“*Laya*”), an insurance intermediary acting on behalf of a health insurer Elips Insurance Ltd, is liable to the HSE under s. 52(3) of the 1970 Act (as amended) for the payment of the in-patient charges of its members who opt to be treated privately at a public hospital. In circumstances where, by statute, any such charges are payable by the patient, *Laya* disputed that it had a direct liability of that kind to the HSE. On the final day of the hearing, counsel for the HSE confirmed that the declarations originally sought by it should be framed by reference to the liability of *Laya*’s members rather than by reference to the liability of *Laya* itself.

3. *Laya* has defended the claim on the basis that much of the HSE claim relates to services provided to patients in public hospitals prior to the patient opting to be treated as a private patient. *Laya* also maintains that, prior to any decision by such a patient to opt to be treated as a private patient, the patient must be fully informed as to the consequences of abandoning the entitlement to be treated as a public patient. *Laya* claims that there have been many occasions where its members have been requested by hospital staff to sign forms waiving their entitlement to be treated as public in-patients without any sufficient information being provided to them as to their statutory entitlements such that they have been unable to make a fully informed decision.

4. It should also be noted that part of the relief claimed by the HSE is for an account of the charges alleged to be due by *Laya* in respect of its members. *Laya* has

contended that there is no proper basis to direct the taking of an account in this case. Nonetheless, during the course of the evidence given by Mr. John McCall, Director of Claims at Laya, he agreed to provide certain information to the HSE on a voluntary basis. Against that backdrop, it was ultimately agreed on the penultimate day of the hearing that any issue in relation to the taking of an account could be deferred until after the court has made a decision on the issues addressed in this judgment.

### **The relevant statutory regime**

5. In order to understand the respective positions of the parties, it is necessary to consider, in some detail, the evolution of the statutory provisions which led to the adoption in 2013 of s. 52(3) in its current form. The provisions of s. 52(3) must also be considered in their proper context as part of a larger legislative scheme embodied in the 1970 Act and the many amendments to it.

### **The 1970 Act**

6. Part II of the 1970 Act provided for the creation of health boards to be responsible within specific functional areas for the administration of public health services. In turn, Part III made provision for the maintenance of hospitals by health boards. In substance, Part III provides for what has become known as public hospital care. In particular, s. 38(1) provided that a health board might, with the consent of the Minister for Health, provide and maintain a hospital or similar institution required for the provision of services under the Health Acts, 1947 to 1970.

7. Part IV of the 1970 Act dealt, in more detail, with the provision of health services (which have subsequently become known as public health services). Section 45(1) addressed eligibility for such services. In essence, it provided that adults who were unable “*without undue hardship*” to arrange general practitioner medical and surgical services for themselves and their dependents would be entitled to full

eligibility for the provision of health services under the 1970 Act. The effect of this provision was that adults who passed a “*means test*” were entitled to a medical card which confirmed their eligibility for the provision of these services. In turn, s. 46 of the 1970 Act dealt with persons with “*limited eligibility*”. These included, for example, persons insured under the Social Welfare Act, 1952.

**8.** Chapter II of Part IV dealt with the provision of hospital in-patient and out-patient services. In terms which are largely the same today, s. 51 of the 1970 Act provided that “*in-patient services*” means “*institutional services provided for persons while maintained in a hospital*” or in a range of other facilities. Section 52(1) continues in force today and provides that: “(1) A health board shall make available *in-patient services to persons with full eligibility and limited eligibility*”. As explained further below, the reference to a health board should now be read as referring to the HSE. The significance of s. 52(1) is explored in greater detail in paras. 110 to 113 below. Section 53 dealt with the imposition of charges for inpatient services but made clear that, subject to s. 53(2), charges would not be levied for in-patient services made available under s. 52(1). However, s. 53(2) empowered the Minister for Health (with the consent of the Minister for Finance) to make regulations providing for the imposition of charges for in-patient services in specified circumstances on persons without full eligibility. Thus, the 1970 Act envisaged that persons with full eligibility would receive free in-patient services at hospitals provided by the health boards but the Minister had the power to make regulations imposing charges for the provision of in-patient services to persons without full eligibility.

**9.** Section 55 of the 1970 Act also addressed the provision of services to (a) persons with no eligibility and (b) those with eligibility who were treated in private or

semi-private accommodation and who did not avail of the services to which they were entitled under s. 52. Section 55 was in the following terms:-

*“55. A health board may make available in-patient services for persons who do not establish entitlement to such services under section 52 and (in private or semi-private accommodation) for persons who establish such entitlement but do not avail themselves of the services under that section and the board shall charge for any services so provided charges approved of or directed by the Minister.”*

**10.** It will be seen from the provisions of s. 55 that the criterion for the charging of patients with eligibility under s. 52 for in-patient hospital services was the provision of such services in private or semi-private accommodation in the hospital concerned. As counsel for Laya observed, this was a relatively straightforward criterion which could be applied without difficulty. However, that criterion was removed under subsequent legislation (described below).

### **The Health (Amendment) Act, 1991**

**11.** A number of significant amendments were made to the 1970 Act by the Health (Amendment) Act, 1991 (*“the 1991 Act”*). Section 3 of the 1991 Act significantly expanded the category of persons entitled to *“limited eligibility”* under s. 46 of the 1970 Act. The effect of the amendment was that any person ordinarily resident in the State without full eligibility should, subject to s. 52(3) (addressed further below) have limited eligibility for services under Part IV of the 1970 Act.

**12.** In addition, s. 5 of the 1991 Act introduced a significant new provision in s. 52 of the 1970 Act, namely s. 52(3). Insofar as relevant, the new subs. (3) was in the following terms:-

“(3) ...where, in respect of in-patient services, a person with full eligibility or limited eligibility for such services does not avail of some part of those services but instead avails of like services not provided under section 52 (1), then the person shall, while being maintained for the said in-patient services, be deemed not to have full eligibility or limited eligibility, as the case may be, for those in-patient services.”

Further amendments have since been made to s. 52(3) and I will defer any detailed consideration of its terms to a later point in this judgment. However, the use of the language “*does not avail*” should be noted. The exclusive focus of the subsection was on a person (entitled to full or limited eligibility for in-patient hospital services) who does not avail of those services but instead avails of “*like services*”. In such circumstances, the patient will be deemed not to have eligibility for the provision of those services under s. 52. The effect of the subsection is to make such a patient liable for any charges that may be payable for in-patient services.

**13.** The amendment made to s. 52 of the 1970 Act by s. 5 of the 1991 Act should be read with the amendment made to s. 55 of the 1970 Act by s. 6 of the 1991 Act. Section 55 (as substituted by s. 6 of the 1991 Act) now required a health board to levy a charge for the provision of in-patient services to (among others) those patients who were deemed by s. 52(3) not to have eligibility for such services (namely those described in para. 12 above). The previous criterion (based on the provision of services in private or semi-private accommodation) found in the original version of s. 55 of the 1970 Act was discarded. Section 55 (as substituted by s. 6 of the 1991 Act) was in the following terms:-

“55.— (1) A health board may, subject to any regulations made under

*subsection (2), make available in-patient services for persons who—*

*(a) do not establish entitlement to such services under section 52, or*

*(b) are deemed under subsection (3) of section 52 not to have full eligibility or limited eligibility for such services,*

*and the board shall charge for any services so made available and provided to any such person in accordance with charges approved of or directed by the Minister.*

*(2) The Minister may, for the purposes of subsection (1), make regulations prescribing the manner in which any in-patient services are to be made available and provided by health boards.*

*(3) Every regulation made by the Minister under this section shall be laid before each House of the Oireachtas as soon as may be after it is made and, if a resolution annulling the regulation is passed by either such House within the next 21 days on which that House has sat after the regulation is laid before it, the regulation shall be annulled accordingly, but without prejudice to the validity of anything previously done thereunder.”*

**14.** It will be seen that, by virtue of s. 55(1)(b), those deemed under s. 52(3) not to have eligibility for the services provided under s. 52 were now to be charged in

accordance with a scale of charges approved by the Minister for Health. It will also be seen that s. 55(2) envisaged that the Minister would make regulations prescribing the manner in which any in-patient services were to be made available by health boards. It was left to the Minister to do so. As noted in para. 13 above, the express statutory criterion that the patient was housed in private or semi-private accommodation was removed. Subject to any regulations that the Minister might make under s. 55(2), the only criterion relevant for present purposes was that prescribed by s. 52(3) (as inserted by s. 5 of the 1991 Act), namely that the patient (with either full or limited eligibility) had not availed of some part of the public in-patient service available but had, instead, availed of “*like services*” (i.e. non-public services).

**The 1991 Regulations made pursuant to section 55(2)**

15. As envisaged by s. 55(2), regulations were made by the Minister in the form of the Health Services (In-Patient) Regulations, 1991 (S.I. No. 135 of 1991) (“*the 1991 Regulations*”) which introduced, for the first time, the concept of “*designated*” public beds and private beds. Regulation 2 defines a “*designated public bed*” as meaning a “*bed designated to be public accommodation for the admission of public patients for the purposes of Section 52...*”. In turn, a “*designated private bed*” was defined as meaning “*a bed designated to be private accommodation for the admission of private patients for the purposes of Section 55...*”. Thus, although s. 55 of the 1970 Act (in the new form inserted by s. 6 of the 1991 Act) removed the reference to patients being accommodated in private or semi-private accommodation, the 1991 Regulations appear to have been designed to maintain a link between the nature of the accommodation and the levying of a charge. For completeness, it should also be noted that the regulations envisaged a third category of bed namely “*a non-designated*” bed.



16. Furthermore, Regulation (3) provided that no private patient, admitted as an in-patient on an elective admission, should be accommodated in a designated public bed. Equally, Regulation (4) provided that no public patient admitted on an elective basis should be accommodated in a designated private bed. Insofar as emergency admissions were concerned, Regulation (5) provided that no private patient admitted on that basis should be accommodated in a designated public bed unless (and only for such a time as) a designated private bed was not available.

### **The emergence of problems with the designated bed system**

17. It appears that a number of practical problems arose in relation to the designated bed system. These are described in the 2008 report of the Comptroller & Auditor General, Chapter 37. In due course, it will be necessary to consider whether any reliance can be placed on that report in interpreting the subsequent amendments made to the 1970 Act. At this point, I refer to it solely in the context of the relevant chronology. In the course of his report, the Comptroller explained that, as a consequence of the designation of beds as private beds under the 1991 Regulations, only beds so designated were accepted by health insurers for the purposes of refunding the cost of maintenance of their members in hospitals. At para. 37.4 of the report, it was explained that 45% of all private in-patient throughput was not the subject of a maintenance charge. This occurred as a consequence of the fact that the patient was accommodated in a designated public bed. On the other hand, private patient income was also lost in circumstances where accommodation which had been designated for private patients was used to accommodate public patients. The Comptroller calculated that, as a consequence of designated private beds being used in this way, the income lost equated to 83,541 bed days. The Comptroller noted that, from a financial management viewpoint, the overall effect was that the hospital

system had foregone the potential income from private patients in return for the use of these resources to provide services to public patients. The entirely understandable reason why public patients were sometimes maintained in a designated private bed was explained in para. 37.12. The use of single rooms for isolation facilities was identified as a principal cause. The use of single rooms as isolation facilities in that way was necessary in tackling, for example, the serious threat posed to patient safety by hospital acquired infections such as MRSA.

**18.** A further example of circumstances where a public hospital was unable to charge fees to a private patient was where that patient was treated in a non-designated bed. The report identified that, where a patient was admitted to a coronary care unit (where the beds were non-designated beds) no private patient charges could be levied even where the patient opted to avail of private consultant physician services. In such circumstances, the hospital would not be in a position to levy private accommodation charges. The report explained that the rationale for non-designated beds was that there should be no differentiation in the case of accommodation for persons who were very acutely ill or where a national specialty was concerned.

**19.** In para. 37.21 of the report, the Comptroller indicated that, since the publication of a White Paper on Private Health Insurance in 1999, Government policy had been to move towards charging the full economic costs for the use of public facilities and services for private patients “*while being sensitive to the needs for continuing stability in the private health insurance market and wider inflation concerns*”. In his conclusion which followed, the Comptroller stated:-

*“The objectives of ensuring equitable access and optimising the recovery of the cost of maintenance of all privately treated patients are difficult to achieve simultaneously within the present system.*”

*The principal factor impacting on the recovery of maintenance costs of private patients is the fact that the designated beds system that is operated limits the extent to which maintenance charges can be recovered, even for patients who pay their consultants on a private fee basis for treatment charges. As will be seen from the next section the category of the primary consultant clinician is also relevant to the potential of the health system to levy charges for private patient maintenance.”*

**20.** A further complicating factor of the designated bed system is identified in paras. 37.22 to 37.26 of the report. These paragraphs refer to the impact of the Consultant Contract 2008 in respect of “*Category A consultants*” namely those who are exclusively involved in the provisions of public care and do not have any private practice in public hospitals. In para. 37.24, the report states that the HSE had assumed initially that maintenance charges would be payable to it in respect of patients with private insurance, accommodated in designated private beds and treated by a Category A consultant. The Comptroller stated that this was an erroneous assumption having regard to the terms of the consultant contract. It appears to have been accepted, in practice, that hospitals could not make a charge in respect of patients with private insurance who were treated by such a consultant. It further appears from the report that a direction was given that patients with private insurance should be treated in private rooms by consultants other than Category A consultants. However, in para. 37.25 of the report, the Comptroller identified that, in practice, it was unduly complicated to ensure that rooms designated as private would only be occupied by patients under the care of a non-Category A consultant. A further complicating factor was identified in para. 37.26 in that the volume of private practice that a non-Category

A consultant could carry out was capped as a percentage of patient throughput. This gave rise to obvious complications in managing bed utilisations. Although the Comptroller concluded that it was difficult to quantify the financial effect of these complications, it is clear that he was of the view that the consultant arrangements were likely to have a negative impact on the potential private patient income recoverable by hospitals.

### **The 2013 Act**

**21.** The report of the Comptroller and Auditor General in respect of the 2008 year was published on 10<sup>th</sup> September, 2009. Just under four years later, the 2013 Act was enacted. The 2013 Act introduced a statutory table of charges payable for in-patient hospital care. Part 3 of the 2013 Act introduced a number of significant amendments to the 1970 Act. Section 9 amended s. 52(3). As explained further below, the amendment made by s. 9 introduced a new concept (namely waiver of the right to avail of public health services) into s. 52(3). However, in addition to introducing the concept of waiver, the amendments made by s. 9 to s. 52(3) of the 1970 Act continued to use the language contained in the earlier version of the same subsection, namely *“does not avail of... some part of those services but instead avails of like services...”*. The language of the new version of the subsection suggests that the effect of the subsection is triggered both in those circumstances and also where a patient waives his or her right to avail of in-patient services on a public basis. The amendments made by s. 9 did not come into force immediately. Section 9 was not commenced until 1<sup>st</sup> January, 2017. This is made clear by the Health (Amendment) Act 2013 (Certain Provisions) (Commencement) Order 2016 (S.I. No. 466 of 2016). As a consequence of the amendments made by s. 9 of the 2013 Act, s. 52 of the 1970 Act now reads as follows:-

*“(3) Where, in respect of in-patient services, a person with full eligibility or limited eligibility for such services does not avail of or waives his or her right to avail of, some part of those services but instead avails of like services not provided under section 52(1), then the person shall, while being maintained for the said in-patient services, be deemed not to have full eligibility or limited eligibility, as the case may be, for those in-patient services”.*

**22.** As noted above, this amendment to s. 52(3) introduced a concept which was not previously present in the sub-section – namely the concept of waiver. Counsel for Laya has also highlighted that, in contradistinction to the language used in s. 52(3) as amended by s. 5 of the 1991 Act, this new iteration of s. 52(3) expressly refers to the “*right*” to avail of public health services. Counsel submitted that this is a statutory recognition that the statutory obligation (formerly on the health boards but now on the HSE) to make services available to patients with full or partial eligibility gives rise to a correlative right of the patient to make use of such services. Counsel argued that this is relevant to the case made by Laya that any waiver of the statutory right would have to be a fully informed waiver.

**23.** In addition to the changes made by s. 9 of the 2013 Act, s. 13 introduced a new s. 55 in place of the previous version of that section. In its new form, s. 55(1)(a) empowers the HSE (subject to any regulations which might be made by the Minister) to make available in-patient services for persons who do not establish entitlement to such services under s. 52 or “*are deemed under s. 52(3) to have full eligibility or limited eligibility for such services, or to have waived their eligibility for such services*”. At first sight, this reference to waiver might be thought to relate to the language of the new version of s. 52(3) discussed above. However, as discussed

further below, counsel for Laya has argued that, in fact, s. 55(1)(a) cannot be reconciled with the provisions of s. 52(3). In place of the previous mechanism for making charges, s. 55(1)(b) makes clear that the HSE is now to make a charge in respect of in-patient services in accordance with a table of charges specified in the fourth schedule. Curiously, s. 55(3)(a) continues to empower the Minister, for the purposes of s. 55(1) to make regulations prescribing the manner in which any in-patient services provided under s. 55 are to be made available by the HSE “*including the manner in which hospital beds are to be designated...*”. Thus, contrary to the submissions made to me in the course of the hearing, this new version of s. 55 does not *per se* abolish the concept of bed designation. However, I was informed at the hearing that no such regulations have been made. Accordingly, in the case of any patient who falls within the ambit of s. 55(1)(a), the HSE is simply required to make a charge in accordance with the table of charges specified in the fourth schedule. It no longer matters what kind of bed the patient happens to occupy. There will be a charge to be paid whether or not the bed is a private or semi-private bed, on the one hand, or a public bed, on the other. This has the effect, in practice, that the difficulties encountered under the 1991 regime arising from the bed designation system previously identified in the report of the Comptroller & Auditor General should, in principle, no longer arise.

**24.** As noted above, s. 13 of the 2013 Act was commenced on 1<sup>st</sup> January, 2014. This was three years prior to the commencement of s. 9 of the 2013 Act. This meant that the new version of s. 55(1)(a) was in force (including its reference to cases where patients had waived their eligibility for in-patient services) for a period of three years notwithstanding that, during that time, the relevant version of s. 52(3) in force made no reference to a waiver by a patient. During that three-year period, s. 52(3) referred

solely to circumstances where a patient did not avail of the public services to which the patient was entitled under s. 52(1).

25. There was considerable debate at the hearing as to the proper meaning and effect of s. 55(1)(a) on the one hand, and s. 52(3) on the other. It will be necessary, in due course, to consider the arguments of the parties in greater detail. At this point, it is sufficient to note that there is a significant divergence between the parties as to the interpretation of these provisions.

#### **The Health Insurance Act 1994**

26. There was no dispute between the parties that, by virtue of the Health Insurance Act 1994 (*“the 1994 Act”*) and the Health Insurance (Minimum Benefit) Regulations made thereunder, health insurers such as Laya are required to provide a minimum level of cover to their members. This includes cover for hospital charges payable under s. 55 of the 1970 Act. However, the cover for such charges is not required to be unlimited. For example, health insurers are not required to provide cover for more than 180 days in-patient care in a calendar year.

