

Modelling the Future Burden of Respiratory Syncytial Virus (RSV) in Older Adults in Ireland

A Forvis Mazars Report Commissioned by Pfizer Healthcare Ireland

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Plain summary	Technical summary	Context	Current burden	Future burden	Impact	Findings

Plain Language Summary

The Future Burden of RSV in Older Adults in Ireland

At a glance: RSV already causes serious illness and substantial hospital demand among older adults in Ireland. The report's modelling suggests that this burden is likely to grow as Ireland's population ages, with the greatest impact expected among people aged 80 and over and during the busiest winter weeks.

Respiratory Syncytial Virus, or RSV, is a common seasonal respiratory virus. For many people it causes mild, cold-like symptoms, but it can lead to serious illness in older adults, particularly those with underlying health conditions. Severe infection may require hospital treatment and can worsen conditions such as chronic obstructive pulmonary disease, asthma and heart failure.

Commissioned by Pfizer Healthcare Ireland, and conducted by Forvis Mazars, this report examines how the burden of RSV among adults aged 65 and over in Ireland could develop between 2026 and 2031. It uses Irish surveillance information, population projections and published research to model several possible scenarios - low, central and high. These scenarios are estimates rather than precise predictions, and actual outcomes may differ.

The recorded figures may show only part of the burden

In 2025, Irish surveillance data recorded more than 2,250 medically attended RSV cases among adults aged 65 and over. There were also 740 hospitalisations, 13 intensive care admissions and 46 deaths in which RSV was identified. More than half of the hospitalisations occurred among people aged 80 and over.

However, RSV can be difficult to identify in older adults. Testing is not always carried out, available tests may miss some infections, and older people may not display the symptoms normally associated with RSV. The virus can also worsen an existing condition without being recorded as the main reason for admission. The report therefore concludes that notified cases are likely to capture only part of the true burden.

To reflect this uncertainty, the report presents low, central and high scenarios in the context of the baseline reported data. Compared with the 2,250 medically attended cases recorded through surveillance in 2025, the figures modelled under the low, central and high scenario are 4,950, 9,000 and 17,775 respectively. This illustrates the potential scale of the burden if RSV is more significantly under-identified than the surveillance data suggest. These figures are modelled estimates under different assumptions, not observed case numbers or predictions of what will happen.

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<u>Plain summary</u>	<u>Technical summary</u>	<u>Context</u>	<u>Current burden</u>	<u>Future burden</u>	<u>Impact</u>	<u>Findings</u>

The burden is expected to increase

Ireland's older population is growing, with the number of people aged 80 and over increasing particularly quickly. This matters because the oldest age group experiences the greatest burden of severe RSV illness and tends to have longer hospital stays.

Under the central scenario, medically attended cases among adults aged 65 and over are estimated to rise from 6,871 in 2026 to 8,281 in 2031. Over the same period, hospitalisations are projected to increase from 1,961 to 2,363, intensive care admissions from 38 to 45, and RSV-related deaths from 105 to 129. Of the projected deaths in 2031, approximately 92 are estimated to occur among people aged 80 and over

The greatest pressure will be felt in winter

The impact of RSV is not spread evenly throughout the year. It is concentrated during the winter respiratory virus season, when hospitals are also managing influenza, COVID-19 and other illnesses.

Under the central scenario, RSV-related acute hospital bed use is projected to rise from approximately 18,374 bed days in 2025 to 23,975 in 2031, an increase of about 30 per cent. Average combined inpatient and intensive care occupancy is projected to rise from about 51 beds each day in 2025 to 66 beds each day in 2031.

These annual averages do not fully show the intensity of the winter peak. The analysis estimates that 98 per cent of annual acute bed-day demand attributable to RSV occurs during the 32-week RSV season, with 66 per cent concentrated in a ten-week period when hospital capacity is likely to be most constrained.

The impact extends beyond hospitals

Under the central scenario, the report estimates direct healthcare costs over 2026 to 2031 of €10.3 million for GP visits, €4.6 million for emergency department visits, €115.1 million for hospitalisations and €2.7 million for intensive care admissions. Together, these amount to approximately €132.7 million, with hospitalisations accounting for most of the estimated cost. This analysis measures direct healthcare expenditure for the health system outcomes analysed and is not a full economic evaluation.

The wider effects are also important. Serious RSV illness may lead to prolonged weakness, reduced mobility, deterioration in existing conditions and loss of independence. Families may need to provide care during recovery, while some patients may require rehabilitation, home support or residential care. These wider personal, family and societal impacts are not fully captured in the direct healthcare cost estimates.

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Overall, the report finds that RSV is likely to become a growing source of illness and winter health-system pressure as Ireland's population ages. The greatest impact will continue to fall on people aged 80 and over, who are most vulnerable to severe disease and account for the largest share of hospital bed use. While the central scenario indicates a substantial and growing burden, the high scenario demonstrates that the impact could be considerably greater if current under-identification of RSV is more extensive than assumed in the central analysis.

Important note: This report is based on forecasting and scenario modelling. Its estimates should be interpreted as indicative measures of the possible future burden under the assumptions used, not as predictions of future cases, costs or healthcare requirements.

