

NHS Services: Must the tortfeasor pay

'fons et origo'

1. The provision of a comprehensive and universal healthcare system free to all at the point of delivery was one of the central planks of the Beveridge Report¹ and enshrined in the National Health Service Act 1946. As a principle it has been seen as sacrosanct by politicians across the political spectrum with no one daring to question whether it remains either achievable or desirable. In 2010 this aspirational ideal was enshrined in a much heralded but largely cosmetic NHS Constitution², the first two principles of which are:

- (1) *The NHS provides a comprehensive service, available to all.*
- (2) *Access to NHS services is based on clinical need, not an individual's ability to pay.*

2. For those injured and pursuing a claim for damages, including the cost of medical care and/or treatment, the availability of free provision of NHS facilities gives rise to the prospect of and the need to consider how to avoid double recovery on the part of the claimant. It is of interest to note that this issue is not a new one. It was very much in the minds of the Committee that advised the Government in 1945 on the new vision of a comprehensive health and social welfare available to all.

3. The original recommendation contained in the Beveridge Report suggested that for a person pursuing a claim for damages

*“comprehensive medical treatment is available for every citizen without charge quite irrespective of the cause of his requiring it, he ought not to be allowed, if he incurs special expenses for medical treatment beyond the treatment generally available, to recover such expenses in the action for damages.”*³

This very strong but controversial recommendation in the Beveridge Report was rejected by the Monckton Committee. Although the Committee accepted that in principle the introduction of a comprehensive health service would strengthen the argument that a claimant ought to be content with the services provided by the NHS, it recommended the introduction of legislative provision to protect the right of an individual to pursue private treatment and care. The provision of section 2(4) of the Law Reform (Personal Injuries) Act 1948 has remained unchanged for over 60 years.⁴ Two principle reasons were advanced for rejecting the recommendation of the Beveridge Report. Firstly, it was said that

¹ Report of Inter Departmental Committee on Social Insurance and Allied Services 1942

² The Health Care Act 2009 contains provisions placing a statutory duty on NHS bodies providing care in England to *'have regard to the NHS Constitution'* when making decisions in relation to the provision of NHS services.

³ Beveridge Report (1942) Cmd 6404 para 262.

⁴ The section provides that

“In an action for damages for personal injuries... there shall be disregarded, in determining the reasonableness of any expenses the possibility of avoiding those expenses or part of them by taking advantage of facilities available under the National Health Service.”

*“to decide between the respective merits of the State and other services would be a difficult and invidious duty (for the Courts)”*⁵

and secondly

*“it would be inconsistent with the liberty of the individual”*⁶

4. The caselaw on the interpretation of s.2(4) has developed in a largely predictable and consistent way over the years since its enactment in 1948.

- 4.1 In *Harris v Brights Asphalt Contractors Ltd*⁷ Slade J said of the subsection

*“I think all that it means is that, when an injured plaintiff in fact incurs expenses which are reasonable that expenditure is not to be impeached on the ground that, if he had taken advantage of the facilities available under the National Health Service Act, 1946, those reasonable expenses might have been avoided. I do not understand s.2(4) to enact that a plaintiff shall be deemed to be entitled to recover expenses which in fact he will never incur.”*⁸

- 4.2 In *Woodrup v Nicol*⁹ the court applied to that part of the claim which represented physiotherapy costs, a “*balance of probabilities*” test to determine the likelihood of the claimant using private facilities. The Court of Appeal refused to overturn the finding at first instance that the claimant was likely to have half of his future treatment on the NHS and thus only half would need to be funded privately. A recent application of the principle, this time in relation to the costs of future neuropsychology and neuropsychiatric treatment, is to be found in the Judgment of Clarke J in *Edwards v Martin*.¹⁰

- 4.3 *Eagle v Chambers (No 2)*¹¹ whilst restating the principle¹² added a gloss to the effect that once the court was satisfied that a claimant was likely to fund a private care regime, it would usually be reasonable to conclude that services ancillary to the maintenance of that regime, such as the provision of incontinence materials, chiropody, etc, would also be funded privately unless the defendant satisfied the court of two matters, firstly that the items or service were in fact available and would continue to be available from the NHS, and secondly that the claimant would in fact avail herself of the same. The court in *Eagle* made it clear that “*it cannot be enough for the defendant to say there is no evidence that the services will not be available from the NHS or social services*”.¹³

⁵ Final Report (1946) para 56.

⁶ Ibid. This might legitimately be viewed as an early expression of the 'tortfeasor pays' principle.

⁷ [1953] 1 QB 617.

⁸ Ibid 635.

⁹ 1993 [PIQR] Q104 at 114.

¹⁰ [2010] EWHC QB.

¹¹ [2004] EWCA Civ 1033.

¹² Ibid para 70.

¹³ Ibid para 71

The availability of NHS services to personal injury claimants

5. The National Health Service Act 2006¹⁴ is the principle statute governing the provision of healthcare in England. The structure of the Act reflects the fact that, at least for the present,¹⁵ there are two quite different systems. Part I is concerned with healthcare in hospitals and ‘community health services’ such as NHS Continuing Healthcare, district nurses, and Part II which deals with the arrangements for the provision of GPs, dentists, opticians and dispensing services. Where the question of NHS provision arise in the context of personal injury claims the issues will generally concern the duties arising under Part I of the Act and the extent to which injured claimants might be able to secure from the NHS services such as care, wheelchair and ventilator equipment and consumables.