#### **Relevant facts**

27. As noted above, the changes to s. 55 of the 1970 Act effected by s. 13 of the 2013 Act came into force on 1<sup>st</sup> January, 2014. In advance of that date, Mr. Patrick McLoughlin was appointed by the Minister for Health to carry out a review of measures to reduce costs in the private health insurance market. The participants in the review were the insurers, the Health Insurance Council and the Department of Health. The HSE was not represented. Mr. McLoughlin produced a report in November, 2013. In that report, he noted that, at that time, 2,047,020 people were insured with in-patient health insurance plans which represented 44.6% of the population. In chapter 11 of Mr. McLoughlin’s report, He recommended that the HSE

should introduce standard procedures for public hospitals to ensure that it was clear that a patient had exercised a choice as to whether the patient wished to be treated as a public or private patient. It was confirmed in the evidence of Mr. Mark Fagan, the Assistant National Director of Finance of the HSE, that, at this time, there was no standard procedure operated in public hospitals and that each hospital had its own procedure in relation to the way in which choices made by patients were recorded. Although significant differences emerged as between the HSE and health insurers as to the nature of any standard procedure that might be put in place, Mr. Fagan also confirmed, in the course of his evidence, that the HSE did not have any difficulty with the suggestion that there should be a standard procedure which would ensure that it was clear that patients had exercised a choice as to whether they wished to be treated as public or private.

**28.** In his report, Mr. McLoughlin also recommended that, on discharge, a patient should be provided with the opportunity to confirm the details of the treatment received and the names of the treating consultants. Mr. McLoughlin suggested that this would provide clarity to hospitals, consultants, insurers and patients.

**29.** Very soon after Mr. McLoughlin's report, Laya wrote to the HSE on 23<sup>rd</sup> December, 2013 suggesting that, following the introduction of new rates for private patients who occupy public hospital beds under s. 55 of the 1970 Act (as inserted by s. 13 of the 2013 Act), there was a requirement for all patients who hold health insurance cover to be fully aware of their rights when waiving entitlement to treatment as a public patient in a public hospital and that additional documentation would be required to evidence this. In this context, it should be noted that, with effect from 1<sup>st</sup> January, 2014, the daily charge for a patient treated in a bed in a multi-



occupancy room was increased from €75 (which was the pre-existing Government levy) to either €659 or €800 (depending upon the category of hospital).

**30.** At around the same time, the private health insurers collaborated to prepare a draft Private Insurance Patient form (which has since become known as the “*PIP form*”) which they proposed should be used in all public hospitals on admission and discharge of any patient who opted to be treated as a private patient. The HSE wrote very promptly to Laya (among others) highlighting that the form had not been agreed with the HSE and suggesting that the requirement for the form to be completed both on admission and discharge was unacceptable to the HSE and would lead to delays in the submission of claims. Thereafter, there were significant interactions between the HSE, the private health insurers and the umbrella organisation for the insurance industry in Ireland, namely Insurance Ireland. Those interactions continued in the period between February, 2014 and September, 2014. Although I was taken through these interactions in great detail at the hearing, I do not believe that it is necessary, for the purposes of resolving the issues to be determined in these proceedings, to analyse those interactions in any detail. It is sufficient to record that, on 3<sup>rd</sup> September, 2014, the format of the PIP form was agreed by both sides. The form has the following features:-

- (a) The form states that it is to be completed on admission. There is no requirement to complete any element of the form on discharge;
- (b) The form records that, as a result of changes introduced under the 2013 Act regarding billing by public hospitals, the patient has been requested to complete the form;
- (c) The form then continues in the following terms:-

*“By completing this form you are agreeing to receive treatment as a private patient and authorising the hospital to bill your health insurer for hospital accommodation and medical costs that are eligible for benefit in accordance with your contract of insurance. The information you provide in this form will be used to verify your insurance claim and we ask you to take time to ensure that all questions are completed correctly and in full.”*

- (d) The form then sets out the daily hospital charges that apply for private/single occupancy room, semi-private/multi-occupancy room and for daycare and states that consultant fees would arise also. This is followed by the following warning in bold print:-

**“Please be aware that if you are subject to any waiting periods/pre-existing conditions or if you do not have sufficient insurance cover you will be liable for the full cost of your hospital stay (as per the charges noted above) and treatment by a private consultant.”**

- (e) Having set out that warning, the form requires the date of admission to be given and requires the patient to agree that *“that I am waiving my entitlement to be treated as a public patient and that I wish to avail of my private health insurance cover and be treated by a private consultant for this admission”*.
- (f) The form continues by requiring the patient to agree that:-

*“I understand and agree that by signing this form I am authorising the hospital to bill my health insurer for charges*

*specified by legislation and eligible for benefit in accordance with my contract of insurance. I understand that where my insurer does not cover any or part of the charges, I will be invoiced and liable for this amount.”*

- (g) The form also contains a confirmation that the patient had requested to be treated by a private consultant during the patient’s stay in hospital and an acceptance by the patient that:-

*“the hospital may need to transfer patients to different beds, wards and hospitals and accordingly, I may be required to transfer during my stay. I understand and agree that although I have chosen to be treated privately, I may still be accommodated in a designated public bed/ward and that my insurer will be billed a daily rate payable in accordance with my contract of insurance.”*

**31.** For completeness, it should be noted that, following the introduction of this form, concerns were expressed by the Irish Hospital Consultants’ Association (“IHCA”) that the form was liable to confuse patients and that it seemed to be *“designed to deter patients from electing to be treated as private patients where they have private health insurance”*. Similar issues were reported by the HSE. Given that my task in this judgment is essentially to interpret the applicable statutory provisions, I do not believe that it is necessary to describe these complaints in any detail.

**32.** In February, 2015, the HSE proposed a number of changes to the PIP form. In an email of 11<sup>th</sup> February, 2015 to Mr. James O’Mahony of Laya, Mr. Fagan of the HSE explained that:-

*“I refer to the Private Insurance Patient Form which has now been in use for the past six months. As you know there is no legislative requirement for this form and since its introduction the Department of Health have clarified the situation regarding bed designations. During this time we have also received a lot of feedback from hospitals regarding the operation of the form and the feedback has been overwhelmingly negative in nature. It is seen as confusing, overly complex, too ‘legalistic’ in its use of language and unclear in its purpose.*

*On foot of these issues with the form we have come up with a draft version that we feel is operationally acceptable and addresses the prime purpose of ensuring the patient fully understands they are opting to be treated as a private patient (copy attached). We would welcome the opportunity to discuss the matter with you.”*

**33.** On 19<sup>th</sup> February, 2015, Insurance Ireland responded on behalf of the health insurers rejecting the suggestion that the form required to be modified. The letter stated:-

*“There is requirement for all patients who hold health insurance cover to be fully aware of their rights when waiving their entitlement to treatment as a public patient in hospital. The private health insurers are in agreement that the Private Insurance Patient Form in its current format is the best practice for providing clarity to patients who hold health insurance on their treatment options.*

*The private health insurers have not received any negative feedback from customers around the perceived complexity of the form. They are satisfied with how the form is being utilised as it aides the swift processing of claims for eligible customers in relation to charges for electing to be treated in a private capacity in public hospitals.”*

**34.** Fifteen months later, Laya wrote to the HSE and a number of other parties including the Secretary General of the Department of Health raising concerns about the manner in which the PIP form was being presented to its members. In its letter of 25<sup>th</sup> May, 2016 to the HSE, Laya, having first identified that it was then experiencing a significant increase in billing activity from public hospitals, raised the following concerns:-

*“Laya healthcare has concerns over the manner in which these forms are being presented by Patient Liaison Offices employed by the Hospital to our members, and the lack of clarity that is provided to our members re: what they are signing. When options are presented to our members these options are often being misrepresented, such as “would you like to sign the form or pay yourself”. Laya healthcare has received numerous complaints from our members who advised they were put under undue pressure to sign the form, many in difficult circumstances such as emergency departments, with others indicating that they were pursued around the hospital until they signed the form. We have also encountered instances where members elected to be treated as a public patient and subsequently received a Private Insurance Patient Form in the post requesting a signature.*

*It is very evident that the current practice is not in line with the spirit of the discussions that took place as part of the introduction of these forms, whereby the intention was that patients would be made fully aware of the content of the form and their entitlements. I would request that the HSE honor the commitment given to ensure that all Hospitals are presenting these forms to Laya Healthcare members in an appropriate manner and in the spirit of what was originally intended. As part of our claims payment process, we will be contacting our members to ensure that they were given a clear understanding of what they were signing and that the form was presented in an appropriate manner. Any discrepancies will impact on claims payment.*

*From our conversations with various Public Hospitals there seems to be systemic pressure being applied by the HSE to maximise revenue from private patients. For example; one particular Public Hospital alluded to the fact that their revenue targets were increased by 10% and this additional target has been exceeded by 100%. This focus on maximising revenue is a worrying one and is something that is impacting upon the entitlements of public patients and ultimately impacting on the rising costs of our member's premiums."*

**35.** The HSE responded on 2<sup>nd</sup> September, 2016 and stated that if there was any evidence of ongoing systemic problems, Laya should revert with appropriate evidence following which the matter would be investigated further by the HSE. Laya responded promptly on 14<sup>th</sup> September, 2016 in which it was suggested that information received from their members supported the position described in the letter of May, 2016 but no details were given. In the same letter, Laya also suggested that one of the purposes of

the PIP form was to evidence the date when patients chose to waive their right to be treated as a public patient.

36. During the course of September, 2016, the HSE became aware that, where the date of signing of the PIP form occurred after admission, Laya was only prepared to pay for the relevant accommodation charges from the date the patient signed the PIP form rather than from the date of admission. By way of example, this was brought to the attention of the HSE in an email of 29<sup>th</sup> September, 2016 from the finance manager of Our Lady's Hospital, Navan, County Meath. During the course of January, 2017, a number of letters were written by Laya to public hospitals. A sample of such a letter was provided in the course of the evidence at the hearing. In that letter, Laya made clear that it regarded itself liable only for accommodation charges which accrued from the date of execution of the PIP form. The letter stated:-

*"I am writing to you to make you aware for the period October 2014 to September 2016, Laya Healthcare has been billed and paid private per diem charges, pertaining to nights where no evidence has been received indicating that the patient had waived their rights to be treated as a public patient.*

*You will be aware that Laya Healthcare are paying the private accommodation per diem rates in accordance with the date that our member has signed the Private Patient Insurance Form (the "Waiver Form"), thereby effectively indicating their consent to waive their entitlement to avail of public treatment and consequently electing to be treated in a private capacity. We deem the date the Waiver Form was signed to be demonstration of our member's active consent to invoke the use of their health insurance*

*At this juncture we have received no other communication or indication, other than the signed Waiver Form, that our member elected to be treated privately or waived their eligibility for public treatment. If however you are in possession of any other documentation or evidence confirming that the attached listed members elected to be treated privately on the date of admission, I will be happy to review the circumstances on provision of the aforementioned evidence”*

37. Subsequently, in February, 2017, Laya wrote to a number of parties including the Minister for Health in which Laya complained about the manner in which the PIP form was being presented to patients and provided, in an appendix, a number of anonymised examples where it alleged that the patient was put under pressure. In the same month, Insurance Ireland wrote to the HSE complaining that the hospital charges imposed since the introduction of the 2013 Act “*grossly exceed the expectation set by the then Minister for Health...*”. The letter also raised concerns in relation to the manner in which patients were approached by hospitals with a view to signing the PIP form. The letter attached a number of “*guiding principles*” which it was suggested should be applied. These included a suggested requirement that patients should have their public and private treatment rights appropriately explained to them before executing the form and that charges for private treatment should not be raised until such time as the patient has given informed consent to waive the right to be treated as a public patient. In the case of elective admissions, it was suggested that the PIP form should be completed at the point of service and that, for emergency department admissions, the form should be completed within 24 hours of admission. In the course of the hearing, this 24-hour period was referred to as “*the grace period*”.



38. During the course of March, 2017, Laya wrote to hospitals indicating that it had identified a substantial number of charges during the period running from October, 2014 to September, 2016 in respect of charges previously paid by Laya in respect of accommodation for patients on days prior to the signing of the PIP form. Laya invited the hospitals to provide documentation or evidence confirming that the member had elected to be treated privately on admission and indicating its intention, in the absence of such evidence, to begin setting off any amounts previously paid by it in respect of accommodation supplied prior to execution of the form against future charges. In the course of the hearing, I was referred, by way of example, to a response received from one hospital group (responsible for a number of hospitals in the western and north-western areas of the State) in which the position taken by Laya was contested. The letter stated that the PIP form:-

*“...clearly sets out the admission date the waiver relates to, regardless of the actual date the patient signed the form.*

*Accordingly, the episodes listed are deemed to have private patient status for the full period of hospitalisation. Laya Healthcare is not sanctioned to make the deductions outlined above from any of the hospitals in the Saolta University Healthcare group.*

*At a general level, please confirm if the Consultants involved in these episodes of care have been paid professional fees payments when Laya Healthcare does not seem to accept the waiver form submitted with the claim. I am aware of claims in two hospitals within the Saolta University Healthcare Group where the professional fees were paid to Consultants but correspondence issued from*

*Laya during claim processing indicated that the waiver form was only deemed applicable to the accommodation charges and not to the payments due to Consultants. I am at a loss to establish how a patient may be private to the Consultant but not deemed by Laya to have waived their entitlement to public healthcare and be liable for the relevant hospital accommodation charges set out in legislation.”*

In this context, it should be noted, in the course of his evidence, Mr. O’Mahony of Laya acknowledged that it was Laya’s practice to pay consultants in respect of services between the date of admission and the date of execution of the PIP form. He sought to justify that practice on the basis that it was more complex to adjust consultants’ charges than the daily maintenance charges payable by hospitals. I can appreciate that such an adjustment may not always be straightforward but, as a matter of principle, it is difficult to accept that Laya has any proper basis to treat hospital charges differently from the fees of consultants and other professionals. The sample material provided to the court showed that many professional fees are identified by reference to the date of the service provided and, to the extent that some of them are not, it is difficult to understand why Laya could not agree a standard mechanism with consultants under which the specific dates of supply of services would be provided.

**39.** The approach taken by Laya in respect of charges arising prior to execution of the PIP form was contested by the HSE in a letter dated 28<sup>th</sup> April, 2017 in which confirmation was sought that Laya would cease making retrospective deductions and that arrangements would be put in place to reimburse monies previously deducted by Laya from payments made to hospitals. Laya was not, however, persuaded to change the position adopted by it. Ultimately, on 23<sup>rd</sup> October, 2018, the solicitors for the HSE wrote a detailed letter to Laya warning that, if Laya did not accept the

interpretation of s. 52(3) of the 1970 Act (as amended) set out in that letter, High Court proceedings would follow. In that letter, it was argued that, correctly construed, s. 52(3) had the effect that, once a patient elects to be treated privately, during any part of their stay in hospital, the patient is deemed not to have eligibility under the 1970 Act for any in-patient services received in respect of that stay. In such circumstances, it was argued that the patient was to be treated and billed at the statutory private in-patient rate from the date of admission.

**40.** The letter of 23<sup>rd</sup> October, 2018 also dealt with the PIP form. The solicitors argued that the language used in the PIP form clearly demonstrates that any election to be treated as a private patient related to the entire period of the patient's stay in a hospital and that it was not confined solely to the period subsequent to execution of the form. A detailed response was received from the solicitors acting on behalf of Laya on 9<sup>th</sup> November, 2018. In that letter, the solicitors for Laya rejected the case made in the letter of 23<sup>rd</sup> October, 2018 on behalf of the HSE. They also raised the following issues in relation to waiver (including a contention that any waiver would have to be a fully informed one):-

*“In practical terms, a patient admitted to a public hospital should receive services as a public patient unless and until they have waived this entitlement. It is difficult to envisage circumstances where a patient in a public hospital could be said to have availed of private in-patient services unless that patient has made an active decision or election to do so (invariably by relying on their private health insurance). A public patient may be accommodated in a bed which has been designated as a private bed as a result of a shortage of available accommodation or, for clinical reasons, but such would not affect their status as a public patient. Accordingly, the question is whether a patient*

*has waived the right to receive public in-patient services and whether that waiver has retrospective effect, so that services already received when the patient was, under the terms of the legislation, a public patient are deemed to have been received as a private patient.*

*In order for a waiver to be valid, a patient must have made an informed election not to receive public in-patient services to which they have a statutory entitlement. If it was intended that such an election or waiver would have retrospective effect rather than simply applying to those in-patient services received after the election was made, this would have been specified in the legislation. Rather, it appears that the purpose of Section 52(3) is to ensure that a patient who is initially admitted as a public patient and subsequently elects to receive part of their treatment privately cannot receive the benefit of the public accommodation rate for the remainder of their admission.*

*Should a Laya Healthcare member make an informed election not to avail of his or her entitlement to access healthcare services through the public system and to rely on his or her private cover, the charges specified in the Fourth Schedule of the Act are applicable. That said, any services received prior to such election having been made will have been received as a public patient and the public charge applies.”*

**41.** These proceedings were subsequently instituted by plenary summons issued on 22<sup>nd</sup> November, 2018 and were admitted into the Commercial Court List in December, 2018.

**The evidence**

**42.** In the course of the hearing, I heard evidence from a total of nine witnesses over the course of three and a half days. In my view, only a small part of that evidence is relevant to the legal issues which I am required to address in this case and which were debated on the remaining two and a half days of the hearing. Much of the evidence related to the origins of the dispute between the parties and as to their dealings with each other over the course of the period running from 2013 to the date of commencement of these proceedings in October, 2018. I have to say that I cannot see how the evidence in relation to such matters can be said to be relevant to the issues of statutory interpretation which arise. In the course of the cross-examination of the witnesses, each side sought to suggest that the approach taken by the other was inconsistent with a number of aspects of the statutory regime. In my view, the positions adopted historically by the parties are of no assistance in the determination of the issues before the court. As I have already highlighted, those issues relate exclusively to the interpretation of statutory provisions. The interpretation of such provisions cannot be affected by any practice or position adopted by either or both of the parties. In these circumstances, I do not propose, in this judgment, to address all of the evidence which I have heard or to make findings in relation to many of the matters that were the subject of extensive cross-examination on both sides. These matters seem to me to be wholly irrelevant. I will, therefore, confine myself to factual matters which are relevant in order to understand the context in which the statutory provisions are to be applied.

**43.** In the course of the hearing, I heard helpful evidence from Ms. Helen Byrne of the HSE and from Ms. Joanne Sheehan (the patient accounts manager at the Mercy University Hospital (“*MUH*”) in Cork) in relation to the process of admission of patients to public hospitals.