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Technical Summary

Background and Policy Context

Forvis Mazars in Ireland was commissioned by Pfizer Healthcare Ireland ('Pfizer') to undertake this report modelling the likely future health system burden (2026-2031) of Respiratory Syncytial Virus (RSV) in older adults under realistic assumptions regarding under-ascertainment, population ageing and healthcare demand.

RSV is a common, cold-like virus that causes infections of the respiratory tract. Almost all children get RSV by the time they are 2 years old, with the virus being most prevalent in winter and early spring¹. However, older adults are at risk of serious complications as a result of contracting RSV, including exacerbation of congestive heart failure (CHF), asthma, and chronic obstructive pulmonary disease (COPD)². Yet, accurately diagnosing RSV in older adults is challenging, resulting in substantial underestimation and under-ascertainment of the disease burden³.

Ireland, as with other developed countries, is facing an unprecedented 'demographic shift' towards an ageing population. This means that the number and proportion of persons aged 65 and over is increasing⁴, in turn increasing the old-age dependency ratio. This trend has significant policy implications for demand on the health system, on which older adults are disproportionately reliant. This demand will only increase as the trend continues, thereby placing further strain on the health system and its capacity to support vulnerable populations. Notably, these older age groups are also those which are at higher risk of severe RSV infection, meaning that the overall number of severe RSV infections is likely to rise in line with the growth in the older age population¹.

RSV Burden in Older Adults in Ireland

Our analysis of the impact of RSV considers five health system outcomes: medically attended cases; emergency department visits; hospitalisations, ICU admissions and deaths. Analysis of HPSC surveillance data indicates that more than 2,250 medically attended cases of RSV, 614 ED visits, 740 hospitalisations, 13 ICU admissions and 46 deaths were reported among adults aged 65 and over in 2025⁵.

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However, evidence suggests that notified cases capture only a proportion of the true burden. Applying under-ascertainment assumptions broadly consistent with the literature indicates that the actual number of medically attended cases for RSV in older adults may be several times higher than reported figures⁶.

Scenario analysis suggests the actual figure of medically attended RSV cases in 2025 is likely to be at least 9,000 (as under the central scenario in our analysis), but could be as high as 17,775 (as under the high scenario in our analysis). The majority (over 50%) of these cases are observed in adults over the age of 80.

The most important finding from a health-system perspective relates not simply to case numbers, but to the winter capacity burden generated by severe RSV infection. HPSC data shows that hospitalisations are heavily concentrated among older age groups, particularly adults aged 80 years and over, a group which accounts for more than half of RSV hospitalisations and which experiences the longest average lengths of stay⁵. As a result, the oldest age groups consume a disproportionate share of acute hospital bed capacity.

When adjusted for potential under-ascertainment, the estimated capacity burden becomes substantially larger. Under the central scenario, approximately 18,374 acute hospital bed days and 142 ICU bed days were attributable to RSV in adults aged 65 and over in 2025, compared with 6,507 acute bed days and 57 ICU bed days based on reported data alone. These findings suggest that the operational burden of RSV on the healthcare system may be much greater than is apparent from surveillance data alone.

Table 1: Summary of Number of Medically Attended Cases of RSV by Age Subgroup and Scenario, 2022-2025				
	2022	2023	2024	2025
Baseline (Reported Cases)				
65 - 69 years	164	146	118	233
70 - 74 years	274	243	197	389
75 - 79 years	316	281	228	450
80 years and over	827	735	597	1,178
Total	1,581	1,405	1,140	2,250
Low				
65 - 69 years	361	321	260	514
70 - 74 years	602	535	434	857
75 - 79 years	695	618	501	989
80 years and over	1,820	1,618	1,313	2,591
Total	3,478	3,091	2,508	4,950
Central				
65 - 69 years	656	583	473	934
70 - 74 years	1,095	973	789	1,558
75 - 79 years	1,264	1,123	911	1,798
80 years and over	3,310	2,941	2,386	4,710
Total	6,324	5,620	4,560	9,000
High				
65 - 69 years	1,296	1,152	934	1,844
70 - 74 years	2,162	1,921	1,559	3,077
75 - 79 years	2,496	2,218	1,800	3,552
80 years and over	6,536	5,809	4,713	9,302
Total	12,490	11,100	9,006	17,775

Source: Forvis Mazars analysis of HPSC data

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Forecast of RSV Burden in Older Adults in Ireland (2026-2031)

We developed a static forecasting model estimating the likely burden of RSV in older adults in Ireland between 2026 and 2031. We integrated HPSC's notified RSV case figures with CSO population projections to produce scenario-based forecasts for the number of RSV-attributable medically attended cases, emergency department visits, hospitalisations, ICU admissions and deaths.

Our forecasts clearly indicate that the clinical burden of RSV in older adults aged 65 and over will continue to increase. Furthermore, this impact is most acutely felt in the oldest age sub-group, i.e., those aged 80 years and over. When we consider the fact that the 65+ age group is growing at the fastest rate across the whole population – and the 80+ age subgroup growing at the fastest of all⁷ – the policy implications are clear: the number of medically attended cases, hospitalisations, ICU admissions and deaths (each requiring bed days) will only continue to increase as a result of population ageing, and this will place further strain on an already overburdened healthcare system⁸.