The starting point

6. NHA 2006 s.1 places a general duty to provide services on the Secretary of State in England and Wales. The Act provides:

“(1) *It is the Secretary of States’¹⁶ duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement*

(a) *in the physical and mental health of the people of those countries and*

(b) *in the prevention diagnosis and treatment of illness,*

(2) *The services so provided shall be free of all charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed.”*

7. NHA 2006 s.3 sets out those general services which it is the Secretary of States’ duty to provide. Section 3(1) provides:

“3. ***Secretary of State’s duty as to provision of certain services***

(1) *The Secretary of State must provide throughout England, to such extent as he considers necessary to meet all reasonable requirements -*

(a) *hospital accommodation,*

(b) *other accommodation for the purpose of any service provided under this Act,*

(c) *medical, dental, ophthalmic, nursing and ambulance services,*

¹⁴ The 2006 Act was a consolidating Act and the structure of the same remained largely the same as under the 1946 and 1977 Acts.

¹⁵ Radical reforms are proposed by the Coalition Government in a series of White Papers on NHS Reform. It is proposed that the majority of non hospital services, including it is assumed NHS community care services will be provided via GP consortia.

¹⁶ The responsibility for actual provision of services under the NHA 2006 Part I was transferred to NHS trusts under NHSCA 1990.

- (d) *such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as he considers are appropriate as part of the health service,*
- (e) *such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service,*
- (f) *such other services or facilities are as required for the diagnosis and treatment of illness.”*

8. A reading of the provisions of ss.1 and 3 of the 2006 Act demonstrates that in contrast to the specific and directly enforceable legislative duties imposed upon social services authorities (see, for example, ss.21 and 29 NAA 1948), the NHS’ statutory duties are general and indeterminate. The duties therein set out, usually described as public law duties, are elastic and aspirational, requiring the public authority to 'do its best' without any requirement to achieve the stated aim. In the discharge of these duties the public authority is very likely to be able to take into consideration practical realities including budgetary limits and resource constraints when deciding how best to fulfil the target duty.

9. The nature and scope of the duty imposed on the Secretary of State and through delegated powers PCT's, was closely examined by the Court of Appeal in the case of *R v North and East Devon Health Authority ex parte Coughlan*.¹⁷ In *Coughlan* the issue concerned, inter alia, the duty of the North and East Devon Health Authority to continue to provide nursing care services to a group of individuals cared for in a NHS nursing home setting. In the particular circumstances of that case the Health Authority considered that budgetary constraints warranted the closure of that particular home and it was argued by the Health Authority that the needs of the residents were of a type that fell within and could legally be met by social services discharging their duties under section 21 NAA 1948.¹⁸ The residents, unsurprisingly, wanted their care to be provided in the setting which had been their home for many years and importantly, was provided free of charge. In the course of its judgment the Court of Appeal noted that:

“Section 1(1) does not place a duty on the Secretary of State to provide a comprehensive health service. His duty is ‘to continue to promote’ such a service. In addition the services which he is required to provide have to be provided ‘in accordance with this Act’.”

and

*“...the Secretary of State’s section 3 duty is subject to two different qualifications. First of all there is the initial qualification that his obligation is limited to providing the services identified to the extent that he considers that they are **necessary** to meet **all reasonable requirements...**”*

and

¹⁷ (1999) 2 CCLR 285; [2000]2 WCR 51.

¹⁸ One significant and immediate impact of the transfer of responsibility from the NHS to the relevant social services authority was the fact that social services had a duty to charge for the delivered services whereas the Health Authority had to provide the same free.

“24. The first qualification placed on the duty contained in section 3 makes it clear that there is scope for the Secretary of State to exercise a degree of judgment as to the circumstances in which he will provide the services, including nursing services referred to in the section. He does not automatically have to meet **all** nursing requirements. In certain circumstances he can exercise his judgment and legitimately decline to provide nursing services. **He need not provide nursing services if he does not consider they are reasonably required or necessary to meet a reasonable requirement.**

25. When exercising his judgment he has to bear in mind the comprehensive service which he is under a duty to promote as set out in section 1. However, as long as he pays due regard to that duty, the fact that the service will not be comprehensive does not mean that he is necessarily contravening either section 1 or section 3. The truth is that, while he has the duty to continue to promote a comprehensive free health service and he must never, in making a decision under section 3, disregard that duty, a comprehensive health service may never, for human, financial and other resource reasons, be achievable. Recent history has demonstrated that the pace of developments as to what is possible by way of medical treatment, coupled with the even increasing expectations of the public, mean that the resources of the NHS are and are likely to continue, at least in the foreseeable future, to be insufficient to meet demand.

26. In exercising his judgment the Secretary of State is entitled to take into account the resources available to him and the demands on those resources. In *R v Secretary of State for Social Services and Ors ex parte Hincks* [1980] 1 BLMR 93 the Court of Appeal held that section 3(1) of the Health Act does not impose an absolute duty to provide the specified services. The Secretary of State is entitled to have regard to the resources made available to him under current government economic policy.”