**44.** There are 48 acute hospitals in the country providing public hospital services. Patients are admitted to such hospitals principally in two ways: either by elective admission or through the emergency department of the hospital. In 2018, there were a total of 1,467,646 attendances at the emergency departments of these hospitals. Of this number, 439,443 (representing approximately 30% of the total) were admitted to hospital as in-patients. I did not hear evidence as to the number of elective admissions. In the case of such elective admissions, very little difficulty arises. It will be clear from the admissions process whether or not the patient has decided to avail of private as opposed to public services. In the case of a patient who has chosen to be treated privately, the consultant or a member of the consultant's staff will refer the patient to the bed management unit of a hospital following which an admission offer is made to the patient. Once the patient accepts this offer, the patient details will be entered on the Integrated Patient Management System ("*IPMS*") which is an electronic patient admitting system used in most acute hospitals which was initiated in 2014. The name of the treating clinician of the patient is entered in the IPMS together with the relevant specialty. Details of the patient will also be entered on the IPMS. When a bed is allocated to that patient, the specific ward in which the bed is to be made available will also be entered on the IPMS. The system also allows the patient to be designated either as a private patient or a public patient. In the case of a private patient, details of the health insurer will be entered on the system. The paper PIP form is not used in such cases. Ms. Sheehan explained that, in the case of an elective admission, the system pre-populates the PIP form electronically. The patient needs to click the relevant boxes agreeing to be admitted as private and the patient signs the form electronically. In the case of a patient who is to be treated publicly, a record will be made as to whether or not the patient holds a medical card. Where a patient is

admitted in this way, there is no issue as to their status. In either case, whether a patient is admitted as a public patient or as a private patient by way of elective admission, the decision taken by the patient is clear. Once a patient has been admitted by way of an elective admission as a private patient, the IPMS system will trigger the hospital's billing system. It will also trigger the "*Claimsure*" system (which was put in place in late 2015 or early 2016) which is an electronic claim system which hospitals use to build, as Ms. Sheehan described, the "*the claims pack*" for the relevant health insurer. The system is set up in such a way as to enable the export of data from the IPMS system to the Claimsure system. The Claimsure system is designed to replicate the claim form issued by a health insurer such as Laya. Prior to the introduction of the PIP form, the claim form was the only form that was required by health insurers. A sample of the claim form used by Laya was produced in the course of the hearing. It requires the relevant policy details to be inserted together with the personal details of the Laya member and relevant details in relation to the hospital, the medical condition of the patient, and the names of any treating doctors. The patient is required to sign the claim form. As noted above, all of the relevant information is now stored electronically and Ms. Sheehan gave evidence that, on the day after discharge of a patient, after checking all details, the claim form would be transmitted electronically to the health insurer.

**45.** In the case of an admission through the emergency department, the procedure, of necessity, is different. Some patients will have been brought to the emergency department by ambulance and will be unwell or so badly injured that it is not feasible to interview the patients prior to their admission as an in-patient. Many other patients will have arrived at the emergency department without any prior warning. Typically, such patients will come to the emergency department where their first interaction with

staff will be at the reception desk manned by clerical staff. The patient will generally be asked for a name and address and the clerical staff will check on the computer records of the hospital as to whether the patient is the holder of a medical card or whether the patient has previously been recorded as having private health insurance. If the patient has previously been treated in the hospital (or in another hospital that uses the same system), the patient details will already be on the system. However, Ms. Sheehan made clear that the details would have to be confirmed again. In the case of some patients, the medical card previously held by them might no longer be valid. In the case of a patient previously recorded as having private health insurance, there may have been a change of insurer or the patient may have decided to terminate the relevant insurance cover. Once this initial interaction with the clerical staff takes place, the patient is asked to wait in a waiting area where a triage nurse will review the patient who will subsequently be seen by the medical team in the treatment area. At that point, a decision will be made as to whether or not the patient should be admitted to hospital. If a decision is made that the patient requires to be admitted as an in-patient, the reception desk will be informed that the patient requires a bed. Regrettably, the wait for a bed may take some time. Once it becomes apparent that a bed has become available (or will imminently become available), clerical staff will meet the patient again. If the patient holds private medical insurance, the procedure which should be adopted is as follows: the patient will be asked by the clerical staff to confirm whether or not he or she is happy to use that insurance and whether or not the patient would prefer to be admitted as a public or as a private patient. If the patient wishes to be admitted as a private patient, two forms will need to be completed, namely the PIP form and the claim form. The claim form is produced by the health insurer. It is designed to record the membership number of the patient, the date of



birth, address and telephone number of the patient and also contains a question asking: “*Did you elect to be a private patient of the Consultant? (Please place “X” in the required box)*”. This is followed boxes where a “X” can be entered to signify either “Yes” or “No”. The form also requires the name of the hospital to be entered and the date of admission.

**46.** According to the evidence of Ms. Sheehan, some patients will sign the forms there and then. Others may wish to think about it and may wish to make contact with their health insurer. There is often a period of time in the admissions process, after the PIP form and claim form is presented to the patient, before the bed actually becomes available. Once the patient has made a choice as to whether to be admitted as a public or private patient, the relevant category chosen will be entered on the IPMS system. Ms. Sheehan gave evidence that, where the patient opts to be treated privately, the patient will be seen directly by the consultant rather than by the consultant’s team.

**47.** Ms. Sheehan explained that there are circumstances where the relevant PIP form and claim form are not executed before a patient is admitted as an in-patient through the emergency department. Ms. Sheehan explained that there are circumstances where the patient is simply too ill at the point of admission to consider signing any forms. In addition, there are occasions where clerical staff are simply not available at the moment of admission to ensure that the forms are completed. This may arise at particularly busy periods. It also appears that there are periods where there are simply no clerical staff on duty in some emergency departments. There may also be occasions where the patient needs more time to make up his or her mind. In such circumstances, the responsibility to deal with the patient will pass to the ward clerk or other patient liaison staff of the hospital who will approach the patient in the relevant ward. Ms. Byrne explained that, in the case of “*Model 4 hospitals*”, patient

services staff are available 24 hours a day, seven days a week. Model 4 hospitals are those providing highly specialised medical care such as University Hospital Limerick or the Mater Misericordiae University Hospital in Dublin. In the meantime, if the patient has indicated at the outset that they have private health insurance and has verbally agreed to be treated as a private in-patient, the patient may be recorded on the IPMS system as a private patient even though, at that point, the relevant PIP form has not been executed. If the patient subsequently decides not to execute the PIP form and, instead, decides to be treated as a public in-patient, the IPMS system will be amended to record the patient as a public patient. There can, however, be some anomalies in that, in the intervening period, the consultant treating the patient may have understood that the patient was a private patient rather than a public patient. Ms. Sheehan explained that this could happen where a patient is admitted on a Friday evening and the relevant clerical personnel are not available until the following Monday morning to interview the patient and to ascertain whether or not the patient wishes to be treated as a private patient and, if so, whether the patient is prepared to execute the PIP form.

**48.** There is no facility in the IPMS system to record a patient as, for example, “*undecided*” in the circumstances described in para. 47 above during the period between admission as an in-patient and any subsequent discussion with patient liaison staff. There was some controversy at the hearing as to whether the system had an inbuilt default that, in the period between admission as an in-patient and the subsequent discussion with patient liaison staff, the patient would be recorded as a private patient purely on the basis that the patient had private health insurance. However, I do not believe the evidence goes so far as to suggest that this is so. While Mr. Woods of the HSE had given the impression in para. 6.2 of his witness statement

that “*by dint of holding health insurance it should follow that the person is electing to use the insurance for their entire episode of care even if the person for whatever reason is not able to confirm so at the point of admission*”, he later clarified in his oral evidence that he had not intended to suggest that the holding of health insurance should be regarded as an implied waiver of the right to be treated as a public patient.

**49.** That said, the evidence I heard was necessarily limited. While Ms. Byrne of the HSE purported to give evidence of the approach taken nationally, the only evidence I have of interactions between hospitals and patients is that of Ms. Sheehan and of the two witnesses described in paras. 51 to 54 below. Ms. Byrne explained that the proportion of PIP forms that are not signed on admission and require additional follow-up by clerical staff varies depending on the activity profile of the hospital and on the availability of the necessary staff. Ms. Byrne estimated that, taking the example of 2018 admissions, there are, on average, approximately 23,000 PIP forms per annum where the signing and admission dates differ. Not all of these forms relate to patients insured by Laya. Mr. James O’Mahony of Laya gave evidence that, in the period between 2014 and 2019 (inclusive), Laya “*adjusted*” 5,630 claims. As I understand it, this adjustment is made in those cases where there was a gap of more than 24 hours between the date of admission and the date of signing by the patient of the relevant PIP form. Mr. O’Mahony confirmed, in the course of his evidence, that, in calculating those figures, Laya had applied the “*grace period*” of 24 hours described in para. 37 above. Of the total figure of 5,630 claims adjusted in this way by Laya, 584 claims related to the 2014 year, 2,031 related to the 2015 year, 2,244 related to 2016, 524 to 2017, 157 to 2018 and 90 to 2019.

**50.** Ms. Byrne also gave evidence as to the nature of the interaction that should take place between patients and hospital staff members when a person holding health

insurance is admitted as an in-patient through the emergency department of a hospital. According to Ms. Byrne, it is part of the “*standard procedure*” that hospital staff are advised:-

- (a) to always give the patient or, where appropriate, the next-of-kin of the patient, time to read and review the forms;
- (b) to provide hospital booklets or documents setting out frequently asked questions (“*FAQs*”); and
- (c) not to advise patients on specific insurance cover related matters but to direct patients to their insurance provider to answer any such question.

**51.** However, under cross-examination, Ms. Byrne acknowledged that she could not say with any certainty that this procedure is followed in all cases. Moreover, I heard evidence both from a patient and from the daughter of a patient who complained about the nature of the interactions which took place during the course of admission as an in-patient from an emergency department. In the case of the first of those witnesses, she described the manner in which a member of staff of the hospital approached her while she was in the emergency department awaiting admission to hospital as an in-patient. She said:-

*“Well, what happened was, it was pretty uncomfortable, because at that point I had been told to stay lying on my back and not move. So, the girl had a number of sheets of paper in her hand, there were two or three of them and they were stapled together, and I was conscious of the advice from Laya that -- in relation to the public/private treatment fees, that there could be an issue here, so I asked her to give me the papers. Now, she pointed at a part of it and she said: ‘Just sign there if you want to be treated as a private patient’. And I said: ‘I’d prefer to read the documents’. So, she gave them to me, and I*

*was working my way through them when she again said to me, you know: 'You can just sign here'. So, I said: 'No, I really want to read this'. And she said something on the lines of: 'I can't understand why anyone would be a private patient in Letterkenny because it's only a public hospital'. So, I read my way through them, and it was on the third page of the ... documents that I realised that what I was being asked to do was to actually waive my right as a public patient, so I said I wasn't willing to do that, and that was it, basically."*

**52.** The witness explained that she asked the staff member would she get a private room and was told that she would not and, in those circumstances, she was not prepared to waive her entitlement as a public patient. Her evidence was that, notwithstanding that she so indicated, the staff member continued to attempt to persuade her to waive her right to be treated as a public patient. She said:-

*"Well, that was while I was attempting to read the thing. Now, I was particularly slow because I was in a very uncomfortable position and I was struggling with the papers in one hand, trying to turn them in the other and trying to read them, and she, on a number of times while I was at it, she kept pointing me towards the place where she wanted my signature, and said you know: 'If you just sign there'."*

**53.** This witness also complained that, while in the course of being discharged from hospital, the consultant who treated her berated her for not agreeing to be treated as a private patient and complained that Laya had no problem at all paying a consultant in a private clinic €13,000 for such a procedure.

**54.** A public health nurse also gave evidence about the interactions she had with a staff member at the time of admission of her 82-year old mother as an in-patient through a hospital emergency department following a fall in her home. She described

how her mother was taken to hospital by ambulance and, after two nights in the emergency department, she was ultimately admitted as an in-patient. This witness gave evidence that, in her opinion, her mother was not capable of understanding any request to elect as between private or public in-patient care. The witness gave evidence that, at no point, was she approached by any staff member regarding the choice of being treated as a public or as a private patient. Nonetheless, the witness's mother subsequently received a statement from Laya advising that the hospital had raised an invoice based on her status as a private patient. Laya provided the witness with a copy of the authorisation/waiver form submitted to it by the hospital concerned and she gave evidence that the signature on the form was not that of her mother. Under cross-examination, the witness confirmed that, subsequently, the hospital, after investigation, withdrew its claim for payment by Laya.

**55.** I am very conscious that I have only heard one side of the story insofar as the incidents described by these two witnesses are concerned. I am also conscious that elements of the evidence given by these witnesses might properly be regarded as hearsay. However, their evidence was not contested by the HSE and there is no reason to doubt its veracity. On the other hand, although Laya has maintained that there have been a significant number of similar incidents involving its members, I have no direct evidence as to how widespread such incidents might be. For present purposes, I believe it is sufficient to acknowledge that, from time to time, there are likely to be incidents of this kind where, either through pressure of work or failure to follow appropriate procedures, staff members do not follow the course suggested by Ms. Byrne (as summarised in para. 50 above).

**56.** It should also be borne in mind that, as Ms. Byrne has stated, hospital information booklets (containing relevant information to assist the patient) should also

be available in most hospital emergency departments. That said, the booklet specifically cited by Ms. Byrne from Portiuncula Hospital is not particularly helpful to a patient. It does not describe the reality that, as Ms. Sheehan made clear in her evidence, a patient opting to be treated as a private in-patient, is unlikely to be accommodated in a private or semi-private room. The information booklet in question appears to date from a time when a private in-patient was likely to be accommodated in a private or semi-private bed in a public hospital. The relevant text of the booklet states:-

*“Hospital Fees*

*If you are the holder of a current Medical Card, it is important that you bring the Card with you to the hospital – the number alone will not suffice.*

*If you are a member of the VHI or BUPA, you will be asked to provide the Subscribers Name and Membership Number on admission. As a service to you, the hospital has a direct payment arrangement, which enables your claim to be settled between the hospital and your Insurance provider.*

***IF YOU CHOOSE TO BE A PUBLIC IN-PATIENT:***

- *You will be required to avail of a public bed*
- *You are not a private patient of any Consultant and you do not pay Consultant fees.*

***IF YOU CHOOSE TO BE A PRIVATE IN-PATIENT:***

- *You will be required to avail of a private or semi-private bed.*

- *You are the private patient of your own Consultant and also of the other consultants involved in your care (e.g. radiologist, pathologist, anaesthetists etc.) and are liable for all consultants' fees and accommodation."*

57. It is true that, on the next page, the patient is told that a private or semi-private bed might not be available but the booklet does not explain that patients have a right to be treated as a public patient where they are admitted to a public bed. The booklet simply states:-

*"HOSPITAL FEES FOR BOTH PUBLIC AND PRIVATE PATIENTS ARE DISPLAYED IN THE ADMISSIONS DEPARTMENT*

*Every effort will be made to meet your accommodation preference depending upon occupancy rates at the time of admission.*

*If, in emergency, you must be admitted immediately to hospital, you will be accommodated in whatever bed is available. For example, if you are a private patient and a private / semi-private bed is not available, you will be admitted to a public bed until a private / semi-private bed becomes available.*

*If you are a public patient and admitted to a private bed, you will be requested to move to a public bed once it becomes available. Failure to comply with this request will result in you being charged for the private bed."*

58. A further source of information about the options available is Laya itself. Laya has been assiduous in advising its members about the issue. In one of the member information booklets published by Laya (which was placed before the court during the hearing), the issue is addressed in considerable detail. This document explains that the



Laya website contains information about *“everything that gets wrapped up in the cost of health insurance”* and continues as follows:-

*“One such issue is public hospital bed charges, first introduced in 2014, which involves a fundamental change in the way public hospitals charge private health insurers. Previously, health insurers were charged up to 10 times the overnight accommodation rate if their member was accommodated in a semi-private or private room. Now, all privately insured patients are being asked to sign a Public Hospital Waiver Form when admitted to hospital via A&E, effectively waiving their right to be treated publicly and in so doing agreeing to be charged up to €813 a night, that’s 10 times the cost, regardless of whether they secure a semi-private or private bed or not.*

*Sounds unfair, right? For many it can be. The most important thing is to know your rights as a private patient when being admitted to a public hospital and to ask one key question before signing the waiver form: “what additional services and benefits will I receive if I sign and waive my right to be treated publicly?””*

**59.** In the same document, Laya members are informed that:-

*“Every Irish citizen is entitled to be treated in our public hospitals as a public patient at a maximum charge of €80 per night (up to a maximum charge of €800 in any 12-month period), a cost that will be fully covered by your health insurance.*

*Since 2014 however, privately insured patients have to pay to use the public healthcare system, often whether or not they are given private facilities or get*

*a choice of consultant. An unfair situation when you think that, just like everyone else, they have already contributed to public healthcare through their taxes, PRSI and the Universal Social Charge.*

*Private patients being admitted through a public A&E will be asked to sign a Private Patient Insurance Form (waiver form) that allows the hospital admit them as a private patient rather than a public patient, but with potentially no additional services or benefits. Signing this waiver means that the private patient's insurer pays up to €813 for each night of their stay in hospital instead of €80. That's over 10 times the cost.*

*It's important that you understand your rights as a private patient, if you're being asked to choose to be treated as a private patient, you should ask what additional services and benefits you'll receive if you waive your rights to be treated publicly. Ask this question to ensure you're making an informed decision before you sign."*

### **The arguments of the parties**

**60.** I heard argument on behalf of the HSE and Laya and also on behalf of Irish Life Health DAC ("*Irish Life*") as notice party. On 1<sup>st</sup> April, 2019, Haughton J. made an order joining Irish Life as a notice party to the proceedings. Irish Life was joined in circumstances where the court's determination as to the correct interpretation of s. 52(3) of the 1970 Act (as amended) will have an impact on the health insurance industry as a whole. Below, I seek to summarise, in broad outline, the arguments of each of the three parties.

### **The case made by the HSE**

**61.** According to counsel for the HSE, the first and most fundamental issue to be determined in these proceedings is the question of when statutory charges properly arise and when they are required to be paid. Counsel suggested that the first issue can be broadly defined as follows:-

*“Where a patient expresses a decision to be treated privately on admission to hospital, which decision is recorded by the hospital, and the patient goes on to receive treatment as a private patient, are they liable to pay the private statutory charges pursuant to section 55?”*

**62.** The HSE submits that, once a decision is made by a patient to take the benefit of or make use of private services at a public hospital, the patient has a liability to pay the charges prescribed by s. 55(1)(b) of the 1970 Act (as amended). Counsel submitted that a decision to take the benefit of such services was sufficient to come within the language of s. 52(3) and that, by doing so, the patient was availing of private services. Counsel submitted that the alternative concept of waiver introduced by the 2013 Act should not be viewed as a limitation on the possibility of charging but as an expansion of the circumstances in which a charge could be imposed. Counsel also drew attention to the evidence of Ms. Sheehan which identified the advantages to a patient who decides to avail of private services including direct access to the consultant (rather than his or her team) and the possibility (albeit no more than that) that the patient may be allocated a private or semi-private bed. In addition, on discharge, a private patient would have more rapid access to continuing out-patient care at the consultant’s private clinic than would be the case if the patient was treated publicly at a hospital out-patients’ department (although Laya made the point that there was nothing to stop a patient who had been treated as a public in-patient from switching to private status for the purposes of follow up out-patient services).

**63.** Once a patient has decided to avail to be treated as a private in-patient, counsel submitted that s. 52(3), when properly interpreted, operates in respect of the entirety of the in-patient services provided even those that were provided prior to the date of the decision. It was argued that, accordingly, if a person elects to receive private in-patient services at any point during an “*episode of care*”, then the HSE is obliged, in accordance with the charging provisions contained in s. 55(1)(b) to make a charge for the full in-patient services on a private basis for the entire “*episode*”. It was argued that the use of the phrase “*while being maintained for the said in-patient services*” in s. 52(3) makes clear that the section is referring to the full period during which the services were provided. In this context, counsel submitted that the language used in s. 52(3) replicates the language used in the definition of in-patient services in s. 51 of the 1970 Act where such services are defined as meaning “*institutional services provided for persons while being maintained in a hospital*”. Counsel submitted that this makes clear that in-patient services refers to the full period during which services are provided from the point of admission as an in-patient to the point of discharge from the hospital. On the basis of its case that the period of in-patient care is “*unitary*”, it was argued on behalf of the HSE that, accordingly, the same patient cannot be both a public and private patient during the same episode of care. Thus, it does not make any difference whether the decision to be treated as a private patient (or the record of that decision) is not made until a date subsequent to the date of admission. Once the patient, during an episode of care, elects to be treated as a private patient, the case made by the HSE was that the patient becomes liable for payment of charges as a private patient for the entire episode.