Table 2: Summary of Forecast Number of RSV-Related Health System Outcomes for 65+ Age Group, Scenario Analysis, 2025-2031							
	2025	2026*	2027	2028	2029	2030	2031
Baseline (Reported Cases)							
Cases	2,250	1,718	1,785	1,854	1,925	1,998	2,070
ED Visits	614	585	607	631	654	679	703
Hospitalisations	740	784	815	847	879	912	945
ICU Admissions	13	15	16	16	17	18	18
Deaths	46	42	44	46	48	50	52
Low							
Cases	4,950	3,779	3,927	4,079	4,235	4,396	4,555
ED Visits	736	702	729	757	785	815	843
Hospitalisations	888	941	978	1,016	1,055	1,095	1,134
ICU Admissions	16	18	19	19	20	21	22
Deaths	55	50	53	55	57	60	62
Central							
Cases	9,000	6,871	7,141	7,417	7,700	7,993	8,281
ED Visits	1,534	1,462	1,518	1,577	1,636	1,697	1,757
Hospitalisations	1,850	1,961	2,038	2,117	2,198	2,281	2,363
ICU Admissions	33	38	39	41	42	44	45
Deaths	115	105	110	114	119	124	129
High							
Cases	17,775	13,569	14,103	14,649	15,207	15,786	16,355
ED Visits	2,025	1,930	2,004	2,081	2,159	2,240	2,319
Hospitalisations	2,443	2,588	2,690	2,794	2,901	3,011	3,119
ICU Admissions	43	50	52	54	56	58	60
Deaths	152	139	145	151	157	164	170

Source: Forvis Mazars analysis of HPSC data

* Note that 2026 estimates reflect an average of 2023-2025 figures, with 2025 representing a high-case year.

While the growth in RSV-attributable admissions demonstrates a clear growing burden on the system, explicitly modelling the number of bed days attributable to RSV demonstrates a more nuanced outlook on the likely burden on the system. RSV-related acute bed day utilisation among adults aged 65 and over is projected to increase steadily between 2025 and 2031 under all scenarios, reflecting growth in RSV-related hospitalisations and the increasing number of older adults at highest risk of severe disease.

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Plain summary	Technical summary	Context	Current burden	Future burden	Impact	Findings

Under the central scenario, annual inpatient bed day utilisation is projected to rise from approximately 18,374 bed days in 2025 to 23,975 bed days by 2031. Depending on assumptions regarding average length of stay, annual RSV-related bed day requirements could range from 9,460 bed days under the low scenario to 39,913 bed days under the high scenario by 2031. The projected increase in RSV-related activity translates into a requirement for the equivalent of 15 additional acute hospital beds occupied every day by 2031.

RSV-related ICU bed day utilisation among adults aged 65 and over is projected to increase steadily between 2025 and 2031 across all scenarios, reflecting the growing burden of severe RSV disease in an ageing population. Under the central scenario, annual ICU bed days are forecast to rise from approximately 142 in 2025 to 196 by 2031, representing an increase of around 38%.

However, it is important to note that this figure likely understates the operational impact of RSV on the health system. RSV is a highly seasonal infection, with the majority of cases occurring during the winter respiratory virus season when hospitals are simultaneously managing influenza, COVID-19 and other acute respiratory illnesses. As a result, RSV-related health system demand is more concentrated over a relatively short period of the year, meaning that peak bed requirements are likely to be substantially higher than annual averages suggest⁹. Indeed, our analysis shows that 98% of the total annual bed day requirement occurs during the RSV season (32 weeks, or 62%, of the year). Furthermore, in the 10-week spell (between weeks 48 through to 4) where RSV is most prevalent, we expect that 66% of the bed-requirement will be concentrated, showing the burden that RSV places on the health system, when operational capacity is at its most constrained.

Table 3: Number of RSV-Attributable Acute Bed Days Required During Winter Respiratory Virus Season, 2026-2031, Central Scenario						
	2026	2027	2028	2029	2030	2031
Total RSV-Attributable Annual Bed Days	19,595	20,430	21,291	22,174	23,083	23,975
In-Season Bed Days Required	19,183	20,001	20,844	21,709	22,598	23,472
Bed Days Required in 10-Week Peak	12,618	13,156	13,710	14,279	14,864	15,439

Source: Forvis Mazars analysis of HPSC data

Meanwhile, it is forecast that 97% of ICU bed days are required in-season, with 81% of the bed-requirement concentrated in the 10-week peak.

Between 2025 and 2031, RSV-related hospitalisations are projected to increase by approximately 28%, while acute bed day utilisation is projected to increase by approximately 30%. This indicates that hospital capacity pressures associated with RSV are expected to grow faster than admission volumes alone due to population ageing and longer lengths of stay among adults aged 80 years and over. These capacity pressures will be felt most acutely during the winter season.

Table 4: Forecast Comparison of Annual Growth in Number of Hospitalisations vs Growth in Number of Bed Days (2026-2031), Central Scenario						
	2026	2027	2028	2029	2030	2031
Hospitalisations	5.96%	3.93%	3.88%	3.81%	3.80%	3.60%
Acute Bed Days	6.64%	4.26%	4.22%	4.15%	4.10%	3.87%

Source: Forvis Mazars analysis of HPSC data

Overall, these findings suggest that RSV should be viewed not solely as a source of additional hospital admissions, but as a growing driver of winter hospital capacity pressures. Even modest increases in RSV incidence may translate into significant operational challenges through increased bed occupancy, reduced surge capacity, delayed patient flow and greater pressure on already constrained acute hospital services.