10. The guidance in *Coughlan* clearly identifies the duty under ss.1 and 3 as a target or aspirational duty and not one that is readily amenable to direct enforcement. On a correct interpretation of the Act, the Secretary of State (and a PCT):
 - (i) Has a discretion in determining what eligible nursing needs he will meet; and
 - (ii) Even where it is identified that the individual has eligible needs of a type that the NHS is empowered to provide, there can still be a lawful decision made that the individual has no ‘reasonable requirement’ for those needs to be met by the Secretary of State.
11. Section 3 NHA 2006 does not specify what factors the Secretary of State is required to take into consideration in the exercise of his discretion. It goes without saying that the Secretary of State and PCTs must comply with the law in respect of fundamental human rights and must ensure that decisions are reached in accordance with established public law principles. Thus they cannot ignore published guidance, operate a perverse policy which is irrational or fetters their discretion. That said the discretion is still a very wide one and provides the decision maker with wide powers. For example it must follow that if there is a discretion not to meet a required health need under the NHS, the individual concerned will either have to meet that need using his own or some other private resources or the need will be left unmet.

The ‘tortfeasor pays’ principle

12. A claimant seeking damages for future care and other expenses has the right to recover all his or her reasonable losses from the tortfeasor even where those needs could be adequately met by way of provision from statutory sources. In relation to the provision of services by the NHS the above principle derives from and is the clear effect of s.2(4) of the 1948 Act¹⁹. The statutory position in respect of NHS services has been replicated in the context of social services provisions by the important decision of the Court of Appeal in *Peters v East Midlands Strategic Health Authority and Another*.²⁰ The full implication of this decision is yet to be played out but it is clear authority for the proposition that even where it can be demonstrated that the public authority has a directly enforceable duty to the claimant and that the authority is willing to discharge that duty in a manner that will as a matter of fact meet the need occasioned by the tort, the claimant is still entitled to choose to recover this loss from the tortfeasor. At paragraph 53 Dyson LJ, giving the judgment of the court, expressed the principle as follows:

“We can see no reason in policy or principle which requires us to hold that a claimant who wishes to opt for self-funding and damages in preference to reliance on the statutory obligations of a public authority should not be entitled to do so as a matter of right. The claimant has suffered loss which has been caused by the wrongdoing of the defendants. She is entitled to have the loss made good, so far as this is possible, by the provision of accommodation and care.”

13. The above passage represents a clear and authoritative statement of the 'tortfeasor pays' principle. The obligation referred to in *Peters* was the funding of the claimant's care needs. There appears to be no reason of principle for the same to be restricted to care costs. It extends, as stated in the judgment, to any 'statutory obligation' that might be said to be capable of meeting a need that is also the subject matter of a claim for damages²¹. On the facts this was available from and being supplied by both the NHS and from social services. The strong statement of principle set out in the judgment was applicable both to the NHS and the social services care. It can thus be stated that there is now no distinction in approach between the rights of a claimant protected by s.2(4) and those protected by the *Peters* principle. A claimant who has available to him statutory funding has an absolute right to choose to forgo the same and require the tortfeasor to pay.
14. The tortfeasor pays principle as described above is now well settled and well understood, at least when viewed from the perspective of the choices available to a claimant²². What must now be considered is the relevance of the 'tortfeasor pays' principle when viewed not from the perspective of a common law claim for damages by a claimant, but from the perspective of the statutory provider. In the usual case the successful invoking of this principle by a claimant will benefit the statutory provider in relieving it of its statutory obligation to the claimant. What of a situation where the claimant in principle wants to rely or seek to avail himself of the statutory provision in whole or in part or is indifferent to the question of the

¹⁹ See the reasons for rejection of the Beveridge Committee recommendations mentioned at para 2 above.

²⁰ [2010] QB 48.

²¹ Services and equipment provided by GP's and under GP's prescription, district nursing etc would logically fall within this principle.

²² It is arguable that this principle was again at play in the judgment of Anthony Thornton QC in *Drake v Tina Starkey (Executrices of the Estate of James Thomas Wilson decd) and Foster Wheeler Ltd* [2010] EWHC 2004 QB. where he allowed as a head of loss the costs of hospice care provided to the deceased that represented that element of the notional cost of the care not met by PCT funding to the hospice but presumably funded by its general charitable funds and provided free to the patient. (It appears that Smith LJ. has recently granted the defendant permission to appeal this aspect of the decision)

source of the provision. Can the principle be relied on by the statutory provider for its own benefit and to relieve it of its statutory obligation, and if so in what circumstances?

Statutory provider's reliance on the 'tortfeasor pays' principle

(a) common law claim for damages

15. This most obvious way of ensuring that a tortfeasor pays for the harm caused is to impose on him a direct liability to make good the loss caused by the tort. Take for example the cost of medical treatment in a NHS hospital consequential on injuries negligently inflicted, or the cost to a local authority of providing for the care of an individual negligently injured. If the statutory provider had a right of action against the tortfeasor then there is no question but that the tortfeasor would be paying and importantly all could be satisfied that the damages would be going to meet the costs occasioned by the tort²³.
16. In *Islington LBC v University College Hospital*²⁴ a somewhat ingenious attempt was made to recover from the tortfeasor, damages representing the likely future cost of care and other services that a local authority was obliged to meet in the discharge of its statutory duty to a service user.
17. The claimant had been injured by the negligence of UCL in the course of surgery. As a consequence she was brain injured and required significant care. The claimant was receiving care in a residential care home and Islington, as the responsible local authority, acknowledged its obligation to fund the cost of this care pursuant to its duty under section 21 NAA 1948. Prior to the settlement of the claimant's claim for damages against UCL, Islington had paid out a significant sum in excess of £80,000 in care home fees. In the settlement between the claimant and UCL damages in the form of a lump sum and periodical payments were agreed. This lump sum settlement did not include the past care home fees on the basis that the claimant would not be liable for the same. Islington had a duty to charge the claimant for the residential care cost likely to be incurred in the future, but because she was a protected party the damages received from UCL were protected from the charging regime of Islington. The claimant was thus entitled to free care from Islington and UCL was spared the obligation of meeting these costs. Islington commenced an action to recover the past and future cost of funding the claimant's care from UCL as the tortfeasor.
18. Islington's argument was deceptively simple. It was contended that its claim against UCL satisfied the three stage test in *Caparo v Dickman*.²⁵ Firstly, it was foreseeable, said Islington, that UCL's negligence would lead to damage of the kind sustained by the claimant and the need for care of the type that Islington was funding. Thus the loss to Islington as well as any loss to the Claimant was said to be foreseeable. Secondly, it was argued that there was sufficient proximity between Islington and UCH and thirdly, that it would be fair just and reasonable for the tortfeasor to make full recompense for its tort. The court accepted that the test of foreseeability and proximity might well be satisfied given the nature of the relationship between the two public authorities and the well understood statutory regime that imposed a responsibility on Islington. The CA was also willing to accept that, at a simple level it could be persuasively argued that it was