**64.** Counsel for the HSE rejected any suggestion that the interpretation placed by the HSE on s. 52(3) was undermined by the reference in the subsection to the patient

not availing of or waiving the right to avail of “*some part of those services*” (emphasis added). Counsel argued that the closing words of s. 52(3) are key insofar as they refer to a person “*while being maintained for the said-in-patient services*” being deemed not to have eligibility for such services. Counsel argued that the words “*in-patient services*” must be construed as referring back to the same phrase in the opening words of the subsection which is a defined term. As noted above, counsel argued that this definition envisages one episode of care and counsel submitted that, consistent with the principles which emerge from the judgment of Henchy J. in *State (McGroddy) v. Carr* [1975] I.R. 275, the phrase “*in-patient services*” should be given the same meaning wherever that phrase is used in s. 52(3).

**65.** The “*episode of care*” argument is therefore a further issue relating to the interpretation of s. 52(3) which requires to be addressed in this judgment. A further related issue arises in relation to the date of execution of the PIP form. Counsel for the HSE argued that Laya is wholly mistaken in its contention that the date of execution triggers prospectively (but not retrospectively) the imposition of a charge. Counsel for the HSE argued that there is nothing in the language of s. 52(3) which supports such a contention. Counsel submitted that, moreover, s. 52(3) is concerned with establishing eligibility and that it is s. 55 which imposes the charge. Counsel for the HSE emphasised that the 2013 Act abolished the “*restrictive regime of bed designation*” introduced by the 1991 Regulations made under the 1991 Act and that it introduced a more flexible capacity to levy charges for private patients who wish to be treated privately. While counsel argued that ss. 52 and 55 of the 1970 Act (as amended by the 2013 Act) were clear in their terms, she also submitted that, if the court took the view that the provisions were unclear or ambiguous, the court is entitled to take a purposive

approach and to have regard to the factors that prompted the changes introduced by the 2013 Act.

66. In addition, counsel for the HSE argued that there is nothing in the language of s. 52(3) which requires the execution of the PIP form. A related issue arises insofar as Laya has contended that, to be valid, a waiver under s. 52(3) must be a fully informed waiver made only after a patient is fully aware of the right to be treated as a public patient. Counsel for the HSE characterised this submission as seeking to impose a precondition into s. 52(3) which is nowhere imposed by the language of the subsection. Furthermore, it was argued on behalf of the HSE that this contention on the part of Laya fails to have regard to the fact that the waiver limb of s. 52(3) is only one of two elements addressed in the subsection and that the position adopted by Laya fails to take account of the “*availing*” limb of the subsection.

#### **The case made by Laya**

67. Counsel for Laya argued that the dispute between the parties is concerned with choice, namely the exercise by patients of a statutorily conferred choice; about when they exercise that choice, how they exercise that choice and their entitlement to exercise that choice in a manner that the HSE and the hospitals may not like. Counsel submitted that, in its original iteration, the 1970 Act prescribed a very clear and straightforward litmus test as to whether a person was availing of public or private services based on whether or not the patient was accommodated in a private or semi-private room. Counsel then turned to a consideration of the 1991 Act. In doing so, counsel sought to rely upon the explanatory memorandum for the bill leading to the enactment of that Act. In the explanatory memorandum, one of the four purposes for that bill was described in the following terms:-

*“To amend the Health Act 1970 so as to provide that those persons who choose to avail of private health services forego their entitlement to public hospital services as a public patient in defined circumstances.”*

**68.** Counsel argued that it is permissible to have regard to the explanatory memorandum. Counsel also argued that the memorandum shows that the Oireachtas had in mind that, even in the case of availing of private health services, patient choice is involved.

**69.** Counsel for Laya referred to the fact that the 1991 Act was accompanied by a system of bed designation. He also drew attention to certain evidence given by Mr. Liam Woods of the HSE which suggested that the bed designation process was informed by a national policy limiting private activity in public hospitals to 20% of total activity. Mr. Woods explained that, because of this upper limit, a situation could arise where a hospital reached its capacity of designated private beds but where, nonetheless, patients chose to be treated privately and were availing of private consultant care albeit accommodated in a public bed. In that instance, the hospital could not charge for the accommodation of the private patient albeit that the consultants were paid on a private basis. Counsel also referred to a White Paper published by the Department of Health in 1999 which described the then current system as involving a requirement that patients have to make an explicit choice between private and public care at the point of delivery of hospital services. Counsel emphasised that this refers not only to the need for patients to make an explicit choice but also to the timing at which that choice is to be made, namely the point of delivery. Counsel also referred to an extract from the White Paper at p. 16 which stated that the Government recognised that a close correlation exists between the viability of a broadly-based health insurance market and the curtailment of claims costs. Counsel

submitted that the Government was clearly seeking to strike a balance between trying to increase revenue from private patients, on the one hand, and driving up the cost of private health insurance, on the other.

**70.** Before turning to the provisions of the 2013 Act, counsel for Laya also referred to certain extracts from the report of the Comptroller & Auditor General (to which I have already referred). Counsel then moved on to a consideration of the 2013 Act itself. In the first place, he highlighted that s. 52(3) as amended by s. 9 of the 2013 Act makes explicit that the ability of a person with full or limited eligibility to avail of public in-patient services is characterised as a “*right*”. Counsel stressed that this is important in the context of the submission (summarised in more detail below) that there must be an informed choice by the patient before there can be any valid waiver of the right to be treated as a public patient. Counsel also referred to the marginal note which makes no reference to availing but makes explicit reference to the concept of waivers. Counsel argued that, by reference to s. 7(1) and s. 18(g) of the Interpretation Act, 2005 (“*the 2005 Act*”), marginal notes are admissible as an aid to construction. In this case, the marginal note states:-

*“Inpatient services for persons not entitled or who have waived entitlement to services under section 52.”*

**71.** Counsel for Laya also highlighted three matters which he stressed need to be borne in mind in the context of the amendments to the 1970 Act made by the 2013 Act:-

- (a) In the first place, he drew attention to the fact that, while the new version of s. 55 commenced as of 1<sup>st</sup> January, 2014, the amendments made to s. 52(3) were not commenced until 1<sup>st</sup> January, 2017. Counsel emphasised that, in the intervening period, the concept of waiver was



nonetheless part of the operation of s. 55 given that s. 55(1)(a)(ii) explicitly refers to circumstances where persons in receipt of in-patient hospital services “*are deemed under section 52(3) not to have ... eligibility for such services, or to have waived their eligibility for such services*”. In those circumstances, counsel submitted that effect had to be given to the language of waiver in s. 55(1)(a)(ii) in the three-year period in question and he strongly rebutted the suggestion made by the HSE that the health insurers were “*premature*” in seeking to introduce the PIP form in the course of 2014.

- (b) Secondly, counsel argued that there is a significant inconsistency between s. 52(3), as amended by the 2013 Act, and s. 55(1)(a)(ii). Read on its own, s. 52(3) (as amended by the 2013 Act) would suggest that two categories of person are deemed under the sub-s. not to have eligibility for public in-patient services, namely those who avail of private services and those who have waived their right to be treated as a public in-patient. However, for reasons which are addressed in more detail at a later point in this judgment, he argued that s. 55(1)(a)(ii) (as inserted by the 2013 Act) appears to proceed on the basis that the deeming provision applies only to a person who avails of private in-patient services (i.e. the first limb of s. 52(3)) but not to those who “*have waived their eligibility*”. Insofar as relevant, s. 55(1)(a) provides that the HSE may, subject to any regulations made by the Minister under s. 55(3) make available in-patient services for persons who:-

“(i) *do not establish entitlement to such services under section 52, or*

(ii) *are deemed under section 52(3) not to have full eligibility or limited eligibility for such services, or to have waived their eligibility for such services”*

(emphasis added)

Counsel for Laya stressed that the language and syntax used in the sub-s. seems to treat waiver as not falling within the class of cases which are deemed under s. 52(3) not to have eligibility. Counsel characterised this as being very obviously inconsistent with s. 52(3) and he submitted, on that basis, that it would be a basis for the court to take the view that it is not possible to simply give a: *“straightforward plain vanilla literal interpretation to these provisions. I think the court is effectively compelled to approach them on the basis of a purposive construction to try and get these two sections to sit properly together.”*

(c) Thirdly, counsel for Laya submitted that, in circumstances where s. 55 is a charging provision, it is subject to strict construction in accordance with the principles which apply, for example, in the case of taxation statutes. Counsel also argued that, in circumstances where s. 55 is the relevant charging provision, the court should commence any consideration of the issues by addressing the proper interpretation of s. 55.

**72.** It was submitted by counsel for Laya that the effect of the language used in s. 55(1) clearly demonstrates that services can only be made available and be the subject of a charge where there has been either a deemed lack of eligibility or a waiver of eligibility. Counsel drew attention, in this context, to the opening words of s. 55(1)(a) which provides that the *“HSE may... make available in-patient services for persons*

*who... are deemed under section 52(3) not to have... eligibility... for such services, or to have waived their eligibility for such services*". Counsel submitted that the "*clear use*" of the past tense means that the services can only be made available from the point of the waiver. I believe counsel had in mind in this context the use of the words "*to have waived*". Technically, I believe the tense used in this s. 55(1)(a) is not simple past tense but is, in fact, the perfect infinitive which I understand can be used to refer to something which has happened in the past. In substance, the argument advanced by counsel for Laya appears to be that the words "*to have waived*" refer to a waiver which has occurred prior to the making available of services by the HSE.

**73.** With regard to the interpretation of s. 52(3), counsel for Laya submitted that the reference to "*said in-patient services*" in the sub-s. plainly refers back to the words "*like services not provided*". In turn, the reference in the concluding words of the sub-s. to "*those in-patient services*" likewise refers back to the words "*like services not provided*" which is, he argued, very clearly, a reference back to the services being provided on a private basis. Counsel argued that the words did not refer back to the services which were not availed of.

**74.** With regard to the argument made by the HSE that the election or waiver can be made at any time, counsel for Laya argued that the words "*while being maintained for the said in-patient services*" did not have the effect suggested by counsel for the HSE. Counsel highlighted that this phrase is not used anywhere in s. 55 which is the relevant charging provision. Counsel for Laya sought to illustrate this by reference to the hypothetical patient who is told, immediately before admission, that there are no private rooms and who decides, in those circumstances, that he or she wishes to be admitted as a public patient. A few days later, while still in hospital, the patient is told by staff that a private room has now become available and the patient, at that point,

decides to be treated as a private patient. On the construction proposed by the HSE, the hospital would be entitled, in those circumstances, to retrospectively charge for the public services provided up to the point where the patient is changed to a private room even though the patient had expressly been admitted as a public patient and had made a conscious choice to be treated as such up to the point that the private room became available.

**75.** Counsel for Laya further submitted that the concept of a single episode of care is nowhere to be found in the 1970 Act (as amended). Furthermore, counsel drew attention to the fact that the maintenance charges are imposed on a daily basis such that, if the status of a patient changes from day to day, then the charge can readily be levied or not levied depending on the status of the patient on any particular day.

**76.** It was suggested by counsel for Laya that the reason why the Oireachtas decided to introduce the concept of waiver in 2013 was to address the difficulty that could arise in deciding, for the purpose of the 80/20 split between public and private work, whether a Type B consultant was treating a patient as private or public. However, in my view, this submission is speculative. There is no sufficient basis to form the view that this was the object of the Oireachtas in introducing the concept of waiver. There is nothing in the terms of the 1970 Act (as amended by the 2013 Act) or in any admissible aid to its construction that would allow such a conclusion to be reached. For that reason, I do not propose to address this element of counsel's submissions in this judgment.

**77.** Counsel for Laya also submitted that the HSE had "*vacillated*" on the issue as to whether the concept of "*availing*" in s. 52(3) required the exercise of choice or, instead, was satisfied on the basis of the mere fact that a patient received private treatment at a public hospital. I do not believe that it is necessary to spend time on this

issue. It was made clear by counsel for the HSE that the HSE accepts that the concept of “*availing*” involves the exercise of a choice by the patient. In this context, the real issue between the parties with regard to the interpretation of s. 52(3) relates to whether hospitals have an obligation to ensure that any decision by a patient to avail of private services or to waive the entitlement to be treated as a public patient requires what counsel for Laya characterised as “*informed consent*”. In making his argument, counsel for Laya drew attention to the provisions of the National Healthcare Charter published by the HSE in which, in the context of the principle of participation, patients are told that they will be involved “*in making informed decisions about treatment and care to the degree and extent that you choose*”. Counsel submitted that this is a fundamental principle in terms of the delivery of healthcare services. While counsel accepted that such a document cannot be used as an aid to the interpretation of the provisions in issue, he submitted that it does establish that it is a norm, in the provision of health services, that patients are given choices.

**78.** Counsel for Laya also submitted that, if the court is weighing up two competing interpretations of ss. 52(3) and 55, the court should lean in favour of the interpretation which involves and preserves patient choice. Counsel argued that it is intrinsically unlikely that the Oireachtas would have intended that the legislation would bring about a situation where a person could be deprived of a statutory entitlement to public healthcare and could be forced to be treated privately, without that person having made an informed choice in that regard.

**79.** Counsel drew attention to the way in which the concept of waiver by election (in a contractual context) is addressed by Wilken & Ghaly “*The Law of Waiver, Variation and Estoppel*” (3<sup>rd</sup> Ed., 2012) and he highlighted the analysis of the concept of waiver by election in the opinion of Lord Goff in *Motor Oil Hellas v. Shipping*

*Corporation of India* [1990] 1 Lloyd's Rep. 391 which is cited by the authors. In that case, Lord Goff said at pp. 397-398:-

*“Waiver may refer to forbearance from exercising a right or to an abandonment of right. Here we are concerned with waiver in the sense of abandonment of a right, which arises by virtue of the party making the election. Election itself is a concept which may be relevant in more than one context. In the present case we are concerned with an election which may arise in the context of a binding contract, when the state of affairs comes into existence in which one party becomes entitled either under the terms of contract or by the general law to exercise a right and he has to decide whether or not to do so. His decision being a matter of choice for him is called in law an election. Characteristically the effect of the new situation is that a party becomes entitled to determine or to rescind the contract or to reject an uncontractual tender of performance; but, in theory, at least a less drastic course of action may become available to him under the terms of the contract. In all cases he has in the end to make his election not as a matter of obligation but in the sense that if he does not do so the time may come when the law takes the decision out of his hands, either by holding him to have elected not to have exercised the right which has become available to him or sometimes by holding him to have elected to exercise it, in particular, where, with knowledge of the relevant facts a party has acted in a manner which is consistent only with his having chosen one of the two alternative and inconsistent courses of action then open to him, for example to determine a contract or alternatively to affirm it, he is held to have made his election accordingly. It can be communicated to the other party by words or conduct,*

*though perhaps because a party who elects not to exercise a right which has become available to him is abandoning that right he will only be held to have done so if he so communicated his election to the other party in clear and unequivocal terms.”*

**80.** Counsel emphasised that knowledge of the relevant facts is an essential element of an election of this kind. Counsel cited in this context the view expressed by Wilken & Ghaly at p. 41:-

*“Lord Goff made one additional point. He stressed that a waiver by election could only properly exist where X at least had knowledge of the facts giving rise to its choice. It follows that two elements must be present for there to be a waiver by election. An unequivocal representation by X in relation to the right allegedly being waived and at least knowledge by X of the facts to show that it has to choose between the two inconsistent courses of conduct.”*

**81.** Counsel also referred to a number of further authorities in other areas of law. Counsel frankly accepted that many of these authorities are distinguishable either on the facts or by reference to the subject matter but he suggested that a common theme nonetheless emerges from the authorities – namely that, for an election or a waiver to be valid and legally effective, it has to be both voluntary and fully informed. In support of this contention, counsel referred, for example, to Article 9 of Directive 2013/48/EU on the right of access to a lawyer in criminal proceedings. Article 9 deals with the right to a lawyer in criminal proceedings while Article 10 deals with the right to a lawyer in European Arrest Warrant proceedings. Article 9(1) deals with the requirements for a valid waiver of those rights. It provides as follows:-

*“...Member States shall ensure that, in relation to any waiver of a right referred to in Articles 3 and 10:*

- (a) *the suspect or accused person has been provided, orally or in writing, with clear and sufficient information in simple and understandable language about the content of the right concerned and the possible consequences of waiving it; and*
- (b) *the waiver is given voluntarily and unequivocally.”*

**82.** While the right of access to a lawyer in a criminal context may seem far removed from the circumstances of this case, counsel submitted that the underlying principle is consistent with the case law discussed by Wilken & Ghaly and that it identifies what counsel described as the “*core requirements*” for a valid waiver. Counsel also referred to the observations of Finlay P. in the High Court and Walsh J. in the Supreme Court in *G v. An Bord Uchtála* [1980] I.R. 32. That case was concerned with the process of adoption of a child and the lawfulness of the surrender by the mother of a child to her constitutional right to custody of her child and to control of the child’s upbringing. Finlay P., at p. 46, observed that the court must place particular emphasis upon the safeguards created in the adoption legislation to prevent such abandonment of rights taking place “*without the full knowledge, complete understanding and mature judgment of the person concerned*”. On appeal, in the Supreme Court, Walsh J. observed that the consent of the mother must be fully informed and free and willing and he also stated that a consent motivated by fear, stress or anxiety or dictated by poverty would not constitute a valid consent.

**83.** Counsel also referred to the decision of the Court of Appeal of England & Wales in *Peyman v. Lanjani* [1985] 1 Ch 457 relating to the need for full knowledge in the context of affirmation of a contract. Counsel referred to the observation of Stephenson L.J. at p. 481 who said that:-



*“A man may have a right given him by his contract or by statute or by the common law, and a right to choose whether to enforce or waive that right.”*

Counsel argued that, by analogy, the same situation applies here where a person has a statutory right to be treated as a public patient in a public hospital. Counsel placed particular reliance on the following passage from the judgment of May L.J. in the same case at p. 494:-

*“...the doctrine of election comes into play when at a particular stage of a relationship or transaction between two parties the conduct of one is held as a matter of law to entitle the other to a choice between two mutually inconsistent courses of action...”*

*This being so, I do not think that a party to a contract can realistically or sensibly be held to have made this irrevocable choice between rescission and affirmation unless he has actual knowledge not only of the facts of the serious breach of the contract by the other party which is the pre-condition of his right to choose, but also of the fact that in the circumstances which exist he does have that right to make that choice which the law gives him...”*

**84.** Counsel submitted that it could not plausibly be suggested that there is any difference in principle between a waiver of a contractual right of the kind discussed in *Peyman v. Lanjani* and waiver of a statutory right. In addition, he highlighted that, although the circumstances in that case are quite different, the decision nonetheless affirms the principle that, for a valid election to be made as between two different courses of action open to a person, that person must have knowledge of the facts and of the existence of the right to make a choice.