Estimating the Socio-Economic Impact of RSV in Older Adults

To estimate the direct economic impact of RSV in older adults, forecast activity levels for each healthcare outcome were combined with average unit cost estimates derived from Irish healthcare data sources. The modelling considers four principal categories of healthcare utilisation: GP visits, Emergency Department (ED) visits, hospitalisations and ICU admissions.

Under the central scenario, RSV-related hospitalisations are projected to generate approximately €115.1 million in healthcare costs between 2026 and 2031, compared with €10.3 million for GP visits, €4.6 million for ED visits and €2.7 million for ICU admissions. The economic burden is concentrated among adults aged 80 years and over, who account for the largest share of costs across all care settings due to higher rates of severe disease, hospitalisation and longer lengths of stay. These findings suggest that the future economic impact of RSV will be driven principally by its effect on acute hospital capacity and the growing population of the oldest older adults.

Table 5: Summary of Total Estimated Direct Economic Impact of RSV-Related Medical Outcomes, 2026-2031, (€m)				
	Cost of GP Visit (€m)	Cost of ED Visit (€m)	Cost of Hospitalisation (€m)	Cost of ICU Admission (€m)
Baseline (Reported Cases)	€2.6	€1.8	€46.0	€1.1
Low	€5.7	€2.2	€55.2	€1.3
Central	€10.3	€4.6	€115.1	€2.7
High	€20.3	€6.0	€151.9	€3.6

Source: Forvis Mazars analysis of HPSC and HIQA data

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Plain summary	Technical summary	Context	Current burden	Future burden	Impact	Findings

However, the impact of RSV extends beyond direct healthcare expenditure and places a wider burden on individuals, families and society. Severe RSV infection can result in premature mortality, loss of independence and prolonged recovery periods, particularly among older adults with underlying health conditions¹⁰. As labour force participation among adults aged 65 and over continues to increase, RSV-related illness and hospitalisations are also likely to generate growing productivity losses for both patients and family caregivers¹¹. Based on our estimated hospitalisation rates under the central scenario, by 2031 almost 120 older adults may be out of work for a period due to the impacts of RSV-based hospitalisation. In addition, increased demand for informal care, home support services and long-term care following severe RSV infection may create further societal costs that are not captured within hospital-based cost estimates, suggesting that the overall burden of RSV is substantially greater than direct healthcare costs alone¹⁰.

Overall Conclusions

The projected increase in bed occupancy highlights how RSV will continue to impact on winter capacity pressures, including reduced bed availability, increased patient flow challenges, and greater demand on acute hospital services.

Overall, the findings suggest that the future burden of RSV in Ireland will be characterised not only by increasing numbers of cases and hospitalisations, but also by a growing demand for acute hospital capacity, with the greatest impact concentrated among adults aged 80 years and over.

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Plain summary	Technical summary	Context	Current burden	Future burden	Impact	Findings

1. Background and Policy Context

Introduction

Forvis Mazars in Ireland was commissioned by Pfizer to undertake this report modelling how the burden of the RSV winter respiratory virus in older adults in Ireland could evolve to 2031 under different scenarios. Respiratory syncytial virus (RSV) is a common seasonal respiratory virus transmitted through airborne respiratory droplets. RSV symptoms are typically mild and can include runny nose, congestion, a decrease in appetite, coughing, sneezing, fever and wheezing. While most people who contract RSV experience mild symptoms, it can cause significant illness such as pneumonia or bronchiolitis in some cases, particularly among infants and older adults. Those with underlying conditions are also at risk as RSV can exacerbate underlying lung conditions like chronic obstructive pulmonary disease (COPD) or asthma¹³.

The RSV season begins in Autumn and lasts about six months, typically peaking around December/January each year⁶. Each year, RSV together with other winter respiratory viruses (primarily flu and COVID-19), put significant capacity pressure on the Irish health system. Given that Ireland has fewer hospital beds per 1,000 population than the OECD average (2.9 vs 4.2)¹⁴, the impact of these viruses from a health system perspective is more pronounced than in many other developed countries. Each RSV case, hospitalisation and admission to an Intensive Care Unit (ICU) is also associated with economic and social costs.

Currently, Ireland's RSV prevention strategy is centred on the seasonal administration of a long-acting monoclonal antibody that provides passive protection against RSV for infants¹⁵. The National Immunisation Advisory Committee (NIAC) recommends RSV immunisation with one of three vaccines for those aged 75 and over, those aged 60 to 74 with an additional risk factor for severe RSV infection, and those aged 60 and over residing in a long-term care facility¹². A recent Health Technology Assessment (HTA) carried out by HIQA found no vaccination scenario for older adults to be cost effective¹⁶.

Demographic Change – An Ageing Population

Ireland, as with other developed countries, is facing an unprecedented ‘demographic shift’ towards an ageing population. This means that the number and proportion of persons aged 65 and over is increasing⁴, in turn increasing the old-age dependency ratio. Data from the Central Statistics Office demonstrates this demographic shift. When considering forecasts of the population by age group between 2023 and 2042, the 65+ age subgroup is expected to grow at the fastest rate (around 3% per annum), as demonstrated in Table 6.