“fair just and reasonable that UCH rather than Islington should bear the cost of Mrs J's care. UCH has been negligent Islington has not. It is not only unreasonable but also unfair that a tortfeasor should avoid liability for part of the results of his negligence simply through the double accident of his

²³ The Law Commission has in the past considered whether such a right of action should be given to the NHS.

²⁴ [2005] EWCA Civ 596.

²⁵ [1990] 2 AC 605

victim being cared for by a public body rather than privately, and the victim not being able to afford to pay for that care”

The court nonetheless rejected Islington's argument. In a detailed judgment that merits further reading, it concluded that the issue of what was 'fair just and reasonable' could not be read as a literal application of the test restricted to the issues between the two parties before the court, but instead required the courts to consider much wider policy issues. These included looking at the intention of Parliament and those advising Parliament, such as the Law Commission, in the imposition and allocation of responsibility between public authorities for the discharging of public functions; the question of who should be required to meet the cost of care of those regarded as 'in need' was a classic example of social legislation. The court regarded it as a matter for the legislature rather than 'ill-equipped courts' to resolve such issues and that it would not be fair just and reasonable to impose liability on behalf of UCH merely because it was a tortfeasor.

(b) Statutory intervention to ensure that the tortfeasor pays

19. Parliament has in certain circumstances seen fit to intervene. Section 157 and 158 Road Traffic Act 1988 allowed for recovery of certain NHS charges in the case of victims of road traffic accidents.
20. A comprehensive review of the recovery legislation was introduced under the Health and Social Care (Communities Health Standards) Act 2003. Section 150, in force with effect from 29th January 2007, now provides a comprehensive regime for the recoupment of NHS treatment charges for victims of injuries. The recoupment provisions are no longer limited to road traffic accidents and cover all injuries, whether physical or psychological, where the same arises as a consequence of negligence or other breach of duty. The charges are based on a tariff in relation to ambulance charges and the daily cost of treatment in a NHS hospital. In 2007 the cap on the recoverable charges was £37,100. The present limit is £42,999. In calculating the amount payable it is permissible for the payment to be reduced to reflect any discount for contributory negligence. It is however necessary for there to be a clear memorandum of agreement identifying the degree of contributory negligence in those cases where there has been no judicial finding. Unlike the earlier RTA scheme the recoupment scheme under the 2003 Act is not restricted to cases where there is an insurer.
21. It is of some interest to note that the Regulatory Impact Assessment in relation to the implementation of the above provisions identifies the fundamental aim of the statutory provisions as being '*an intention to ensure that the NHS and thus the tax payer should not have to subsidise those responsible for causing injuries to others*'.²⁶ These recoupment provisions and the explanation of the intention of Parliament might be said reflect a clear intention on the part of Parliament to ensure that where possible the tortfeasor pays.²⁷
22. The Law Commission has given detailed consideration to the question as to whether the NHS should have a general right of recovery in respect of the cost of treatment provided to those tortiously injured. For a variety of reasons it has hitherto concluded that beyond the limited rights of recovery thus far implemented, it would be difficult to put into effect a workable system of recovery of future costs.²⁸ Thus there is at present no immediate plans to provide a statutory right to recover future costs of care and treatment from the tortfeasor.

²⁶ See paragraph 11.2

²⁷ A similar purpose might be identified in relation to the provisions for CRU recovery.

²⁸ Law Commission Report '***Damages for Personal Injury: Medical Nursing and Other Expenses***'

Can a statutory funder have regard to the 'tortfeasor pays' obligation when deciding how it will discharge its statutory duty?

23. This issue has arisen obliquely in the context of the rights of a local authority to devise its own charging policy in accordance with the guidance issued by the government under *'Fairer Charging'*.²⁹ Whilst a local authority is required to exclude the claimant's award of damages in any assessment of his/her eligibility for domiciliary care services, it is open to an individual authority to include as part of the claimants income and capital the personal injury award recovered from the tortfeasor when deciding whether to charge that individual for the services provided. Whilst it can be argued that to do so is no more than an application of the wide discretion available to an authority under s17 HASSASSA³⁰ 1983, it is perfectly arguable that an individual authority's policy decision to include as part of the user's income damages recovered from the tortfeasor, could be explicitly based on a desire to ensure that the tortfeasor pays.
24. What of a situation where a claimant has or is entitled to damages from the tortfeasor but who wants to continue with the NHS provision of care or receipt of equipment, such as ventilators? Can the statutory funder refuse to provide these services on the basis that the claimant has an absolute right to recover the cost from the tortfeasor? This was the issue before the court in the case of *Booker v Oldham Primary Care Trust and Direct Line (Interested Party)*³¹.