85. Counsel for Laya argued that all patients who are treated in a public hospital are entitled to choose whether to be treated as a public patient or a private patient. He submitted that the default position is that a patient should be treated as a public patient unless and until that patient elects to be treated as a private patient. Counsel highlighted that it had been acknowledged by Mr. Woods, in the course of his evidence on behalf of the HSE, that the patient is “*in the first instance a public patient, pending making a choice*”. On that basis, counsel argued that, in order to exercise the choice, a patient has to be asked whether he or she wishes to be treated as a public or private patient and it cannot be assumed that the patient wishes to be treated privately even where the patient holds appropriate medical insurance. Next, counsel for Laya submitted that the choice to be treated as a private patient must be freely made and that the patient cannot be subjected to any pressure to choose to be treated as a private patient. Again, counsel highlighted that this had been acknowledged by Mr. Woods, in the course of his evidence, and also by Mr. Mark Fagan, the HSE Assistant National Director of Finance. Furthermore, as outlined above, counsel maintained that a patient can only make a valid choice where he or she has been given the information necessary to enable an informed choice to be made. Counsel stressed that the effect of a waiver has significant consequences and that the patient who opts to be treated as a private patient becomes liable to be charged the scheduled maintenance charges which are over ten times the statutory charge levied in the case of a patient who opts to be treated as a public patient. In addition to these statutory charges, the patient will also become liable to pay the fees of consultants and other professionals such as radiologists and also to pay for any tests carried out. While a patient is unlikely to be asked by a hospital whether he or she wishes to be treated privately unless they have medical insurance, counsel highlighted that there are limits

to the insurance cover available. Counsel drew attention, in this context, to the way in which, in the PIP form, a patient is informed that most insurance companies will only cover a maximum of 180 days' in-patient care for any patient in any calendar year; secondly, that there may be a waiting period before any additional benefits apply where a patient has, for example, recently upgraded the insurance; and, thirdly, there may be limitations in terms of the types of procedures to be covered. Against that backdrop, counsel submitted that, where a patient is asked whether he or she wishes to be treated as a private in-patient, the patient must be told of these potential liabilities.

**86.** It was also argued by counsel for Laya that, given the significance of the making of an election between public and private in-patient care, such an election or waiver must be documented. For that reason, the PIP form is a necessary part of the procedure. Counsel submitted that any problems encountered by hospitals in relation to the signing of a PIP form are attributable to the hospital's desire to be in a position to levy private in-patient charges and that insurers cannot be blamed for any difficulties encountered on the ground. He also argued that, if a person is too unwell when admitted into the emergency department of a hospital, any decision as to an election as between public and private care should be deferred until the patient is well enough to make an informed decision. In the intervening period, the patient should not be entered in the IPMS system as a private patient even where the patient holds private health insurance.

**87.** I asked counsel for Laya whether Laya accepts that the execution of the PIP form constitutes evidence of an appropriately informed waiver. Counsel responded to say that he could not give an unqualified answer to that question given the evidence of the witnesses described in paras. 51 to 54 above. However, counsel accepted that, if a patient receives the form and is given an adequate opportunity to review it and to ask

questions in relation to it and if, in all other respects, the form is properly used, that should ensure that a patient is in a position to make an informed choice.

**The position taken by Irish Life**

**88.** Irish Life has adopted the submissions made on behalf of Laya. Irish Life argues that there must be a conscious act of “*knowing election*” by the patient. Irish Life also submits that there is nothing in the language of s. 52(3) which envisages any retrospective effect. Irish Life maintains that s. 52(3) does not purport to deem any past in-patient service to acquire a character which it did not possess when it was actually availed of by the patient. It was emphasised that the operation of s. 52(3) is not calibrated by reference to a particular period or a single “*episode*” of care.

**89.** Irish Life also drew attention to the observations of Simons J. in *Board of Management of Malahide Community School v. Conaty* [2019] IEHC 486 where he stressed (in the context of a purported waiver of rights under the Unfair Dismissals Act, 1977) that such a waiver would have to be done on an informed basis if it was to be valid. At para. 73 of his judgment, Simons J. stated:-

“...*The principle of “informed consent” as set out in the judgements in Hurley v. Royal Yacht Club and Sunday Newspapers Ltd. v. Kinsella (discussed above) apply by analogy. A person can only be said to have waived a statutory right if they do so on an informed basis. If one assumes for the moment that... it is competent for an employee to waive their right of permanent employment by entering into a fixed term contract under section 2(2)(b), it is nevertheless necessary that that waiver be given on the basis of informed consent. There is an implicit obligation on an employer to put an employee on notice that the entering into of a particular contract will entail the loss of statutory rights previously acquired by the employee. A bald statement in the contract to the*

*effect that the Unfair Dismissals Act does not apply to dismissal consisting only of the expiry of the fixed term would not be sufficient...*”

**90.** Irish Life also submitted that a similar approach should be applied under ss. 52(3) and 55 to that which the Supreme Court recognised should be applied in the context of consent to the carrying out of medical procedures and the corresponding duty that arises to warn of risks. Irish Life referred, in this context, to the judgment of Kearns J. (as he then was) in *Fitzpatrick v. White* [2008] 2 I.R. 551 where he said at p. 560:-

*“...in Walsh v. Family Planning Services Ltd. [1992] 1 I.R. 496... O’Flaherty J. expressed a clear preference for the “reasonable patient” test as offering a better yardstick for assessing the scope of the duty to warn. The reasonable patient test is one whereby the patient has the right to know and the practitioner a duty to advise of all material risks associated with the proposed form of treatment. In the course of a judgment which I delivered in Geoghegan v. Harris [2000] 3 I.R. 536, ... I expressed my own preference for the views of O’Flaherty J in Walsh v. Family Planning Services Ltd.”*

### **The response of the HSE**

**91.** In response, counsel for the HSE characterised the position adopted by Laya as wholly inconsistent with the approach taken by it between 1991 and 2014 during which time the Laya claim form described in para. 44 above was considered to be sufficient. With regard to the issue of whether informed consent is required, counsel for the HSE submitted that it is open to the court to form a view as to whether informed consent is required in principle and, if so, whether a patient must be given all of the information currently contained in the PIP form or whether the claim form or hospital records would, in themselves, be sufficient for that purpose. However,

counsel submitted that the court should find that the hospital does not have an obligation to ensure that the patient's consent is a full and free consent. As a secondary proposition, counsel for the HSE stressed that the court is not in a position to decide whether, in any individual case, informed consent may or may not have been given.

**92.** In the context of the issue as to whether informed consent is required, counsel for the HSE submitted that the authorities cited both by Laya and Irish Life were entirely inapt and inapplicable. Insofar as the contract law principles are concerned, counsel submitted that they are not applicable to circumstances where a patient is simply making a choice in relation to the type of services available. Counsel submitted that the patient is not approaching the emergency department in a hospital within the context of a pre-existing contract. Counsel submitted that the reliance by Laya on *G v. An Bord Uchtála* was also inappropriate. What was in issue in that case related to an irrevocable decision to give up a hugely important constitutional right to custody of a child. Counsel submitted that the circumstances of a patient deciding on what type of in-patient service to engage is utterly different.

**93.** Likewise, counsel sought to dismiss the attempt by Irish Life to rely on cases dealing with consent to medical treatment. Counsel highlighted that, in such cases, the medical treatment would, in the absence of consent, constitute an assault or battery. Subject to the caveat that no analogy is perfect, counsel submitted that the position of the patient exercising a choice under s. 52(3) is not unlike that of a driver who approaches a toll booth on a motorway. Such a motorist has to pay a charge which is imposed under the Roads Acts. Counsel posed the rhetorical question as to whether the operator of the toll booth is supposed to say to such a person "*well, you know what, you don't have to go down this motorway, you can take a secondary route...*

*but, I have... to yell you, if you go this way, there is going to be a toll... whereas you could go the old road and get there for nothing”.*

**94.** It was further argued on behalf of the HSE that much of the PIP form relates to information relevant to the relationship between the insurer and the insured. Counsel submitted that, on no construction of the 1970 Act (as amended), could it be said that the HSE has a statutory obligation to convey information of that kind. Counsel also submitted that, while a person has to choose to be treated either as a public patient or as a private patient under one or other of the two limbs of s. 52(3), there is no requirement that flows from the statutory provisions to provide information. All that can be required is to ask the patient if they wish to be treated as a public patient availing of the statutory right to be so treated or to be treated as a private patient. It was argued that it cannot have been the intention of the Oireachtas that hospital staff will be required to provide all of the information currently contained in the PIP form. If that had been the intention of the Oireachtas, it would have been spelled out as an express statutory requirement. Counsel also dismissed any suggestion by Laya or Irish Life that, until such time as the PIP form is signed, a person who presents at an emergency department wishing to be treated as a private patient cannot actually be admitted as a private patient. On the contrary, counsel submitted that if a patient is “*adamant*” that he or she wishes to be admitted as a private patient using health insurance, it cannot be correct that the patient cannot be so treated (or charged) until a PIP form has been signed.

**95.** With regard to the interpretation of ss. 52(3) and 55, counsel for the HSE submitted that the interpretation placed by Laya on s. 55(1)(a)(ii) is incorrect. She submitted that para. (ii) should be understood as meaning:-

*“are deemed under section 52(3) not to have full eligibility or limited eligibility for such services or deemed to have waived their eligibility for such services.”*

Counsel submitted that this is the only way the words can be read. Otherwise, the words *“or to have”* do not make sense. Counsel argued that the comma which appears in the text of the subsection after the words *“for such services”* is an obvious error in the syntax of the subsection. Counsel submitted, accordingly, that the reference to waiver in s. 55(1)(a) refers back to the deeming provision in s. 52(3). With regard to the time lag between the date of commencement of the amendments made by the 2013 Act to s. 55 of the 1970 Act and the date of commencement of the amendments made to s. 52(3), counsel submitted that, during the intervening three year period, s. 55 was *“inoperable”* insofar as the waiver element is concerned *“because that hadn’t yet commenced due to the temporal discrepancy”*.

**96.** Counsel submitted that the court can and should apply a literal interpretation to both ss. 52 and 55 and she argued that, accordingly, the court did not have to resort to a purposive interpretation in order to reconcile the provisions with each other.

**97.** Counsel for the HSE also rejected the argument made by counsel for Laya as described in para. 74 above that a hospital could not retrospectively charge for public in-patient services provided prior to the point where a patient opts to be treated as a private patient. Counsel submitted that the right of the hospital to do so flows from the *“legislative fiction”*, namely the deeming provision. Counsel argued that this is what the Oireachtas chose to do and that *“once deemed, always deemed”*, such that the section operates retrospectively in respect of the period prior to the patient’s election. Counsel submitted that the policy considerations underlying the deeming provision are as follows:-



*“Well, the policy considerations, one can readily imagine that no hospital wishes to have a patient who can switch willy-nilly between having full eligibility or not; you can’t decide one morning that you are going to have your MRI performed privately and the next day revert to public and then the next day say you want a private room and the next day revert back to public. That can’t happen. What the Act is doing is ensuring that, for the episode of care, as we put it, there is one eligibility.”*

**98.** Counsel submitted that waiver is not the only trigger under s. 52 and that both Laya and Irish Life have failed to properly acknowledge that there are two limbs to s. 52(3). That said, counsel suggested that the addition of the waiver limb to s. 52(3) did not add very much. Counsel suggested that it may have been thought by the Oireachtas that the concept of waiver could provide additional clarity in circumstances where the services provided to a patient in a public hospital (whether admitted as a public patient or a private patient) were, following the amendments made by the 2013 Act, likely to become more similar. With regard to the suggestion made by counsel for Laya that the 2013 amendments meant that beds could no longer be treated as a litmus test, counsel for the HSE argued that beds have never been used a litmus test. It was always the patient’s election on admission to hospital that was used as a litmus test.

### **Principles of interpretation**

**99.** Before addressing the competing arguments of the parties on the interpretation of the 1970 Act (as amended), it is necessary to identify the approach which a court is required to take in relation to the interpretation of statutes. The principles to be applied in interpreting any statutory provision are well settled. The main principles were described in some detail by McKechnie J. in the Supreme Court in *Dunnes*

*Stores v. The Revenue Commissioners* [2019] IESC 50 at paras. 63 to 72 and were reaffirmed in *Bookfinders Ltd v. The Revenue Commissioners* [2020] IESC 60.

Having regard to the approach taken by the Supreme Court, the relevant principles can be summarised as follows:-

- (a) If the words of the statutory provision are plain and their meaning is self-evident, then, save for compelling reasons to be found within the Act as a whole, the ordinary, basic and natural meaning of the words should prevail;
- (b) Nonetheless, even with this approach, the meaning of the words used in the statutory provision must be seen in context. McKechnie J. (at para. 63) said that: “... *context is critical: both immediate and proximate, certainly within the Act as a whole, but in some circumstances perhaps even further than that*”;
- (c) Where the meaning is not clear but is imprecise or ambiguous, further rules of construction come into play. In such circumstances, a purposive interpretation is permissible. Section 5 of the Interpretation Act, 2005 (“*the 2005 Act*”) may also be relevant in this context. As explained further below, subject to satisfaction of the statutory conditions prescribed by the section, the court is empowered by s. 5 to construe a statutory provision to reflect the plain intention of the Oireachtas where a literary interpretation will not achieve that purpose. However, it should be noted that, in *Irish Life & Permanent plc v. Dunne* [2016] 1 I.R. 92, Clarke J. (as he then was) struck a note of caution at p. 108 to the effect that courts should not too readily conclude that a literal construction leads to absurdity;

- (d) Whatever approach is taken, each word or phrase used in the statute should be given a meaning as it is presumed that the Oireachtas did not intend to use surplusage or to use words or phrases without meaning.
- (e) In the case of taxation statutes, if there is ambiguity in a statutory provision, the word should be construed strictly so as to prevent a fresh imposition of liability from being created unfairly by the use of oblique or slack language;
- (f) Nonetheless, even in the case of a taxation statute, if a literal interpretation of the provision would lead to an absurdity (in the sense of failing to reflect what otherwise is the true intention of the legislature apparent from the Act as a whole) then a literal interpretation will be rejected.

**100.** It is clear from the decision of McKechnie J. in *Meagher v. Minister for Social Protection* [2015] 2 I.R. 633 at pp. 652-654 that the same principles apply to the interpretation of a “*deeming*” statutory provision. On that basis, the principles outlined in para. 99 above apply also to the interpretation of s. 52(3) of the 1970 Act (as amended).

**101.** In addition, it is important to keep in mind the approach taken by Henchy J. in *State (McGroddy) v. Carr* (mentioned in para. 64 above) that, in the absence of some indication to the contrary, a phrase used in a statute should be given the same meaning wherever it is found in that statute. In this context, the provisions of s. 20(1) of the 2005 Act should be kept in mind. Under s. 20(1), the definition used in a statute should be read as applicable to the entire statute except insofar as a contrary intention appears. Furthermore, under s. 20(2) where a statutory definition provides an interpretation of a word or expression, other parts of speech and grammatical forms of

the relevant word or expression will be interpreted as having a corresponding meaning.

**102.** A further aspect of the 2005 Act that should be borne in mind is s. 26(1) which makes clear that, where an enactment repeals a statutory provision and substitutes other provisions for the enactment so repealed, the repealed enactment will continue in force until the substituted provisions come into operation. This is relevant in the context of the interplay between s. 52(3) and s. 55(1) in the period between 2014 and 2017. In that period, the provisions of s.52(3) as amended by the 1991 Act continued in force until 1<sup>st</sup> January, 2017 when the amendments made by s. 9 of the 2013 Act came into operation.

**103.** I was also referred to a number of other principles of statutory interpretation such as the presumption that, in the absence of express or clear implication, legislation will not readily be interpreted as removing an existing right. However, I do not believe that this principle is relevant in the present case. Section 52(3) as amended by s. 9 of the 2013 Act does not purport to remove a right. On the contrary, the terms of the amendments made by s. 9 of the 2013 Act explicitly acknowledge the existence of a right to public in-patient services. While s. 52(3) envisages that the right to public in-patient services can be waived or not availed of, the sub-s. does not abrogate the right in any way.

**104.** As outlined in para. 67 above, I was also asked by counsel for Laya to consider the explanatory memorandum issued in respect of the bill leading to the enactment of the 1991 Act. While a number of English authorities were cited in support of a submission that the explanatory memorandum is an admissible aid, I do not believe that it has been established that it is acceptable to do so in this jurisdiction. Dodd in "*Statutory Interpretation in Ireland*", at para. 9.19, expresses considerable

doubt as to the admissibility of such material, having regard to the approach taken by the Supreme Court in *Crilly v. T&S Farrington Ltd* [2001] 3 I.R. 251. As Dodd observes at para. 9.19:-

*“Following the decision in Crilly, whether reference to explanatory memoranda is permissible is unclear. An explanatory memorandum cannot be attributed to the Oireachtas. It is not the text of an Act nor is it text in the nature of legislation, and it is not drafted by parliamentary counsel. It might be surprising if an explanatory memorandum made clear the wider purpose of an Act, where the Act itself obscured that purpose. The pre-Act law should be ascertainable elsewhere. It would appear to be anomalous to permit the use of explanatory memoranda as aiding interpretation of an enactment but to refuse to allow ministerial statements or Oireachtas debates to be admitted. If they are to be admissible, it might be argued that explanatory memoranda are more akin to textbooks or articles than Ministerial statements.”*

**105.** In my view, in light of the observations made by Dodd (which seem to me to be correct), it would be unsafe to have regard to the explanatory memorandum. I was also referred to the White Paper described in para. 60 above and to the report of the Comptroller & Auditor General described in paras. 17 to 20 above. It was submitted by counsel for the HSE that, because the latter report must be placed before Dáil Éireann under s. 3 of the Comptroller & Auditor General (Amendment) Act, 1993, the court is entitled to have regard to it for the purposes of identifying the purpose underlying the amendments made by the 2013 Act. In this context, Dodd refers, at paras. 9.20 to 9.24 to the ability of courts to have regard to reports which have led to the enactment of particular legislation such as reports of the Law Reform Commission or of the Landlord and Tenant Commission. Counsel for the HSE also referred to the

observation of Lord Diplock in *Fothergill v. Monarch Airlines Ltd* [1981] A.C. 251 at p. 281, where he said that, where legislation has been preceded by a report of some official commission or committee that has been laid before parliament and the legislation is introduced in consequence of that report, the report can be considered as an aid to identifying the “*mischief*” that the legislation was intended to remedy. In my view, this principle must be approached with caution in this jurisdiction. As Dodd explains at para. 9.24:-

*“While reports may be used, caution is required because it is the text enacted which is the pre-eminent indicator of the legislature’s intention. The legislature may in fact not follow the recommendations of a particular report.”*

**106.** In my view, it is doubtful that the White Paper could be said to have any sufficient *nexus* with the enactment of the 2013 Act which followed fourteen years after the publication of the paper. It is also open to question whether there is any sufficient *nexus* between the report of the Comptroller & Auditor General and the enactment of the 2013 Act four years later. Moreover, such a report is not of the same nature as those described in Dodd. It is reporting on matters relating to how the resources of the State are being applied and on any perceived difficulties that the Comptroller believes should be highlighted. The report is not designed to function as a precursor to legislation in the same way as a report of a committee charged with the task of reporting on legislative changes that might be necessary. That said, the report of the Comptroller & Auditor General does provide objective material which identifies problems in the application of the 1970 Act (as amended by the 1991 Act) concerning the recovery of accommodation costs in respect of in-patients being treated as the private patients of consultants in public hospitals. Those difficulties

were clearly well known at the time the Oireachtas came to enact the 2013 Act which, significantly, introduced a new charging regime for private patients in public hospitals and which, for the first time, imposed substantial charges for beds in multi-occupancy rooms. In this regard, Dodd, at para. 6.49, cites (albeit in the context of the application of a purposive interpretation) the decision of Moriarty J. in *M. v. D.* [1998] 3 I.R. 175 as an example of a case where the court, in interpreting a statute, took judicial notice of well-known facts in existence prior to its enactment. In that case, an issue arose in relation to the interpretation of the Proceeds of Crime Act 1996 and, at p. 178, Moriarty J. (without suggesting that he was applying a purposive approach) expressed the following view in relation to the court's entitlement to have regard to the background to the enactment of that Act: *"It seems to me that I am clearly entitled to take notice of the international phenomenon, far from peculiar to Ireland, that significant numbers of persons who engage as principals in lucrative professional crime, particularly that referable to the illicit supply of controlled drugs, are alert and effectively able to insulate themselves against the risk of successful criminal prosecution through deployment of intermediaries, and that the Act of 1996 is designed to enable the lower probative requirements of civil law to be utilised in appropriate cases ..."*

**107.** In any event, there was a certain measure of agreement between the HSE and Laya that the mischief at which the 2013 amendments were directed was the problem that costs were not being recovered for private patients by reason of the way in which the bed designation system operated. This is consistent with the picture painted in the report of the Comptroller & Auditor General discussed earlier. Thus, to the extent that it may become appropriate to take a purposive approach to the interpretation of the

2013 Act, it may be permissible to have regard to this mischief in seeking to interpret the relevant provisions of the 1970 Act as amended by the 2013 Act.