Table 6: Projected Annual Growth Rates Within Irish Population by Age Subgroup, 2026-2031						
	2026	2027	2028	2029	2030	2031
0-14	-1.7%	-1.8%	-1.8%	-1.7%	-1.6%	-1.5%
15-24	2.2%	1.7%	1.3%	0.9%	0.5%	0.2%
25-44	-0.3%	-0.3%	-0.2%	0.1%	0.4%	0.4%
45-64	2.4%	2.2%	2.0%	1.7%	1.4%	1.4%
65+	3.3%	3.2%	3.1%	3.1%	3.1%	2.9%
Total	1.0%	0.9%	0.9%	0.9%	0.8%	0.8%

Source: CSO population projections

This trend has significant policy implications for demand on the health system, on which older adults are disproportionately reliant. This demand will only increase as the trend continues, thereby placing further strain on the health system and its capacity to support vulnerable populations. Notably, these older age groups are also those which are at higher risk of severe RSV infection¹, meaning that the overall number of severe RSV infections is likely to rise in line with the growth in the older age population.

Furthermore, when we consider the expected growth *within* the 65+ age subgroup, we see that the number of older adults (80 years and over) is forecast to grow at the fastest rate – around 5% per annum, which is significantly higher than the average across the whole population.

Table 7: Projected Growth Rates Within Irish Adults Over 65 by Age Subgroup, 2026-2031						
	2026	2027	2028	2029	2030	2031
65 - 69 years	3.0%	2.9%	3.0%	3.0%	2.6%	1.9%
70 - 74 years	2.1%	2.2%	1.4%	2.2%	2.5%	3.1%
75 - 79 years	2.4%	2.6%	2.9%	1.9%	2.3%	2.3%
80 years and over	5.5%	5.2%	5.1%	5.1%	4.9%	4.5%
Total	3.3%	3.2%	3.1%	3.1%	3.1%	2.9%

Source: CSO population projections

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The Burden of RSV Among Older Adults – Issues of Under-ascertainment

The RSV burden in Ireland and reasons for under-ascertainment

In Ireland, RSV has been a notifiable disease since 2012 and data on RSV burden (notified cases, hospitalisations and ICU admissions) is available from the Respiratory Virus Notification Data Hub maintained by the Health Protection Surveillance Centre (HPSC). While this data provides a good baseline picture, international evidence suggests that such data can significantly underestimate* the true burden of RSV. This is particularly true for older adults¹⁷.

Reasons for the potential underestimation (under-ascertainment) of RSV burden among older adults identified by the literature include:

- **Infrequent routine testing for RSV:** Owing to the lack of RSV-specific treatment for adults, RSV testing is often not carried out¹⁸. While HIQA note that testing practices may have improved over time, data gaps remain¹⁶.
- **Issues with test sensitivity among older adults:** Even where older adults are tested for RSV, issues with test sensitivity can lead to false negatives. This is due to factors such as lower viral load among older adults¹⁹.
- **Atypical symptoms among older adults:** The literature reports that adults often display different symptoms to infants, for instance lacking fever and classic respiratory symptoms. When case definitions rely on fever, this can contribute to under-ascertainment²⁰.
- **Instances where RSV is not recorded as a main cause of hospitalisation:** Among the older population, RSV can often lead to an exacerbation of an underlying condition²² e.g. COPD^{10 2}. In these cases, the diagnosis may not be recorded as RSV.

* In this context, underestimation (under-ascertainment) refers to the difference between the number of RSV cases identified through routine testing and diagnostic testing and the actual true number of infections, hospitalisations and deaths occurring within the population.

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Assessing the true burden of RSV

A number of recent studies have aimed to account for this under-ascertainment and assess the true burden of RSV. To understand the approaches used and resulting estimates of the true RSV burden, Forvis Mazars conducted a review of the literature on the burden of RSV. The team began by examining papers included in HIQA's HTA and in Pfizer's consultation submission on the draft HTA. Following this initial review, the Forvis Mazars team identified a number of additional studies through online searches. These were accessed via PubMed or Google Scholar. As changes in RSV testing since the COVID-19 pandemic may have impacted on under-ascertainment, it was decided to focus primarily on studies published since 2020.

The studies examined typically used one of two approaches to estimating the burden of RSV:

- 1. Diagnostic Under-Ascertainment Adjustment Methods:** This approach estimates the true burden of RSV by adjusting observed RSV-positive hospitalisations for incomplete testing and imperfect diagnostic test performance. Studies using this method recognise that many RSV cases are not identified due to a lack of routine testing or because available tests do not detect all true infections. Correction factors are therefore applied to observed case counts to estimate the number of missed cases.
- 2. Statistical Attribution (Regression-Based) Methods:** This approach estimates RSV-attributable hospitalisations using statistical models that relate respiratory admissions to patterns of virus circulation over time. Rather than adjusting observed RSV-positive cases, these models assess how fluctuations in RSV activity correspond to changes in respiratory hospitalisation rates and attribute a proportion of admissions to RSV accordingly. As a result, they capture RSV-associated burden even where testing is limited or absent.

* In this context, underestimation refers to the difference between the number of RSV cases identified through routine testing and diagnostic testing and the actual true number of infections, hospitalisations and deaths occurring within the population.