Factual background

25. The claimant was injured in a road accident in 2001. She was then aged 9. She suffered catastrophic injuries leaving her tetraplegic and ventilator dependent. Liability for the accident was admitted and judgment was entered on a 100% basis. Following hospital discharge the claimant's care needs were met in her own home by Oldham PCT. The method of provision chosen by Oldham was its own dedicated Paediatric Ventilator Care Team. The claimant was assessed as requiring 2 carers around the clock. However because she was a child Oldham, consistent with general PCT approach, took into consideration the obligation of parents to look after children and the claimant's care need was met by a mixture of PCT and family care. It was however accepted by the PCT that as an adult the contribution of the claimant's mother could not be taken into account and that fully funded care would need to be provided by the PCT.
26. The case was settled in late 2009 by which time the claimant had reached adulthood. At the date of the settlement negotiations there remained an issue between the claimant and the insurers for the defendant as to when any private care regime would be implemented. The claimant had by that date been in receipt of PCT care for some 9 years, she was in the process of transferring from her paediatric team to an adult team, there was an insistence that the claimant who had full intellect should be actively involved in the choice of carers recruited by the PCT, and it was argued on behalf of the insurers that it was likely that the claimant would allow a period for the PCT's recruited adult team to settle in and only after that would she begin the process of introducing privately employed carers to train alongside the established team. So far as the litigation was concerned this issue was resolved by an acknowledgement on behalf of the claimant that the private regime would commence two years from the settlement, namely in December 2011.
27. In accordance with the above agreement the settlement agreement provided for a lump sum payment for all heads of loss excluding care and case management, and a deferred PPO, in the

²⁹ *Fairer Charging Policies for Home Care and other non-residential Social Services LAC (2001)* 32

³⁰ Health and Social Services and Social Security Adjudication Act 1983.

³¹ [2010] EWHC 2593 (Admin)

sum of £247,500 to commence on 15 December 2011. The agreement also contained a number of undertakings by the claimant in relation to seeking continuation of PCT funding up to 2011, not to accept the same thereafter without agreement from the Insurer, and to cooperate in ensuring that the funding remained in place, including where necessary, lending her name to the pursuit of judicial review proceedings. The insurer also gave a series of undertakings including to cooperate in the above process, to fund the steps reasonably necessary to retain funding, including the pursuit of proceedings where appropriate, and to provide an indemnity in relation to the cost of care during the deferred period. This was to provide the claimant with a 'safety net' in the event that PCT funding was withdrawn. This was limited to a maximum sum representing the agreed annual care costs.

28. Prior to the settlement Oldham had threatened to withdraw its care services relying on the fact, as it understood the position, that the claimant would recover, from the date of trial, damages reflecting 100% of her care costs. After the settlement and notwithstanding the fact that a copy of the terms of the same was made available, Oldham repeated its intention to withdraw the care being provided and to require the claimant to pay for some of the care previously delivered. Eventually Oldham identified a deadline for the removal of the claimant's ventilator care team of 1 September 2010. This was said to be on the basis that it no longer had any statutory obligation to provide the same. The claimant with the support of the Interested Party commenced judicial review proceedings against Oldham. The insurer was an Interested Party. The application was issued in early September and the substantive hearing took place in early October.

The argument advanced on behalf of Oldham PCT

29. In what was accepted to be novel issues with significant ramifications and on which there was no decided authority, Oldham advanced the following arguments:
- (1) That a PCT's obligation to provide NHS services under ss 1 and 3 of the NHS Act 2006 was a 'target duty', not an absolute directly enforceable duty and that a PCT had a discretion as to what services to provide and to what level.
 - (2) That a PCT was entitled to conclude that a claimant in the position of Ms Booker did not have a '*reasonable requirement*' for PCT services within section 3 of the Act because she had made an election, pursuant to Section 2(4) of The Law Reform (Personal Injuries) Act 1948, to rely on the tortfeasor as the person from whom funding of her care needs would be met.
 - (3) That in the alternative a PCT was entitled to reach a decision that was not susceptible to judicial review, that a person who had a right to receive and *a fortiori* had received damages from a tortfeasor, no longer had a '*reasonable need*' for the services that a PCT might provide.
 - (4) That a PCT was entitled to draw a distinction between somebody who has the means to pay for care from his/her own private resources, in which case the PCT could have no regard to the same in deciding whether or not to provide NHS services, and a claimant who recovers damages for personal injury or who had an indemnity from the insurers of the tortfeasor. In the latter situation the PCT could decide not to fund or continue to fund services. The justification being that to require the Claimant in the latter position to fund services from damages was not to offend 'the free at the point of delivery' principle which was accepted, but merely reflected a separate and important principle namely that the "tortfeasor pays".
 - (5) That the application for a judicial review of the decision taken by the PCT was misconceived because the PCT's duty was a "target duty" and that in deciding how to

discharge the same there was no statutory restriction on the factors a PCT could take into consideration. Indeed the PCT was obliged to take into account a range of matters including cost, other demands upon its budget and its absolute obligation to break even.