**108.** For completeness, it should also be noted that both sides sought to refer to extracts from Dáil debates and the HSE also sought to rely on the evidence of Mr. Liam Woods (the HSE director of acute operations) who provided a commentary on the 2013 Act (and who, in turn, quoted from the Dáil debates). In my view, having regard to the decision of the Supreme Court in *Crilly v. T & S Farrington*, that material is wholly inadmissible in seeking to construe the provisions of the 1970 Act (as amended) either by reference to their natural and ordinary meaning or, if appropriate, by reference to a purposive interpretation.

#### **The approach to be taken in construing ss. 52(3) and 55(1)**

**109.** It is clear from the approach taken by the Supreme Court in the *Dunnes Stores* case that the court should commence any consideration of the meaning to be given to a statutory provision by examining the ordinary and natural meaning of the words used in the statute. It is only where that approach does not bring clarity or leads to absurdity that the court should go further and attempt a purposive interpretation of the provisions or consider the application of s. 5 of the 2005 Act. It is also clear that, in considering the natural and ordinary meaning of a statutory provision, the court should construe the provision in the context of the statute as a whole.

#### **The statutory context**

**110.** Before turning to the language used in ss. 52(3) and 55(1) (as amended), I believe it is important to consider a number of features of the 1970 Act which are potentially of relevance in understanding the language used in the subsections in issue. As stated above, the subsections should be read in context. The immediately adjoining provisions of s. 52(1) seem to me to be important. It is clear from the



language used in s. 52(1) that the HSE is under a statutory duty to make in-patient services available to eligible persons on their admission to hospital (i.e. the services defined in s. 51 which are to be provided while a person is maintained in a hospital). Section 52(1) is expressed in mandatory terms. It provides that “*A health board shall make available in-patient services for persons with full eligibility and persons with limited eligibility*” (emphasis added). While the sub-s. refers to a “*health board*”, it is clear that this should now be construed as a reference to the HSE. The health boards were all dissolved by s. 58 of the Health Act 2004 (“*the 2004 Act*”) which established the HSE and their functions under the 1970 Act were transferred to the HSE by s. 59(1) of the 2004 Act in combination with the Third Schedule to that Act.

**111.** It must be acknowledged that not every statutory duty imposed on a body such as the HSE necessarily gives rise to a correlative statutory right. Nonetheless, it seems to me that, even prior to the commencement of s. 9 of the 2013 Act (which inserted new language in s. 52(3) which now explicitly refers to a “*right*”), s. 52(1) is likely to have been construed as conferring a right to avail of public in-patient services on persons (with either full or limited eligibility) on their admission to hospital. In this context, in so far as the principles described in *Pine Valley Developments v. Min. for the Environment* [1987] I.R. 23 and *Glencar Explorations plc v. Mayo County Council (No. 2)* [2002] 1 I.R. 84 are applicable, it seems to me that s. 52(1) is framed in terms that display a reasonably identifiable protective purpose and also an intention to benefit an identifiable class of persons namely those with full or limited eligibility. While that class is an extremely broad one, it is clear from a consideration of ss. 52(3) and 55 of the 1970 Act (whether one considers their terms before or after the amendments made by the 2013 Act) that there are other classes of the public that do not take the benefit of s. 52(1). The sub-s. would therefore appear to satisfy the *Pine*

*Valley/Glencar* test, if applicable. That said, it is also necessary to point out that nothing I say here is intended to suggest that s. 52(1) goes so far as to confer a right on those with full or partial eligibility to be admitted to a hospital for treatment. The sub-s. is concerned solely with the provision of in-patient services while a person is maintained in a hospital (and some other institutions); the sub-s does not, on the face of it, say anything about a right of admission to a public hospital.

**112.** Moreover, once the new version of s. 55 came into force on 1<sup>st</sup> January, 2014, there can be no doubt that the intention of the Oireachtas was to treat the duty imposed by s. 52(1) as creating a corresponding right to the in-patient services in question. This seems to me to be clear from the language used in s. 55(1)(a)(i) which refers to persons “*who ... do not establish an **entitlement** to ... services under section 52...*” (emphasis added). That language plainly suggests that the Oireachtas regarded the duty imposed on the HSE by s. 52(1) as giving rise to a corresponding entitlement on the part of eligible persons to avail of public in-patient services.

**113.** The fact that s. 52(1) creates a right of the kind described in paras. 110 to 112 above seems to me to be a very relevant factor particularly in light of the provisions of s. 55(1)(b) and the Fourth Schedule to the 1970 Act (as inserted by s. 15 of the 2013 Act). Section 55(1)(b) expressly requires the HSE to make a charge for in-patient services provided under s. 55(1)(a) (i.e. to those with no entitlement, those deemed under s. 52(3) not to be eligible, and those who have waived their eligibility for such services) in accordance with the table of charges set out in the Fourth Schedule. Importantly, in contrast to the position under the previous regime introduced by the 1991 Act and the 1991 Regulations, the combined effect of s. 55(1)(b) and the Fourth Schedule is that a substantial charge will now be payable even where the person in receipt of in-patient services under s. 55(1)(a) is accommodated in a multi-occupancy

room which broadly equates to what previously might have been described as a public ward. The daily charge in such circumstances will be either €813 or €659 (depending on the category of hospital). The daily charge for a bed in a single occupancy room will be more but that is not immediately relevant. The evidence established that, for entirely good reasons, single occupancy rooms in public hospitals are rarely available for private patients. What is relevant is that, from 1<sup>st</sup> January, 2014 (when the Fourth Schedule was commenced), a patient falling within s. 55(1)(a) will now pay a very substantially higher charge than a public patient notwithstanding that both are likely to be housed in precisely similar accommodation and notwithstanding that the latter will pay no more than €80 per day subject to a maximum of €800 in a 12 month period. This highlights that the right to in-patient services conferred by s. 52(1) is a valuable right and that there are potentially significant consequences for a person who decides not to avail of the statutory entitlement conferred by that sub-s.

**114.** The fact that s. 55(1)(b) (in combination with the Fourth Schedule) contains a significant charging provision is also a potentially relevant factor for another reason. As outlined in para. 99 (e) above, if there is ambiguity in a taxation provision, the words will be strictly construed so as to prevent a fresh imposition of liability from being created unfairly by the use of oblique or slack language. The 1970 Act is not a taxation statute but I believe that the logic underlying this principle is nonetheless of some relevance in the event that there is any ambiguity in the language used in the charging provisions in issue.

**The significance of the inclusion of the concept of waiver in s. 52(3)**

**115.** A further relevant feature of the 1970 Act in its current form is the new language used in s. 52(3) which is strikingly different to that used in the previous version of that sub-s. as amended by the 1991 Act. The latter version referred solely to

the concept of “*not availing*”. In so far as relevant, it provided that: “... *where, in respect of in-patient services, a person with ... eligibility for such services does not avail of some part of those services but instead avails of like services not provided under section 52(1), then the person shall, while being maintained for the said in-patient services, be deemed not to have ... eligibility ... for those in-patient services*”.

The amendments made by s. 9 of the 2013 Act (which, as previously mentioned, came into operation on 1<sup>st</sup> January, 2017) introduced a further concept of “*waiver*”. This new version of s. 52(3) now provides as follows (with the new language highlighted for convenience): “*Where, in respect of in-patient services, a person with ... eligibility for such services does not avail of, or waives his or her right to avail of, some part of those services but instead avails of like services not provided under section 52(1), then the person shall, while being maintained for the said in-patient services, be deemed not to have ...eligibility ... for those in-patient services.*”

**116.** As outlined above, there was considerable debate between the parties as to what the Oireachtas intended by adding the concept of waiver to the concept of “*not availing*”. While counsel for the HSE suggested that inclusion of the concept of waiver did not add much to the sub-s., I am of opinion that the new words cannot be dismissed as surplusage. On the contrary, it seems to me to be important that the Oireachtas chose to add the concept of waiver to s. 52(3) in the same piece of legislation that introduced the new charging regime prescribed by s. 55(1)(b). As described above, the new charging regime has the effect that a person deemed under s. 52(3) to be ineligible will end up paying substantially higher daily maintenance charges than those paid by a public patient even though both are likely to be accommodated in the same type of multi-occupancy room and even though the former, in the absence of the deeming effect of s. 52(3), is likely to have been eligible

to be treated as a public patient at a much lower cost. In my view, the addition of the concept of waiver must be seen in that context.

117. On the other hand, it is also the case that, as counsel for the HSE stressed, the Oireachtas did not abolish the concept of “*not availing*”. That concept remains in s. 52(3) as an alternative to waiver. My task is now to try to discern what the Oireachtas intended by providing for these two concepts, side by side. There was no dispute between the parties that, based on the way in which the words “*avail*” and “*avails*” are used in s. 52(3), there must, at minimum, be a conscious decision by a patient to take the benefit of private in-patient services. While the ordinary meaning of the word “*avail*” might suggest that it might be sufficient for the patient to have, as a matter of fact, made use of private treatment, I believe that the Oireachtas must have intended that the patient has done so intentionally. In this context, the Shorter Oxford English Dictionary defines “*avail*” as meaning “*make use of, obtain the benefit of, take advantage of.*” A person may make use of something either intentionally or without thought. However, in light of the consequences for the patient in terms of charging, I do not believe that one could plausibly construe the concept of availing as involving anything other than intentional use of private treatment. As noted above, counsel for Laya and Irish Life went further and submitted that, not only must there be a conscious decision by a patient, but, to be valid, the decision needs to be a fully informed one. That is an issue that I address further below.

**What does the concept of waiver add to the scheme of s. 52(3)?**

118. It is next necessary to consider what the concept of “*waiver*” adds to the concept of “*not availing*”. Having regard to the explicit insertion of the additional words into the sub-s. referring to waiver, the Oireachtas must have been intended to add something extra. In order to tease this out, I think it is useful to keep in mind that

there is a broad spectrum of possible situations that may arise when a patient, holding private health insurance, is advised in the emergency department of a hospital that admittance as an in-patient is necessary. Some patients may immediately express the wish to be treated as a private patient without any thought for the alternative. Such patients may take the view that, irrespective of the type of accommodation available, there are advantages to being admitted in that way such as, for example, that they will be treated by the consultant directly rather than by the consultant's team. Other patients may be equally keen to be treated as a private patient because, having paid their premiums for many years, they have the benefit of private insurance and do not wish to see the taxpayer foot the bill for any aspect of their care. Those patients are at one end of the spectrum. I do not think that any issue of waiver arises in their context. Of their own volition, they are making a conscious decision to be treated as a private patient and are not, in any real sense, waiving their right to be treated as a public patient. The ordinary meaning of the verb "*waive*" is to relinquish or abandon. The Shorter Oxford Dictionary confirms this. There, in so far as relevant, the verb is defined as "*abandon, give up, lay aside ... refrain from insisting on or making use of [a right, claim, opportunity etc.], relinquish ...*". Thus, the concept of waiver appears not to be relevant to patients of the kind just described. They are not consciously giving up or abandoning their entitlement to be treated as a public patient. They never had any intention or desire to be so treated; so, they have not given up anything. But, they have made a conscious decision to be treated as a private patient and, to my mind, they have thereby made a decision to avail of private in-patient services. There is very little difference (if any) between such patients and those that are admitted as private patients through the elective admission route (about which there is no controversy between the parties).

**119.** But, as one looks further along the spectrum, there are likely to be others who, having attended the emergency department of a public hospital, will assume that, if they have to be admitted as an in-patient to such a hospital, they will continue to be treated on a public basis. It may never occur to them to ask to be treated as a private patient. They may not even be aware that they can be so treated in a public hospital. They may therefore be taken by surprise when asked whether they wish to be admitted as a public or as a private patient. Once they know that they are entitled to be admitted in this way, some of them may reach a decided view that, like those described in para. 118 above, they very definitely wish to be treated as private patients. To my mind, such patients fall into the same category as those discussed in para. 118. They are not, in any real sense, giving anything up but are actively opting to be treated as private patients. In my view, they are deciding to avail of private services.

**120.** Of course, others may react quite differently. Others, on being informed of the choice available to them, may, at first, be minded to be treated as public patients and may be quite unsure that there is any benefit to them in being treated as private patients. They may only agree to be treated as private patients with some reluctance. In their case, if they ultimately decide to be treated as private patients, their decision to be so treated can more readily be described as giving up or abandoning the right to be treated as public patients. Accordingly, their decision is more naturally described as a waiver of the right to be treated as a public patient.

**121.** If one travels further still along the spectrum, there may be others who, on being told of the choice available, reach the very definite view that they wish to be admitted as public patients but who, for one reason or another, are persuaded to

change their mind. Again, in their circumstances, their decision falls more naturally into the waiver camp than the non-availing camp.

**122.** There may, also, of course, be patients who are vulnerable or so ill that they are unable to make a decision. There may also be occasions where the choice available is not adequately explained or where undue pressure is placed on a patient (the latter being something that the HSE made clear it did not condone). I will address such circumstances further below in the context of my consideration of the issue raised by Laya and Irish Life as to the need for fully informed and free consent. At this point, I confine myself to a consideration of the meaning of s. 52(3).

**123.** While I fully appreciate that the spectrum of possible patient reactions to the choice of treatment available is much wider and more diverse than that described in paras. 118 to 121 above, I nonetheless suggest that the examples posited above illustrate that there are, indeed, a range of approaches that may well be taken by patients some of which are more naturally characterised as “*availing*” and others as “*waiving*”. The reality is that the circumstances of each individual case would have to be examined in order to determine on which side of the line it falls. In light of the high level approach taken in these proceedings, I cannot put the matter any further. All I can say is that it seems to me that, in adding the concept of waiver to s. 52(3), the Oireachtas intended to cover the full spectrum of approaches that patients may take. Furthermore, as noted in para. 113 above, it is striking that the concept of waiver was expressly added at the same time as the introduction of the new charging regime under s. 55(1)(b) and the Fourth Schedule which saw the imposition of significant daily fees for patients opting to be treated privately even where they are accommodated in multi-occupancy rooms. It is clear from the evidence in this case that, ordinarily, the same accommodation is used for both public and private patients



albeit that the latter are subject to very substantially higher daily charges than the former. The Oireachtas may have thought that, in such circumstances, patients opting to be treated privately are now giving up a very valuable right such as to make the concept of waiver more relevant than before.

**Must the patient's decision to be recorded in writing?**

**124.** There is nothing in the terms of s. 52(3) which requires a patient's decision not to avail of public in-patient services or to waive the right to such services to be in any particular form or even to be recorded in writing. There is accordingly no statutory mandate for the PIP form or similar document. That said, it obviously makes sense both from the hospital's perspective and that of the patient that such a decision should be recorded by the hospital and that it should be signed by the patient or the patient's guardian or next-of-kin. Otherwise, there could be very real difficulties in proving that the patient had opted to be treated as a private in-patient. This is especially so in circumstances where the patient is likely to have been accommodated in a multi-occupancy room. Staff of the hospital would be put in a very difficult position if, in the event of a dispute, they had to try to recall their interactions with an individual in the course of a hectic day or night in an emergency department. Thus, although there is no statutory imperative to do so, it seems to me that, from the standpoint of good administration, a decision of this sort should be recorded and should be signed by the patient. That said, there is nothing, other than the terms of the agreement between the HSE and health insurers, which requires that the record of the patient's decision should contain all of the information contained in the PIP form.

**125.** I address below the issue as to whether the patient's decision must be a fully informed one. It may be necessary in that context to consider, in more detail, the content of the PIP form in so far as the form contains information in relation to the

right of the patient to be treated as a public in-patient and in so far as it addresses the consequences of waiving or not availing of that right.

**One episode of care?**

**126.** In the context of the meaning to be given to the subsection, the next issue that requires to be addressed is the submission made on behalf of the HSE that, once a patient decides not to avail of public in-patient services or waives the right to them, the patient is deemed to be a private patient for the entire “*episode of care*” irrespective of the point at which the patient makes that decision or communicates that decision to the hospital.

**127.** In order to deal with this issue in so far as it relates to statutory interpretation, it is necessary to carefully consider the language used in s. 52(3). However, in the course of preparing this judgment, I was struck that some of the issues of statutory interpretation that arise in relation to the meaning of s. 52(3) might potentially be side-lined by reference to the terms of the PIP form currently in use. On the face of it, the PIP form appears to make clear that the decision of a patient recorded therein is intended to take effect from the point of admission. In so far as relevant, the form states: “*Date of Admission: ... I ... (Please insert your name) ... agree that I am waiving my entitlement to be treated as a public patient and that I wish to avail of my private health insurance cover and be treated by a private consultant **for this admission***” (emphasis added). Those words suggest that the patient has made a decision to be treated as a private patient for “*this admission*” i.e. for the period of admission commencing from the date of admission. The words used do not appear to relate to the period from the date of signing of the form. In this regard, it is, at least, arguable that there is nothing to prevent an individual patient from agreeing with a hospital to be so treated even if the period of treatment predates the signing of the

form and even if the agreement of the patient goes beyond the scheme of s. 52(3). However, I am conscious that I did not hear argument on the interpretation and effect of this aspect of the PIP form. Moreover, no issue as to its interpretation is raised in the statement of claim. In those circumstances, I do not believe that I should reach any determination on this issue in the absence of agreement between the parties and without hearing further argument from the parties. Should the parties agree, I will give liberty to apply to seek to have this issue determined at a later stage of these proceedings. In the meantime, there is clearly a significant issue between the parties as to the proper interpretation of the ss. 52(3) which, in my view, requires to be addressed in the hope of that it will assist in resolving this long running dispute between the parties. That dispute is so wide-ranging that one could not be confident that, even I am right in the tentative view expressed above as to the effect of the PIP form, it would fully resolve the dispute. It seems to me that the criteria for the exercise of the court's declaratory jurisdiction have been satisfied in this case. In *Omega Leisure Ltd. v. Superintendent Charles Barry* [2012] IEHC 23 , at para. 4.4, Clarke J. (as he then was) explained that, in approaching claims for declaratory relief, the court must first be satisfied that there is good reason for doing so. Next, there must be a real and substantial, and not merely a theoretical, question to be tried. Third, the plaintiff must have a sufficient interest to raise the issue and, last, the defendant must be an appropriate *contradictor*. Clarke J. cautioned, nonetheless, that a declaration is a discretionary relief and the jurisdiction must be "*circumspectly exercised*". Bearing those principles in mind, I believe that the issues between the parties as to the proper interpretation of ss. 52(3) should be addressed. The "*one episode of care*" issue is one of the principal areas of difference between the parties. Furthermore, the issues between the parties could not be said to be theoretical. The parties both have a

substantial interest in the outcome. That outcome has the potential to have significant financial consequences for them. In all the circumstances, there is plainly good reason for the court to embark on the interpretative exercise required with a view to resolving as many of the issues between the parties as possible.