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Under-Ascertainment Factors

Medically attended cases

Table 8 below summarises the under-ascertainment scenarios applied in this analysis for medically attended cases. The baseline scenario reflects the reported RSV burden as recorded in the HPSC Respiratory Virus Notification Data Hub. To address the issue of under-ascertainment described, low, central and high scenarios were developed using adjustment factors derived from the published literature, representing a range of plausible estimates of the true RSV burden. Although evidence on under-ascertainment of medically attended RSV in older adults is limited, the selected multipliers are informed by best available evidence from the RSV burden literature and reflect both diagnostic under-detection and incomplete testing in routine clinical practice. Though much of the published evidence is derived from hospital-based studies, the mechanisms driving under-ascertainment, including incomplete testing and imperfect diagnostic sensitivity, are also relevant to medically attended cases, supporting the use of these multipliers as plausible estimates for scenario analyses.

Table 8: Outline of Evidence Underpinning Under-Ascertainment Factors for Medically Attended Cases

Scenario	Factor	Evidence	Methodology
Baseline (Reported Cases)	1.0	Data from the HPSC/HSE Respiratory Virus Notification Data Hub	Baseline RSV incidence and hospitalisation estimates were derived from the HSPC/HSE Respiratory Virus Notification Data Hub
Lower	2.2	- Chan et al.(2025) <i>Respiratory Syncytial Virus Infections in Older Adults in Asia: A Modified Delphi Expert Consensus on Surveillance, Diagnosis, and Prevention.</i>²³ - Zhang et al. (2025) <i>Estimating the Respiratory Syncytial Virus-Associated Hospitalisation Burden in Older Adults in European Countries: A Systematic Analysis.</i>²⁴	- Recommends an adjustment factor of at least 2.2 to account for underestimation of RSV hospitalisation rates when estimates are based on single-specimen PCR testing - Compiled RSV hospitalisations from published studies, surveillance datasets and unpublished national data. Adjusted these estimates for differences in diagnostic testing, clinical specimen collection and case definition using statistical modelling techniques.

Scenario	Factor	Evidence	Methodology
Central	4.0	• HIQA HTA on RSV Immunisation.¹⁶ • Marot et al. (2025) <i>Incidence and Burden of Respiratory Syncytial Virus-Associated Hospitalisations Among People 65 and Older in France</i>.²⁵ • Havers et al. (2024) <i>Burden of Respiratory Syncytial Virus-Associated Hospitalizations in US Adults, October 2016 to September 2023</i>.²⁶	• <i>The multiplier was derived by comparing RSV incidence reported in the international literature with incidence based on Irish surveillance data and was intended to account for cases not confirmed through RSV testing.</i> • <i>RSV-coded hospitalisations identified from the French National Hospital Discharge Database were adjusted using a correction factor derived from virological data from two hospitals.</i> • <i>Laboratory-confirmed RSV hospitalisations identified through RSV-NET were adjusted using under-detection multipliers to account for incomplete testing and imperfect diagnostic sensitivity among hospitalised adults.</i>

Scenario	Factor	Evidence	Methodology
High	7.9	- Krauer et al. (2024) <i>Effectiveness and efficiency of immunisation strategies to prevent RSV among infants and older adults in Germany: a modelling study.</i>²⁷ - Robert Koch Institute (2024) <i>Current Data and Information on Infectious Diseases and Public Health, Epidemiological Bulletin.</i>²⁸ - Cozzolino et al. (2025) <i>Estimation of the Respiratory Syncytial Virus Hospitalization Burden in Older Adults in the Veneto Region, Italy: A Modelling Study.</i>²⁹	- A dynamic transmission model was fitted to German RSV surveillance and hospitalisation data, with adjustments for under-ascertainment of RSV burden in older adults. The correction accounts for cases missed because of incomplete testing and diagnosis. - Observed RSV hospitalisations from German health-insurance and hospital discharge databases were compared with published RSV burden estimates from systematic reviews and modelling studies. This comparison indicated underreporting of RSV hospitalisations in older adults by a factor of approximately 7.9-13.8. - RSV-attributable hospitalisations were estimated using a generalised additive mixed model that linked weekly respiratory infection admissions to RSV circulation measured through surveillance data. The resulting attributed burden was compared with RSV-coded admissions, indicating that administrative coding underestimated the true RSV hospitalisation burden by up to 7.6 fold.

00	00	01	02	03	04	05
Plain summary	Technical summary	Context	Current burden	Future burden	Impact	Findings

Hospitalisations, ICU Admissions and Deaths*

To inform the under-ascertainment figure for hospitalisations, we compared the reported HPSC hospitalisation rates among older adults (per 100,000 people), to hospitalisation rates noted in several relevant pieces of literature, to compute implied under-ascertainment factors. For the lower scenario, we benchmarked against the relevant papers' lower bound. For the central scenario, we benchmarked against the reported central hospitalisation rate. Finally, for the high scenario, we benchmarked against the reported upper bound in the confidence interval.

It is also important to consider how the number of hospitalisations relates to the overall number of reported cases to ensure internal model consistency. Increasing the number of hospitalisations by the same under-ascertainment factor as notified cases would maintain the reported hospitalisation rate of over 30%, which is likely to be much higher than the true population hospitalisation rate, particularly when considering improved testing for patients when hospitalised which is more likely to identify an RSV infection. As such, these under-ascertainment factors are lower than those for medically attended cases alone.