- (6) That unless the decision reached was an unlawful or irrational one, the Court would have no power to quash the same (*R (Rogers) -v- Swindon NHS Primary Care Trust*).³²

The approach adopted by the Court

30. The case was argued over two days in the Administrative Court in Manchester before His Honour Judge Pelling QC, sitting as a High Court Judge. In accepting the arguments of the claimant and the Interested Party and rejecting those advanced by the PCT, the Court reached the following conclusions:

31. The decision of the PCT was unlawful and would be quashed because:

- (1) However packaged in truth the PCT's case was based on the premise that the claimant did not have a reasonable requirement for services because she had the ability to pay for the same.
- (2) To have regard to the claimant's ability to pay was contrary to Section 1 of the 2006 Act, which provides a duty (albeit a target duty) to provide a comprehensive service free at the point of delivery, and was also contrary to the NHS constitution which provided that "*access to NHS services is based on clinical need, not on an individual's ability to pay and that a person who is otherwise eligible for treatment is entitled to receive it free of charge*".³³

32. The attempt to rely upon the "tortfeasor pays" principle was misplaced and misconceived because:

- (1) The jurisprudence supporting the tortfeasor pays principle was one developed in the context of a dispute between a victim and a tortfeasor in a common law action for damages and was primarily concerned with whether the victim should rely on his right to secure damages from the party responsible for the wrong or be required to avail himself of available statutory or other services which might as a consequence relieve the tortfeasor from his prima facie responsibility.
- (2) There was in any event no authority supporting the proposition being advanced, namely that the principle could be relied upon by a statutory provider to relieve it of its duty to provide services where the victim, in this case the claimant, wished to avail herself of those services. The Judge observed that

"There is no authority, however, that supports the proposition that the NHS is entitled to rely upon this doctrine as a basis for

³² [2006] EWCA Civ.

³³ The might have additionally relied on Paragraphs 2(2) and (5) of ***the NHS Continuing Healthcare (Responsibilities) Directions 2007*** which arguably imposed an obligation to provide NHS Continuing Healthcare to the claimant given the outcome of the assessment carried out by the PCT in February 2009. If an assessment is carried out para 2(5) provides that if the PCT decides that a person has a primary health need "*the PCT must decide that the person is eligible for NHS Continuing Healthcare*"

*avoiding the provision of services to a person who would otherwise be eligible to receive them.*¹³⁴

- (3) There was nothing in the legislation referred to, or in the NHS National Framework Document dated July 2009 to support the PCT's argument that financial considerations of the type being considered could be taken into account in the exercise of the discretion.
- (4) The attempt to suggest that the PCT's decision was immune from judicial review was unsound. The cases relied upon could be distinguished. This was not a case where the PCT had decided that a particular form of treatment should not be provided to a class of person because it was low on its list of priorities. Nor was it a case where the PCT alleged that funds were unavailable to provide the care required. This was a decision based upon a desire to avoid funding this particular claimant's eligible needs where the only distinguishing feature was her ability to pay either using her own funds, with the prospect of being indemnified from the Insurer, or using her damages generally.
- (5) The fact that the Insurer had agreed to a 'safety net' indemnity did not change the essential character of what was being required of the claimant by the PCT.

Analysis and implication

33. It is suggested that this is an important decision for all those involved in the litigation of catastrophic injury claims. It is a feature of the most serious cases that the claimant's care needs may well have a sufficient healthcare element such that any statutory obligation to provide care falls upon the PCT under the criteria set out in *Coughlan* and the NHS Continuing Healthcare criteria, rather than upon social services. Even where long term care is not being provided by a PCT many ancillary services are provided to the catastrophically injured such as district nursing services, equipment such as ventilators, and consumables for tracheotomy and incontinence care. In the present case the PCT was seeking to withdraw all of the same leaving the claimant with access to GP services and the right to emergency hospital admissions but precious little else. In many cases a claimant may have no choice but to rely as least in part on PCT provision.
34. As set out above, the meaning of section 2(4) of the 1948 Act is well understood. The statutory protection given to a claimant to secure damages from the tortfeasor where NHS facilities is available, is clear. *Peters* now provides a similar common law protection where the statutory provider is not the NHS. If a claimant secures damages and then seeks local authority domiciliary services, the local authority cannot identify the existence of the damages as a reason not to assess the claimant's entitlement to services but it may take its own and the claimant's resources into consideration in deciding whether it has any requirement to provide services to meet any identified need. The position of the NHS is different. NHS services are free and not subject to any means testing. As such the award of damages or any other source of funds should be irrelevant to the right of an eligible individual to seek such services. In the context of personal injury claims and subject only to issues of undertakings against double recovery being given as part of any settlement in any individual case, the NHS remains an important source of services available to a claimant.
35. In *Booker* the PCT considered that it was entitled to walk away from its obligation to meet the claimant's needs once there had been a deemed election by the claimant to look to the tortfeasor, at least where that had resulted in recovery of damages. The decision of the court has rejected this argument. The PCT argued that it was a matter of importance and a policy

³⁴ Judgment [27]

decision open to PCT's and legitimate in these stringent times. It prayed in aid the importance of the tortfeasor pays principle as a matter of 'public policy', highlighted the fact that double recovery was a real possibility in such cases, alternatively that insurers and claimants could reach 'cosy deals' where they both benefitted at the expense of the public purse, and the fact that in the present case the insurer had enjoyed the benefit of 9 years of statutory funding. These were said to be cogent reasons supporting the stance adopted by Oldham.