**128.** Turning, accordingly, to the issue of statutory interpretation, the HSE, in its submissions, has highlighted the opening words of s. 52(3) namely: “*Where, in respect of in-patient services...*”. The HSE submits (correctly in my view) that these words must be construed by reference to the statutory definition of “*in-patient services*” in s. 51. There, they are defined as meaning: “*institutional services provided for persons while maintained in a hospital*” (emphasis added by the HSE). The HSE contends that these words make clear that this is intended to cover the entire period during which the patient is maintained in a hospital – i.e. from the point of admission to the point of discharge. I am not sure that the definition must necessarily be read in that way. However, for the purposes of my analysis of the HSE argument, I am prepared to proceed on the assumption that it does.

**129.** The HSE is correct in so far as it contends that the opening words of s. 52(3) should be read in light of the statutory definition in s. 51. Those words should also be read in light of the provisions of s. 52(1) which, as outlined previously, make clear that the HSE is obliged to make such services available to those with eligibility. Section 52(3) then continues: “... *a person with ... eligibility for such services ...*”. The reference to “*such services*” clearly refers back to the services described in the opening words of the sub-s. which, as outlined in para, 128 above, must be construed as referring to the institutional services provided for persons while maintained in a hospital for which the person is eligible under s. 52(1).

**130.** Section 52(3) next refers to a person not availing of or waiving the right to avail of “*some part of those services*”. Again, the reference to “*those services*” refers back to the institutional services provided for persons while maintained in a hospital under s. 52(1) but, now, those words are qualified by the words “*some part of*”. The section therefore appears to be triggered, at least in part, by a decision not to avail or to waive the right to avail of some part of the institutional services provided for persons maintained in a hospital under s. 52(1). The words “*some part of*” appear to me to be capable of fairly wide application extending from a small part of the services in question to the entirety of the services.

**131.** The next relevant phrase in the sub-s. comprises the words “*but instead avails of like services not provided under section 52(1)*”. Those words seem to me to directly relate back to the words “*some part of those services*”. That follows from the use of the word “*instead*”. The person in question is now availing of “*like services*”. Having regard to the language used, the like services in question are plainly not the public services provided under s. 52(1). Instead, they are like services not provided under that sub-s. In other words, they are private services. The availing of such “*like services*” is the second element of the statutory trigger (the first element being the decision not to avail of or to waive the right to avail of some part of the services available under s. 52(1)).

**132.** The sub-s. then tells us what effect the triggering of it will have. It provides that: “*then, the person, shall, while being maintained for the said in-patient services, be deemed not to have ... eligibility ... for those in-patient services*”. On behalf of the HSE, it was argued that the references to the “*said in-patient services*” and “*those services*” relate back to the words “*in-patient services*” at the outset of the sub-s. and that, in any event, in accordance with the principle discussed in para. 101 above, the

words “*in-patient services*” must be interpreted consistently throughout such that they must be given the same meaning in this part of the sub-s. as the meaning to be given to the same words at the outset of the sub-s. – i.e. the same meaning as the statutory definition in s. 51. In contrast, counsel for Laya argued that the reference to “*the said in-patient services*” can only relate to the services more proximately described in the sub-s namely the “*like services not provided under section 52(1)*” which, in turn, refer back to the part of the in-patient services which the person concerned has decided not to avail of or has waived the right to avail of.

**133.** In my view, counsel for Laya is correct in his submission. The words “*the said in-patient services*” plainly refer back to the words “*the like services not provided under section 52(1)*” (i.e. the services which the patient has chosen to avail of instead of the public services which the patient had a right to avail of under s. 52(1)). The use of the word “*said*” confirms this. It points to the in-patient services previously mentioned i.e. the services which the patient has opted to receive. To my mind, the word “*said*” could not plausibly be read as referring to the services at the outset of the sub-s. The services mentioned at the outset are less proximate to the word “*said*” than the words “*the like services not provided*”. Typically, a statutory provision referring back to an earlier and less proximate reference would refer to “*first mentioned*” rather than “*said*”. Moreover, the words “*while being maintained for the said in-patient services*” clearly refer to the period during which the patient is maintained as an in-patient for the services which the patient has opted to receive privately. As noted in para.137 below, those words “*while being maintained for the said in-patient services*” are different to the words used in the statutory definition which speaks of “*while maintained in a hospital*”. The words are focused on the specific period during which the patient is being maintained “*for the said patient services*” which, for the

reasons outlined above, I believe refers to the private services which the patient has opted to receive.

**134.** In turn, the reference to “*those in-patient services*” at the end of the sub-s. clearly relates to the “*said in-patient services*”. That is the natural way in which the words would be read. In my view, the use of the word “*those*” is significant. Had it been the intention of the Oireachtas to deem the patient to be ineligible in respect of the entire episode of care, it would have been a very straightforward exercise to make that clear. For example, the sub-s. could have said “*all in-patient services*”. In contrast, the use of the word “*those*” appears to be designed to make clear that it is in respect of the “*said in-patient services*” (i.e. those addressed in para. 133 above) that the patient is deemed not to have eligibility. It is, of course, necessary that the patient should be deemed to be ineligible in that way. In the absence of such a deeming provision, the patient would be eligible for all of the services available under s. 52(1) in a public hospital and the charges payable under s. 55(1)(b) could not lawfully be imposed.

**135.** When the sub-s. is read in this way, it seems to me to be clear that the patient falling within its terms will only be deemed to be ineligible for those parts of the in-patient services which the patient opted to take on a private rather than a public basis.

**136.** I do not believe that this interpretation is inconsistent with the principle described in para. 101 above that a phrase used in legislation should be given the same meaning wherever it appears or with the provisions of s. 20(1) of the 2005 Act that a statutory definition used in a statute should, in the absence of a contrary indication, be read as applicable to the entire statute. There is no doubt that the words “*in-patient services*” at the outset of s. 52(3) must be read as a reference to the statutory definition of those words contained in s. 51. Likewise, the reference to “*such*

*services*” which follows must also be construed in the same way. However, the sub-s. then goes on to refer to the patient not availing of “*some part of those services*”. The reference to “*some part of those services*” (emphasis added), identifies that the sub-s. is now speaking of something potentially different, namely that part of the in-patient services that the patient does not avail of or waives his right to avail of. Thereafter, for the reasons explained in paras. 131 to 134, the subsequent references in the sub-s. to “*services*” and “*in-patient services*” appear to me to plainly relate to the services which the patient has chosen to take privately rather than publicly. Thus, I take the view that the language of the latter part of the sub-s. is indicative of an intention that the references therein to “*services*” and “*in-patient services*” should be given a different meaning to the statutory definition.

**137.** I appreciate that, at first sight, the latter part of s. 52(3) may appear to use a very similar formula of words to the statutory definition of in-patient services in s. 51 in so far as the sub-s. refers to “*while being maintained for the said in-patient services*”. However, on closer analysis, I believe that these words are, in fact significantly different to the statutory definition in s. 51. While the statutory definition refers to “*institutional services provided for persons while maintained in a hospital*” (which may suggest, as counsel for the HSE urged, that this refers to the entire hospital stay), the latter part of s. 52(3), in fact, uses a different formula namely “*while being maintained for the said in-patient services*” (emphasis added). That formula of words is materially different to the statutory definition in so far as it does not refer to the period while the patient is maintained in a hospital but to the period while the patient is maintained “*for the said in-patient services*”. As outlined in para. 133 above, the latter words refer back to the words “*the like services not provided under section 52(1)*” (i.e. the private services which the patient has chosen to avail



of). In my view, this confirms that the deeming will only arise in respect of those services which the patient has chosen to avail of privately and not the services for the entire of the hospital stay unless, of course, the patient has opted to be so treated for the entire of the stay.

**138.** Counsel for the HSE submitted that the delivery of patient services is a “*continuum*” and that a patient cannot, during the course of a hospital stay, be a public patient one day and a private patient the next. As noted in para. 97 above, she argued that this would cause significant administrative difficulties for a hospital. I do not disagree that such a situation may well add to the administrative burden on hard pressed hospital staff but this seems to me to be the logical conclusion of the words chosen by the Oireachtas in enacting s. 52(3). Moreover, the administrative burden is compensated to some extent by the substantial additional charges that can be levied where a patient opts to be treated privately.

**139.** The alternative interpretation urged by counsel for the HSE would have some very anomalous consequences which can best be illustrated by a hypothetical example. Take the position of a patient, holding private health insurance, who, in the course of assessment in a hospital emergency department, is told that admittance as an in-patient is necessary and who decides, at that point, that there is no benefit to going private. The patient is subsequently admitted to a medical ward on that basis but finds, after three days, that, although a team including a senior house doctor or registrar has visited several times, the treating consultant has not yet stopped by the patient’s bedside. The patient may, at that point, decide that the most effective way to see the consultant face to face is to opt to be treated as a private patient. This hypothetical patient decides to change status on that basis and sees the consultant on the fourth day of the hospital stay. By that stage, the results of tests taken on day one of the stay are

available. A course of treatment is prescribed and the patient is released that evening. On the basis of the interpretation of s. 52(3) advocated by the HSE, the patient would be deemed to be a private patient for the entire of the four-day hospital stay and would become liable to pay the very substantial daily charges not just for the fourth day of the stay but for the preceding three days even though, during that three-day period, the patient was eligible to be treated as a public patient and had been admitted to hospital on that basis.

**140.** The same issue arises with regard to the hypothetical example put forward by counsel for Laya described in para. 74 above. In that example, a patient who decides to change status from public to private when a private room becomes available in the course of a hospital stay would, if the HSE interpretation of s. 52(3) were correct, be billed as a private patient for the entire hospital stay including the period when the patient had been treated as a public patient.

**141.** In my view, if it had been the legislative intention to retrospectively alter the status of a patient in that way, this would have been spelt out in the statute either in express terms or by clear implication. This is especially so in circumstances where such a retrospective alteration of status has significant financial consequences for the patient as the person liable to pay the charges. It is essential to keep in mind that, under the terms of the Act, it is the patient who is personally liable to pay the charges. The Act does not make the imposition of charges contingent on the patient holding health insurance. Moreover, as previously noted, the minimum health insurance cover available is subject to annual limits and to additional restrictions in relation to waiting periods. In the circumstances, I cannot see any mandate in the language used by the Oireachtas in s. 52(3) that the deeming envisaged thereunder should have

retrospective effect in respect of in-patient services provided prior to a decision by a patient to be treated privately.

**The impact of s. 55(1)(a)**

**142.** My view as to the proper interpretation and effect of s. 52(3) is reinforced by a consideration of s.55(1)(a). That sub-s. empowers the HSE to make available in-patient services to those who do not establish eligibility, those who are deemed to be ineligible under s. 52(3) and those who have waived their eligibility. Absent a provision of this kind expressly empowering the HSE to make such services available it would be open to question as to whether the HSE could lawfully do so. In this context, it should be recalled that the HSE is, by virtue of s. 6(2) of the 2004 Act, a statutory corporation. As such, its powers and functions are limited to those which are conferred upon it expressly by statute or which can be said to be incidental to such express powers or functions or which can be said to be necessarily required for the purposes of giving effect to its express powers or functions. In *Keane v. An Bord Pleanála* [1997] 1 I.R. 184, at p. 212, Hamilton C.J. approved the following passage from Halsbury's Laws of England as a correct summary of the legal position: "*The powers of a corporation created by statute are limited and circumscribed by the statutes which regulate it, and extend no further than is expressly stated therein or is necessarily and properly required for carrying into effect the purposes of incorporation or may be fairly regarded as incidental to or consequential upon those things which the legislature has authorised. What the statute does not expressly or impliedly authorise is to be taken to be prohibited*".

**143.** Bearing that principle in mind, it is necessary to understand what s. 55(1)(a) empowers the HSE to do. It plainly authorises the HSE to make available in-patient

services to the categories of person identified in paras. (i) and (ii) of the sub-s. Those identified in para. (i) are not immediately relevant for present purposes. However, those identified in para. (ii) are very relevant. They comprise persons who “*are deemed under section 52(3) not to have ... eligibility for such services, or to have waived their eligibility for such services.*” (emphasis added). The tenses used in para. (ii) are significant. They clearly suggest that the HSE may make available the in-patient service in question (i.e. private services) to persons who either are deemed (present tense) or have waived their eligibility (perfect infinitive used to signify something that has happened). Thus, if at the point when the service is to be provided, the deeming effect of s. 52(3) is not already operative or the waiver of eligibility has not already occurred, the HSE would not appear to have the authority under s. 55(1)(a) to make the private in-patient services available. That seems to me to follow inexorably from the language of the sub-s. and from the principle described in para. 142 above. There is nothing in the language of the sub-s. to suggest that the HSE is empowered to make available private in-patient services to patients prior to the point at which the deeming effect of s. 55(1)(a) becomes operative or prior to a waiver of eligibility. This reinforces my view that as to the meaning and effect of s. 52(3). Both provisions are interconnected and form part of the same statutory regime addressing the circumstances in which private in-patient services will be made available by the HSE. To my mind, both provisions are in harmony. Neither provision appears to me to operate in a way that would alter the status of a patient from public to private with retrospective effect.

**144.** It would, however, be wrong to take an overly purist view of the operation of s. 55(1)(a). There may be circumstances where there is a short gap in time between the moment of admission as an in-patient and the communication of a decision by a

patient to be treated as a private patient but where it is clear that the patient always intended to be so treated or would have so intended had the patient, at the moment of admission, been in a position to communicate such a decision. This may occur, for example, where, as a consequence of the severity of the illness or injury, the patient, on admission, is unable to signify an intention one way or the other. There may also be cases where the patient has a wish to be treated as a private patient but there is no one immediately available to record that decision or to go through any necessary formalities. It seems to me that, in such circumstances, it would not be a breach of the *Keane v. An Bord Pleanála* principle to disregard any short interval of that kind. I believe that it is appropriate to take the view that it is consequential upon or incidental to the power conferred by s. 55(1)(a) that a period of grace should be allowed to address small intervals of this kind. Given the dynamics of a hospital emergency department and the obvious difficulties that can occasionally arise on the ground in ascertaining or recording decisions of patients immediately on admission, it seems to me to be necessary to take this approach. In the context of the PIP form, it is therefore unsurprising that Laya has been prepared to accept a grace period of 24 hours between the date of admission and the date of execution of the form. That is a recognition of the practical difficulties that can arise. If such an approach is not taken, the effectiveness of s. 55(1)(a) would be undermined.

**145.** I believe, however, that it would be unduly dogmatic to take the approach that such a grace period can never exceed 24 hours. Furthermore, it would plainly be wrong to do so in circumstances where, on admission, the patient orally indicates an intention to be treated as a private in-patient but, for one reason or another, there is a period of days before the PIP form is executed by the patient. Subject to what I say below in relation to the issue as to informed decision making, it appears to me that,

once the patient has communicated a decision to be treated as a private patient, the deeming effect of s. 52(3) becomes operative. In turn, that immediately empowers the HSE to provide in-patient services under s. 55(1)(a) and it does not matter that this decision is not recorded in writing and signed by the patient until later. As stated in para. 124 above, there is no requirement in the statute that the decision of a patient should be recorded in writing although it would be in the interests of good administration that it should be so recorded. Thus, in cases of the kind discussed in this para., the fact that there is a gap between the date of admission and the date of execution of the PIP form or other written record of the patient's decision would not appear to me to give rise to any difficulty under s. 55(1)(a). In my view, the sub-s. becomes operative on the date of the decision of the patient. That is when the patient is deemed by s. 52(3) to be ineligible and the HSE is accordingly empowered, as from that date, to provide private in-patient services under s. 55(1)(a).

**Must the decision of the patient be a fully informed one?**

**146.** I fully accept that, as counsel for the HSE has stressed, the case law which has been cited by Laya and Irish Life in relation to this issue does not address a decision not to exercise or to waive a statutory right. In this context, I do not believe that reliance can be placed on the decision of Simons J. in the *Conaty* case. In my view, the cases addressing waiver of rights under the Unfair Dismissals Act are *sui generis* and cannot be applied, by analogy, to the present case. However, all of the case law shows that courts have been concerned, in a wide variety of situations, to make sure that decisions affecting rights are taken on an informed basis.

**147.** I also accept that a decision to be treated as a private or as a public patient is in a different category to decisions to consent to invasive medical treatment. I therefore

do not believe that the approach taken by the Supreme Court in *Fitzpatrick v. White*, cited by Irish Life, is on point.

**148.** It seems to me that, in considering this question, it is important to keep in mind the broad range of situations that may arise in the course of admission of a person as an in-patient through the emergency department of a hospital. As outlined in para. 118 above, there are likely to be some patients who, on being informed that admission as an in-patient is required, will, without prompting, express a wish to use their health insurance and be treated as a private patient. In such cases, in the absence of some indication that the patient is not acting rationally, it is difficult to see that a hospital has an obligation to make sure that the patient is aware that admission as a public in-patient is available. Every person is entitled to exercise an independent judgment on such an issue. In my view, such a patient is in a somewhat similar position to the patient, on an elective admission, who opts to be treated privately.

**149.** On the other hand, it seems to me that different considerations apply where the hospital requests the patient to avail of any applicable health insurance cover and to be admitted as a private in-patient or to consider being admitted on that basis. In such circumstances, the hospital is, in effect, requesting the patient to forego – or to consider forgoing – what is undoubtedly a valuable statutory entitlement. Moreover, in making that request, the hospital is, in substance, acting on behalf of the HSE whose statutory duty it is to make available public in-patient services to eligible people. By opting to be treated privately, the patient is also undertaking a potential personal liability to pay the hospital charges. It has to be borne in mind that the patient is the person chargeable under s. 55(1)(b). While the evidence establishes that the patient will only be asked to sign such a form where health insurance is in place, there

are limits to that cover not least the fact that some policies do not provide cover for more than 180 days in any calendar year.

**150.** I do not believe that authority is necessary to support the proposition that, against that backdrop, it is a matter of basic fairness that the person being requested to forego the right or to consider forgoing the right (and thereby to absolve the HSE of its statutory duty) should be informed of the statutory entitlements in issue and of the consequences that flow from a decision to forego them. While none of the authorities cited by Laya or Irish Life address the waiver of a statutory entitlement of this kind, the principles underlying them support such a conclusion.