Table 9: Outline of Evidence Underpinning Under-Ascertainment Factors for Hospitalisations, ICU Admissions and Deaths

Scenario	Factor	Evidence
Baseline (Reported Cases)	1.0	<i>Baseline RSV hospitalisation, ICU admissions and deaths were derived from the HSPC/HSE Respiratory Virus Notification Data Hub</i>
Low	1.2	<i>The relevant literature analysed includes Burkart et al (2025)²¹, Osei-Yeboah et al (2023)³⁰, Zhang et al (2025)²⁴ and Savic et al (2022)³¹. Each paper reported estimated hospitalisation rates in the older adult population, within confidence interval bands. The average of these factors is 2.5 for the central estimate, 1.2 for the lower bound estimate and 3.3 for the upper bound estimate, and these figures are applied as the appropriate under-ascertainment figures for each scenario.</i>
Central	2.5	
High	3.3	

To maintain the same rate of ICU admissions and deaths as the reported data, the same under-ascertainment factors have been applied to these health system outcomes**.

* Note that, as our modelling forecast emergency department (ED) visits as a proportion of hospitalisations, a specific under-ascertainment figure is not applied in the case of ED visits.

** 2025 data implies a hospitalisation-to-ICU admission rate of 1.8%. Although literature on RSV-related ICU admissions is scarce, Liang et al (2026)³² suggests this rate could be around 31.2% in older adults, while Abrams et al (2025)³³ suggests "Approximately 10% of older adults hospitalized with RSV infection require ICU admission.". The relatively low number of reported RSV-related ICU admissions in Ireland likely reflects the highly specific surveillance definition, which requires both laboratory confirmation and attribution of RSV as a primary or contributing cause of ICU admission. Despite the uncertainty, evidence suggests the true rate could be higher than the reported 1.8%.

00	00	01	02	03	04	05
Plain summary	Technical summary	Context	Current burden	Future burden	Impact	Findings

Health System Capacity

In demonstrating the likely increase in health system burden – including bed capacity – that RSV in older adults will bring, it is important to acknowledge that future expansions in bed capacity under existing health planning policy are planned. Under the Acute Hospital Inpatient Bed Capacity Expansion Plan 2024–2031³⁴, the government plans to provide an additional 4,656 acute hospital beds by 2031. A significant number of these had already been delivered at the time the plan was published, with a number of others underway. This is broken down in Table 10 below.

Table 10: Number of Acute Hospital Inpatient Beds to be Delivered to 2031 Under Acute Hospital Inpatient Bed Capacity Expansion Plan 2024–2031	
Category	Number of Additional Beds
Delivered 2021–March 2024	1,218
Committed	441
Total Beds Planned March 2025–2028	1,541
Total Beds Planned 2029–2031	1,456
Total 2020–2031	4,656

Source: Acute Hospital Inpatient Bed Capacity Expansion Plan 2024–2031

Given that Ireland has relatively fewer beds per 1,000 people than other countries (2.9 per 1,000 versus an OECD average of 4.2 per 1,000³⁵) these additional beds may assist in easing existing health system burden. However, as the Irish health system has historically been comparatively less well resourced³⁶ than other OECD jurisdictions, it is difficult to say how effective these new beds will be in mitigating against increases in the burden of RSV and other illnesses as the older population grows. Indeed, the planned growth in beds per 1,000 of the population covered by the Plan is relatively modest, at 2.2 per 1,000 in 2023 to 2.6 in 2031*. Nonetheless, the increase in bed capacity may help moderate the increasing burden of RSV infection to some extent and this should be borne in mind when considering our analysis.

* Note that figures in the Plan only include public acute inpatient beds and exclude psychiatry which is covered by a different plan. OECD calculations also include private bed data.

00	00	01	02	03	04	05
Plain summary	Technical summary	Context	Current burden	Future burden	Impact	Findings

Scope of Report

In this context, Forvis Mazars was commissioned to carry out this research project to characterise the likely future health system burden of RSV in older adults under realistic assumptions regarding under-ascertainment, population ageing and health system demand. The scope of this piece of work was to:

- Quantify the current impact of RSV on older adults in Ireland in terms of the number of cases, hospitalisations, length of stay, ICU admissions, deaths, and wider health system pressures.
- Build projections of the healthcare impact of RSV up to 2031 as the older population grows, in the context of other winter respiratory viruses including COVID-19 and influenza.
- Estimate the economic and social impact of RSV in older adults, including healthcare and broader costs.

This report, delivered to Pfizer in September 2026, is the output of this work. HIQA's HTA of immunisation against RSV in Ireland provides an estimate of direct healthcare burden and costs based on reported data and established national methodologies. This report complements that analysis by exploring the potential implications of under-ascertainment and by explicitly quantifying the impact of RSV on hospital capacity.

00	00	01	02	03	04	05
Plain summary	Technical summary	Context	Current burden	Future burden	Impact	Findings

Structure of Report

The remainder of this report is structured as follows:

- Section 2 outlines the current estimated clinical burden of RSV in older adults in Ireland, for each assessed health system outcome (medically attended cases, emergency department visits, hospitalisations, ICU admissions and deaths). Scenario analysis reflects estimates of the under-ascertainment of the disease and its impact on health system burden.
- Section 3 then presents scenario-based forecasts for the future health system burden as a result of RSV between 2026 and 2031.
- Section 4 outlines the range of direct and indirect health system and socio-economic costs that would be associated with the growing clinical burden of RSV in older adults.
- Section 5 concludes by outlining key findings of the analysis.