36. On the particular facts of *Booker* many of these arguments were inapplicable. There was no cosy deal between the parties in the litigation, the claimant was not going to enjoy double recovery, and whilst it was correct that the past care costs and a further saving to the insurer of £500,000 was technically at the expense of the public purse, there were good reasons why the claimant wanted the PCT regime to remain in place. The PCT also argued that the indemnity provided by the insurer should be regarded as equivalent to an award of damages from the tortfeasor. It was contended that under the agreement the insurer was obliged, without qualification, to make payment of the care costs if the PCT ceased its funding and that this was a valid reason for its decision to refuse to fund.
37. Had the PCT succeeded it was made clear that the underlying principle that 'the tortfeasor pays' could in future cases be used to support a refusal on the part of the PCT to continue to fund where the Claimant has a right to recover from a tortfeasor even if no recovery was made. In a letter from the PCT to the Claimant it was noted that 'this difficult issue had fortunately not arisen in the present case'.
38. The "tortfeasor pays" was also seen by the PCT as applying to all cases without any distinction between full liability and partial recovery. The material consideration being the recovery of some award in respect of a service that the PCT had hitherto provided. If the PCT's argument had succeeded, a claimant entitled to recover only 50% of the full value of his damages would be required to make difficult decisions as to how to utilise such funds. On one view if he received a lump sum he would be required to utilise the same, it lasting for only half the time, or attempt to reach some agreement with the PCT. Given the apparent reluctance of many PCTs to enter into shared funding arrangements this would present very difficult decisions for those advising claimants. Further the fear of identifying sums received expressly for care or other services with the risk that it might trigger a decision by a PCT to reconsider provision of services, might have encouraged some claimants to consider bundled up lump sum settlements so as to remove or reduce the risk of withdrawal of services.
39. The issue as to how a PCT might take into consideration the financial position of an individual without carrying out an unlawful means test is not one that is entirely new to the courts. In *Tinsley v Sarker*³⁵ Leveson J. (as he then was) made obiter comments in the context of a hypothetical situation of a cash starved Trust trying to meet its statutory obligation to provide services (under section 117 MHA 1983) and being invited to fund the housing needs of a millionaire. In response to the argument that the PCT was not entitled to have regard to financial position of the claimant and had a duty to provide services irrespective of means (including an award of damages) he said this:

“113. *Of course, the question in Stennett is not the question before me, I am not concerned with whether there is a power to charge but rather whether, when exercising its statutory power, either in connection with the provision of aftercare or the review of such provision, the authority can take account of the extent to which the discharged patient has ample provision for aftercare such that he need not resort to the use of public funds. This issue could be alternatively formulated by asking whether when*

³⁵ [2005] EWHC QB

*assessing damages the Court is constrained by the principles enunciated in **Hodgson v. Trapp** to identify this public source of funding and relieve the tortfeasor of the duty which would otherwise have been imposed to provide for his victim's reasonable needs."*

"122. *Assuming that the Trust is in its present precarious financial state, take now the case of a multi-millionaire who is compulsorily detained following an accident for which there is no question of pursuing a claim for damages but who now needs 24 hour waking support. His needs are the same irrespective of how they can be met but can it be said that his needs "call for" the provision by the Trust of that support? To say that they do not, is not to exercise a means test: a means test is a mechanism whereby the provider tests eligibility for a particular service. Rather, it is to have regard, in a more global sense, to the resources available, the other calls on those resources and the extent to which that particular person requires Trust support. In reality, this is no different from the Trust taking into account the fact that someone who applies to it for support has a house which can provide the basis of any further support which he or she may require."*

The arguments advanced by Oldham adopted the above approach. However it is suggested that the court was right to reject this argument. Any relaxation of the principle that the means of the individual is irrelevant to his entitlement to services should be a matter for Parliament and not for the courts or for public bodies forming individual judgments as to how a claimant should have ran his or her case. The judgment of HHJ Pelling QC strongly reaffirmed the principle that NHS Services must be provided free at the point of delivery.

The problem of double recovery

40. From the perspective of the insurer and the claimant the decision in *Booker* means that double recovery remains an important issue for consideration. One newspaper has reported the *Booker* case under headlines '**Riches no bar to free NHS care**' commenting that despite receiving £2.9 million and £250,000 per annum the claimant will be receiving free NHS care. It will need to be considered whether the above ruling lends further support to the argument that *Peters'* style undertakings will need to be considered even in non Court of Protection cases.
41. The ability to secure an appropriate undertaking from a solicitor acting as financial deputy, or to restrict the scope of the power granted to the financial deputy by the Court of Protection, are not material considerations in the context of an adult of full age and capacity pursuing a damages claim³⁶. In *Peters* the Court of Appeal adopted the consistent policy position seen in other cases³⁷ and considered that the problem of double recovery was one of some importance and had to be addressed. The court endorsed the offer of an undertaking that had been rather dismissed by the court below. The issue of undertakings in the context of a claim by an adult with capacity has not, so far as the writer is aware, be considered by the court. The Law Commission had doubts as to whether the court could require the same from a claimant³⁸ and it might be argued that a finding of fact, in accordance with the *Eagle v Chambers* and

³⁶ The need for some mechanism whereby the Financial Deputy need not strive to bring in external funds in compliance with a fiduciary duty to maximise the protected beneficiary's funds, is well understood.

³⁷ A similar position is to be found in the decisions in *Sowden* and in *Crofton*.