**151.** In light of the considerations outlined in paras. 149 above, I believe that, save in cases where a patient actively seeks to be treated as a private patient, any decision of a patient to waive the statutory entitlement to be treated as a public in-patient must be an informed one, made with knowledge of that entitlement and with knowledge of the consequences of not availing of that entitlement. I fully appreciate that, as counsel for the HSE emphasised, such a requirement has significant practical consequences for hospital staff on the ground and increases the administrative burden on them in the course of their work. However, in a hospital emergency department environment, there is no other source of information immediately available other than hospital staff and it seems to me to follow that, of necessity, the task falls on the hospital to ascertain the patient's wishes and also to check that the patient is aware of the entitlement to be treated publicly and of the consequences of opting to be treated privately. It is in that context that one can see the utility of the PIP form. The form provides the details that the patient needs to know in order to make an informed choice and, if the patient is given an adequate opportunity to consider the PIP form in



advance of making a decision, this will greatly reduce the burden that would otherwise fall on overworked hospital staff.

**152.** That is not to say that the relevant information could not be given orally or in a different format to the PIP form. However, the practical advantage of the PIP form is that it gives the basic information that is required. The form is summarised in para. 30 above and no one has suggested that it is not sufficiently comprehensive to educate the patient as to the choice available or as to the possible consequences that flow from that choice. Once signed, it also provides valuable evidence of the fact that the patient has made an informed choice to be treated as a private in-patient.

**153.** In this context, I have not lost sight of the complaints made by the witnesses whose evidence is summarised in paras. 51 to 54 above. Of course, there may be circumstances where a patient has not exercised free will in signing a form or an authority of this kind. It is also patently unacceptable that a patient should be asked to sign a form in the circumstances described in paras. 51-52 above when it is obvious that the patient has not had any adequate opportunity to review it. One cannot, therefore, exclude the possibility that, on some occasions, the signature of a patient may be obtained without giving the patient any opportunity to consider the terms of the PIP form or where the execution of the form has been procured by duress or through misrepresentation of its terms. However, while recognising the possibility that such circumstances may occasionally arise in an overly stretched emergency department, there is no basis upon which I can conclude that this has happened on a large scale and I do not believe that there is any form of declaration that I can make to deal with such cases. Although Laya has alleged, in the course of its dealings with the HSE, that similar difficulties to those described in para. 51 to 54 above are widespread, Laya has not called any sufficient evidence to prove that allegation in

these proceedings. It is axiomatic that, where any issue is raised about the validity of a consent signed by a patient, it would be necessary to consider the individual circumstances of that case. The issue cannot be addressed on the basis of the material before the court in this case.

**The application of the concept of waiver in the three-year period between the commencement of s. 13 of the 2013 Act and the subsequent commencement of s. 9 of that Act**

**154.** A further issue arises in relation to the application of the concept of waiver in the three-year period between the commencement of s. 13 of the 2013 Act on 1<sup>st</sup> January 2014 and the subsequent commencement on 1<sup>st</sup> January 2017 of s. 9. In that period, s. 52(3) continued in force in the form inserted by the 1991 Act without any reference to waiver. However, during that period, s. 55(1)(a) (as inserted by s. 13 of the 2013 Act) was in force and it refers to waiver. Counsel for the HSE argued that s. 55(1)(a) was inoperable during that period in so far as the reference to waiver is concerned. This was disputed by counsel for Laya who, nonetheless, also argued that, as noted in para. 71(b) above, there is an obvious inconsistency between ss. 52(3) and s. 55(1)(a)(ii). In response, counsel for the HSE submitted that, as summarised in para. 95 above, there is no inconsistency if one ignores the comma in s. 55(1)(a)(ii) that intervenes between the words “... *are deemed under section 52(3) not to have ... eligibility for such services*” and the words “*or to have waived their eligibility for such services.*” On that basis, she argued that the sub-s. should be read as though the words “*are deemed under section 52(3)*” apply to the words which follow after the comma namely “*or to have waived their eligibility for such services*”. On that basis

counsel argued that this element of s. 55(1)(a)(ii) should be construed as though it said: “*are deemed ... to have waived their eligibility for such services*”.

**155.** I do not believe that counsel for the HSE is correct in her suggestion that s. 55(1)(a)(ii) should be construed as though the words “*are deemed*” apply to the words “*or to have waived their eligibility for such services*”. There are no circumstances under the 1970 Act (as amended by the 2013 Act) in which a patient will be deemed to have waived eligibility to be treated as a public patient. It is true that, once the amendments to s. 52(3) made by s. 9 of the 2013 Act were commenced on 1<sup>st</sup> January, 2017, the sub-s. expressly had the effect that a waiver of the right to be treated as a public patient resulted in a deemed ineligibility. But, crucially, it is the waiver which gives rise to the deemed ineligibility. There is no suggestion in the language of the sub-s. that there could ever be a deemed waiver of the right. On the contrary, the relevant deeming effect of the sub-s. is triggered by the waiver of the right. Absent a waiver (or a decision not to avail of public services), there is no deemed loss of eligibility.

**156.** It is true that the rejection of the interpretation advocated by counsel for the HSE has the consequence that it becomes difficult to read s. 55(1)(a) sensibly. The word “*to*” seems to fulfil no purpose. The sub-s. would, however, make sense if that word is overlooked. The sub-s. would be perfectly comprehensible if it is construed as though it read that the HSE may make available in-patient services for persons who “*are deemed under section 52(3) not to have ... eligibility for such services, or have waived their eligibility for such services*” (i.e. as though the word “*to*” were omitted). It would also make sense if the word “*who*” is substituted for the word “*to*” although I do not believe that such a substitution is actually necessary in order to make the sub-s. comprehensible.

**157.** Such an interpretation would also allow the sub-s. to be read in a way that gives it effect even in the three-year period between the date of its commencement in this form and the subsequent commencement of s. 9 of the 2013 Act which introduced the concept of waiver into s. 52(3). Thus, this element of the sub-s. would not be rendered inoperable in that three-year period in the manner suggested by counsel for the HSE. To hold that this element of the sub-s. was inoperable during that period would require the words referring to a waiver of eligibility to be ignored. Such a reading of the sub-s. would appear to offend against the principle that the Oireachtas does not intend to include words which are pure surplusage. On the other hand, reading the sub-s. in the manner suggested in para. 156 involves ignoring the word “to” which would likewise offend against the same principle.

**158.** A significant issue arises as to whether the court is entitled to read the sub-s. in a manner that ignores the word “to”. Dodd, at para. 12.45, has questioned whether the court, at least prior to the enactment of s. 5 of the 2005 Act, has any entitlement to “rectify” what appears to be a drafting error in legislation. Having regard to the separation of powers, that is a matter for the Oireachtas. That said, s. 5 of the 2005 Act expressly permits the court to construe a non-penal statutory provision in a manner that reflects the plain intention of the Oireachtas where, on a literal construction, the provision is obscure, ambiguous or absurd or otherwise fails to reflect the plain intention of the Oireachtas. Section 5 provides as follows: “*In construing a provision ... (other than a provision that relates to the imposition of a penal or other sanction) – (a) that is obscure or ambiguous, or (b) that on a literal interpretation would be absurd or would fail to reflect the plain intention of – ... the Oireachtas..., the provision shall be given a construction that reflects the plain*

*intention of the Oireachtas ... where that intention can be ascertained from the Act as a whole.”*

**159.** Having regard to the language of s. 5, two conditions must be satisfied. First, a literal interpretation must give rise to a difficulty of the kind just described (although as noted in para. 99(c) above, a court should not too readily reach a conclusion that such a difficulty exists). Secondly, the plain intention of the Oireachtas must be apparent from a consideration of the Act as a whole. In *Kadri v. Governor of Wheatfield Prison* [2012] 2 ILRM 392 at pp. 402-403, Clarke J. (as he then was) stressed that both of these conditions must be satisfied for s. 5 to apply. He said: “... *not only is it necessary that it be obvious that there be a mistake in the sense that a literal reading of the legislation would give rise to an absurdity or would be contrary to the obvious intention of the legislation in question, but also that the true legislative intention can be ascertained. There may well be cases where it may be obvious enough that the legislature has made a mistake but it may not be at all so easy to ascertain what the legislature might have done in the event that the mistake had not occurred*”.

**160.** In the present case, it is obvious that the Oireachtas has made a mistake. In my view, there is no reading of the sub-s. open which is capable of giving meaning to the word “*to*”. The real question here is whether the true legislative intention can be gleaned from a consideration of the 2013 Act as a whole. In this context, a number of factors seem to me to be relevant. In the first place, s. 2 of the 2013 Act expressly contemplates that there could be a gap in time between the date of commencement of s. 13 (introducing the new version of s. 55) and the date of commencement of s. 9 (introducing the new version of s. 52(3)). Section 2(2) expressly provides that s. 13 is to come into operation on 1<sup>st</sup> January, 2014. In contrast, s. 2(1) has the effect that the

date of commencement of a number of provisions, including s. 9, is to be left to the Minister for Health. This seems to me to clearly indicate that the Oireachtas intended that the new version of s. 55 of the 1970 Act (as inserted by s. 13 of the 2013 Act) was to take effect on 1<sup>st</sup> January, 2014 regardless of whether the new version of s. 52(3) had taken effect by that date. To my mind, that strongly indicates that the Oireachtas did not intend that any element of s. 55 (such as the reference to waiver of eligibility) should be inoperable during any hiatus in the commencement of s. 53(2). In such circumstances, I believe that the court should strive to give effect to s. 55 in its entirety in the three-year hiatus in issue.

**161.** Secondly, the structure of s. 55(1)(a), as commenced on 1<sup>st</sup> January, 2014 is important. The opening words empower the HSE to make in-patient services available to persons who fall within one of the categories described in paras. (i) and (ii). The first category is that described in para. (i), namely those who do not establish entitlement to such services. Turning to para. (ii), it might, at first sight be thought to create no more than one further category. However, for the reasons described in para. 155 above, I do not believe that the words “*or to have waived their eligibility for such services*” can plausibly be construed as being governed by the words “*are deemed under section 52(3)*”. Section 52(3) does not deem a person to have waived eligibility; on the contrary, its deeming effect is only triggered by a person not availing of public services (or in the period after 1<sup>st</sup> January, 2017, by a waiver of the right to avail of such services). By its terms (both before and after 1<sup>st</sup> January, 2017), it deems a person falling within its ambit not to be eligible. Thus, para. (ii) cannot be considered to comprise a single category of person. Logically, it must follow that the words “*to have waived their eligibility for such services*” are intended to capture an additional category over and above those persons who are deemed not to be eligible

under s. 52(3). While I acknowledge that “*or*” will not always be construed as disjunctive, the use in these circumstances of “*or*” supports this conclusion. The use of the comma also appears designed to achieve the same purpose. Accordingly, the words which follow the word “*or*” appear to be intended to capture a different category of person to those described in the words which precede it. On that basis, para. (ii) of s. 55(1)(a) seems to be designed to cover two categories in addition to the category described in para. (i). Thus, the Oireachtas appears to have clearly intended that “*persons who – ... to have waived their eligibility for such services*” would form a separate category of persons on whom the charges were to be levied under s. 55(1)(b).

**162.** Thirdly, the same phrase is repeated in s. 55(3)(a) which empowers the Minister to make regulations prescribing the manner in which in-patient services are to be provided to the categories of persons described in s. 55(1)(a)(i) and (ii). This reinforces the view that the Oireachtas intended that all of these categories of person were intended to be the subject of the charging regime set out in s. 55 as inserted by s. 13 of the 2013 Act including the inaptly described category comprising “*persons who – ... to have waived their eligibility for such services.*”

**163.** Fourthly, although I do not believe that it is necessary to resort to any further material in the Act to elucidate the plain intention of the Oireachtas, the marginal note is also of some assistance. As noted in para. 70 above, counsel for Laya submitted that, in Ireland, marginal notes can be used as an aid to the interpretation of a statutory provision. Section 7(1) of the 2005 Act provides that, notwithstanding s. 18(g), a court may make use of all matters that accompany and are set out in an Act of the Oireachtas. Although s. 18(g) expressly states that marginal notes are not admissible, it also states that this is “*subject to section 7*”. Counterintuitive though it may be, the

combined effect of the two provisions appears to be that, notwithstanding the express prohibition in s. 18(g), this is overridden by s. 7. On that basis, it would appear that regard can be had to the marginal note which refers in express terms to “*persons ... who have waived entitlement, to services under section 52*”. That seems to me to be an express acknowledgement by the draftsman that the entitlement to services under s. 52 can be waived.

**164.** Given the clear intention of the Oireachtas to bring that category within the ambit of s. 55, it seems to me that it must be an appropriate exercise under s. 5 of the 2005 Act, to construe the section without reference to the word “*to*” which, as I have already said, has plainly been included in error. When read in that way, the category makes sense and covers those persons who have waived their eligibility for the in-patient services available under s. 52(1). There is no alternative meaning open. The word “*to*” simply does not make sense in the context of the other words used to describe the category.

**165.** While stressing the need to satisfy the statutory criteria in s. 5 of the 2005 Act, Clarke J. in *Kadri* observed that there is a broad similarity between the intention underlying s. 5 and the jurisdiction of the court to correct obvious errors in contract. It seems to me that, if the language here were found in a contract, a court, applying the relevant principles applicable in the field of contract law, would have no hesitation in construing the language as though the word “*to*” did not appear therein. While I fully accept that the contract law principles have no relevance in a statutory context, the fact that a court would take that approach to a similar error in a contract provides some support for the reasonableness of the view expressed in para. 164 above.

**166.** When read in that way, the relevant words in issue make sense even in the period between the respective dates of commencement of ss. 13 and 9 of the 2013



Act. I appreciate that it is curious that the Oireachtas would have legislated for the commencement of s. 13 (which contemplates a waiver of eligibility for the in-patient services available under s. 52(1)) while at the same time deferring the commencement of s. 9 which saw the express introduction of a waiver of the right to avail of the same in-patient services. However, as Clarke J. observed in *Irish Life & Permanent plc v. Dunne*, at p. 108, it is not for the court to assess the policy behind any legislation. The Oireachtas may well have had good reason for legislating in that way. Thus, for example, in the present case, the decision of the Oireachtas, in s. 13 of the 2013 Act, to extend the categories in s. 55(1)(a) to include persons who waive their eligibility may have been prompted by the fact that, even prior the commencement of s. 9 of the 2013 Act, there was nothing in law to prevent a person with eligibility from waiving that eligibility. As the decision of the Supreme Court in *G. v. An Bord Uchtála* shows, even constitutional rights can be waived; *a fortiori* statutory rights can likewise be waived. Accordingly, there was nothing to prevent a patient waiving eligibility in the period prior to the commencement of s. 9 of the 2013 Act and the Oireachtas may have considered that it was appropriate to expressly capture such patients in the categories of chargeable patients in s. 55(1)(a).

### **Purposive interpretation**

**167.** Save to the extent that I have sought to apply s. 5 of the 2005 Act in the context of s. 55(1)(a), I have not found it necessary to apply s. 5 or a purposive interpretation to any of the other provisions of the 1970 Act (as amended). I have sought to interpret the provisions in issue by reference to an analysis of the natural and ordinary meaning of the provisions in issue read in context. Where appropriate, in seeking to understand the intention of the Oireachtas, I have borne in mind the factors

outlined in paras. 111 to 116 above which seem to me to comprise part of the relevant statutory context.

### **Summary of conclusions**

**168.** In so far as s. 52(3) is concerned, for the reasons outlined in para. 117 above, I believe that the concept of availing involves a conscious decision by a patient. As further explained in para. 118, it seems to me that, at least in the period after s. 52(3) came into operation, the concept primarily covers those patients who actively seek to be treated as private. Such patients are not, in any real sense, giving up anything. They are not forgoing the entitlement to be treated as public patients because they have no desire to be so treated. It would therefore be wrong to describe them as having waived their right to be treated on a public basis.

**169.** I address the significance of the addition of the concept of waiver in paras. 118 to 123. For the reasons explained in those paras. I have come to the conclusion that waiver is more relevant in the context of those patients who are initially minded to be treated on a public basis but who, following a request by a hospital to consider whether they wish to be treated publicly or privately, agree to forego or give up the right to be treated as public patients.

**170.** While there is nothing in s. 52(3) that requires waivers or decisions not to avail of public in-patient services to be in writing, it seems to me that, as a matter of good administration, it is wise that they should be evidenced in writing and should be signed by the patient. Furthermore, for the reasons explained in paras. 149 to 150 above, I am of opinion that, in cases where a hospital asks eligible patients to consider whether they wish to be admitted on a public or a private basis, patients should be informed of the statutory entitlement available to eligible patients and of the consequences that flow from a decision to forego that entitlement. For that reason, a

form such as the PIP form (while not mandated by the Act) serves a very useful purpose both as a means of conveying the necessary information to the patient and as evidence that the patient has reached an informed decision.

**171.** For the reasons discussed in paras. 154 to 166, I am of opinion that the reference to waiver in s. 55(1)(a) cannot be regarded as surplusage or as inoperable in the period between 1<sup>st</sup> January, 2014 and 1<sup>st</sup> January, 2017. On the contrary, it seems to me that s. 55(1)(a) envisages waivers of eligibility even in the period between 1<sup>st</sup> January 2014 when s.13 of the 2013 Act came into operation and 1<sup>st</sup> January, 2017 when s. 9 of the 2013 Act became operative.

**172.** As explained in paras. 126 to 143 above, I have come to the conclusion that the HSE case based on “*one episode of care*” is incorrect. In cases where a patient opts to become private during the course of a hospital stay as an in-patient, I do not accept that s. 52(3) deems the patient to be ineligible in respect of the period prior to the patient’s decision to be treated privately. The sub-s. seems to me to have the opposite effect. This is reinforced by a consideration of s. 55(1). As a consequence, I do not believe that the HSE is entitled to levy Schedule 4 charges in respect of the period prior to a patient’s decision to be treated privately.

**173.** However, as further explained in para. 144 above, I do not believe that a small interval between the date of admission and the date of a s. 52(3) decision necessarily prevents the HSE from levying Schedule 4 charges where the interval can be explained by difficulties of the kind discussed in that paragraph. Furthermore, subject to what I say in paras. 149 to 150 above, it would be wrong to conclude that Schedule 4 charges are not payable in respect of the entire hospital stay in cases where a patient, on admission, orally indicates an intention to be treated as a private in-patient but, for one reason or another, there is a period of days before a written document is put in

place signed by the patient. As stated in para. 145 above, it seems to me that the deeming effect of s. 53(2) comes into effect once the patient in such cases expresses the decision orally. That means that, where the decision has been conveyed orally on the date of admission, Schedule 4 charges can be imposed from the date of admission.

**Further directions**

**174.** I will list the matter remotely before me at 10.30 a.m. on Thursday, 16<sup>th</sup> December, 2021 for the purposes of hearing the submissions of the parties as to the form of the order to be made and as to costs. In the meantime, I direct the parties to liaise with each other with a view to seeking agreement both as to the form of the order to be made on foot of this judgment and as to the issue of costs. If the parties have not been able to reach agreement on those issues by 10<sup>th</sup> December, 2021, I direct that each of the parties should prepare short written submissions as to the form of the order and as to costs, such submissions (together with a proposed draft of the order to be made) to be exchanged between them and copied by email to the registrar not later than 14<sup>th</sup> December, 2021.

**High Court Practice Direction HC 101**

**175.** Finally, in accordance with the above practice direction, I direct the parties to file their written submissions (subject to any redactions that may be permitted or required under the practice direction) in the Central Office within 28 days from the date of electronic delivery of this judgment.