³⁸ *ibid*

Woodrup v Nicol jurisprudence, namely that the claimant will not in the future rely upon PCT or other statutory funding, renders any issue of the need for an undertaking redundant. On the other hand the insurer may well view with suspicion a claimant who is unwilling to proffer an undertaking and might seek to have this issue tested in the knowledge that the higher courts have repeatedly signalled its willingness to ensure that double recovery is avoided. Further the vast majority of these cases are not litigated to a determination by the court but are the subject of negotiated settlements. In the latter cases the giving of a suitably worded undertaking to avoid double recovery, as was given by the claimant in the present case, is not uncommon and may be required as part of the negotiated settlement.

Double recovery in a future quasi privatised NHS

42. The issue of double recovery and appropriate indemnities may become even more important in the future. Radical changes are planned in the manner in which NHS services will be delivered. PCT are to be abolished with effect from 2013. Many of their functions will be transferred to GP consortia or GP collectives as they are now being called. As a consequence:
- (1) GP consortia are likely to have responsibility for delivering services under what is now Continuing NHS Healthcare.
 - (2) Over the last decade GP's have organised themselves as small private businesses delivering essential services. Putting them in charge of delivering the vast majority of NHS services will inevitably result in a more market driven service.
 - (3) GP consortia are unlikely to have the infrastructure or the inclination to employ staff to deliver such services as critical care in home settings and will be outsourcing the delivery of these functions. Care agencies deliver at present but there is no reason why this will be the only model. The entitlement of individuals to choose other options seems central to the Government's intention that there should be much greater patient choice.
 - (4) On 1 June 2010 the Government introduced the *National Health Service (Direct Payment) Regulations 2010*. These regulations are of immense importance in the way services will in the future be delivered. They, for the first time in the history of the NHS, provide a mechanism whereby a PCT can make direct cash payments to a recipient of services instead of providing the service itself. Thus allowing the patient to choose the method of delivery of the service and to control the purse strings. Such a facility is ideally suited for the provision of care and in giving the patient the right to select and employ his or her own care staff.³⁹
43. It is almost certain that GP consortia will have similar powers. A claimant will almost certainly be entitled to receive a cash equivalent instead of services. The present regulations prevent the PCT from funding only part of any assessed need. A claimant recovering 50% of his damages from the tortfeasor may find that he has to look to his local GP consortia for funding. The Consortia will provide funds but on the basis that it fund the full extent of the assessed need. The decision in *Booker* means that the GP consortia cannot refuse to fund on the basis of the Claimant's receipt of damages. The risk of double recovery is obvious. Agreements between the insurer and the Claimant appear to be one possible option. Where there is no agreement the question arises as to what options will the court have at its disposal to prevent double recovery? Will the solution suggested by Flaux J. in *Burton v Kingsbury* become the way forward?

³⁹ There are a number of cases where PCT are already agreeing to Case Managers receiving direct funding for to employ care staff. The 2010 Regulations will remove the need for the use of IUT's which appear to have been unpopular with PCT's.

Terms of the indemnity agreement

44. The precise terms of the agreement between the claimant and the insurers was the subject of close scrutiny by the court. It was argued on behalf of the Interested Party that whilst the court was obliged to construe the agreement to ascertain its meaning and effect, it was irrelevant and impermissible to investigate why the parties had reached the agreement in question. The court agreed. It is also suggested that the court reached a correct conclusion as to the interpretation of the agreement and the context in which the indemnities were to be seen. An insurer who provides an indemnity against loss of PCT funding is usually providing a safety net provision rather than a primary right to call upon performance of that obligation especially where the agreement expressly records the understanding of the parties as to the claimant's right to the statutory provision and where there are obligations imposed on both parties to seek to secure or preserve such funding. It is however clear that it will be important to ensure that proper consideration is given to the drafting of such agreements in each case and that a bespoke document meeting the particular requirements of the parties in that case is prepared.
45. The PCT argued that it was not bound to take at face value the terms of settlement reached between the claimant and the insurers and that if parties to settlements wanted to achieve certainty they would have to engage the PCT in the discussions or negotiations. This argument did not find favour with the court. As was observed, in such circumstances no claimant would risk settling upon terms that envisaged some element of PCT funding without the express approval of the PCT. This would in turn require the involvement of the PCT in any settlement negotiations leading to uncertainty, delay and costs. The judge whilst acknowledging that it was right that where ever possible the tortfeasor should be the person who pays, concluded that his reasoning and rejection of this novel attempt to relieve a PCT of its obligation, accorded with the conventional approach and that if there was to be such fundamental changes of approach then it was a matter for Parliament.
46. The approach of Oldham appears to have been encouraged by a strongly worded opinion from counsel advising the PCT as to its ability to transfer the burden of meeting such care needs from 'a cash strapped and demand heavy service' provided by PCT, to the tortfeasor.⁴⁰ It is a matter of debate whether the facts of this case provided the ideal vehicle to launch this rather bold attempt to address the issue of who funds what. The PCT have sought and had refused an application for permission to appeal. The indications are that an application for permission will be sought from the Court of Appeal. The decision of the Administrative Court in this case is not fact sensitive;⁴¹ it is based on fundamental questions as to whether the means of the individual can ever be relevant to a NHS body providing eligible services. It is not known whether the Court of Appeal will wish to provide authoritative guidance on this matter.

Winston Hunter QC

Byrom Street Chambers

⁴⁰ This Advice was secured during the application by a disclosure request under CPR 32.14

⁴¹ Although it might be argued that the case could have been decided in the same way on narrower fact sensitive grounds.