Limitations of Study

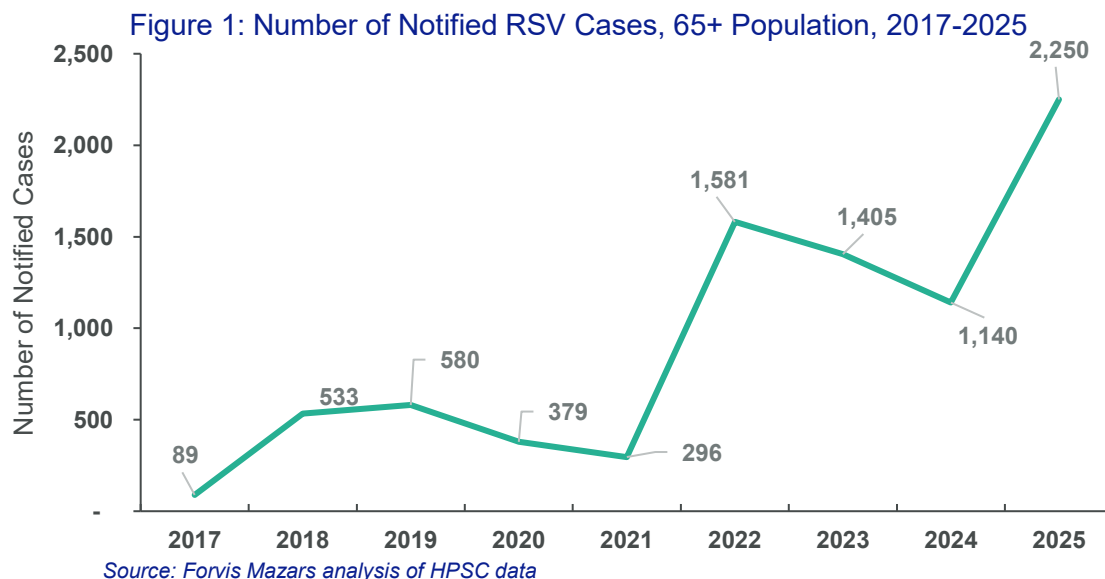
This report is a forecasting and scenario-modelling exercise and we therefore acknowledge a number of limitations. Firstly, as acknowledged throughout the report, baseline estimates of RSV burden are based on currently available surveillance and notification data, which are likely to understate the true burden of disease among older adults due to under-testing, under-diagnosis and challenges in attributing hospitalisations, ICU admissions and deaths to RSV. Consequently, the scenario-based adjustment factors applied in this report are informed by published literature which uses mathematical modelling to account for under-ascertainment of RSV and should be interpreted as plausible estimates which are subject to uncertainty, rather than precise measures of under-ascertainment. Secondly, the model does not explicitly account for future changes in RSV epidemiology, healthcare utilisation, testing practices, treatment pathways, vaccination policy or healthcare capacity. Finally, economic and capacity burden estimates are based on average costs and average lengths of stay and therefore do not fully capture variation in patient complexity, seasonal peaks in demand or the wider societal impacts of RSV, including impacts on carers, long-term care needs and quality of life.

2. RSV Burden in Older Adults in Ireland

Medically Attended Cases – Reported Cases

This section explores recent trends in RSV-related medical outcomes and health system outcomes (i.e., notified medically attended cases, hospitalisations, ICU admissions and deaths) as they are publicly recorded via the HSE's Respiratory Virus Notification Data Hub and prior to consideration of the impacts of under-ascertainment of RSV.

The pattern of notified medically attended cases for RSV has shown significant variation over the last number of years due to changes in testing and reporting of RSV. As shown in Figure 1, around 2,250 adults over the age of 65 had a reported medically attended case of RSV in 2025, up from 1,140 in 2024. It is important to note that this data reflects only the *reported* number of cases as per published HPSC data and therefore does not reflect the known issue of the under-ascertainment of the disease, which is considered in more detail in our scenario analysis.



According to HPSC data, among adults aged 65 and over, the population aged 80+ was most impacted, with over 50% of all cases in the 65+ category related to adults in the oldest age band.

ED Visits, Hospitalisations, ICU Admissions and Deaths – Reported Cases

More severe cases of RSV require additional medical attendance, including emergency department (ED) visits, hospitalisation and ICU admission, while the severe cases can lead to death. These medical outcomes are more likely for those with more vulnerable immune systems – typically babies aged 0-2 years and adults aged 65 and over ⁶.

Table 11 summarises the reported (as per HPSC data) breakdown in the number of RSV-related ED visits, hospitalisations, ICU admissions and deaths between 2022 and 2025. 740 adults aged 65 and over were in-patients with a laboratory confirmed RSV test. Of these, the majority (52%) were older adults aged 80 and over. There were 13 reported ICU admissions in 2025, though it should be noted that reported ICU admissions fall under a stricter definition than other medical outcomes, where RSV should be the primary or contributing cause for a person's ICU admission. In 2025, around 46 people aged 65 and over had a reported death in which RSV was recorded as a cause of death. HPSC data indicates that around two-thirds of these deaths were adults aged 80 and over.

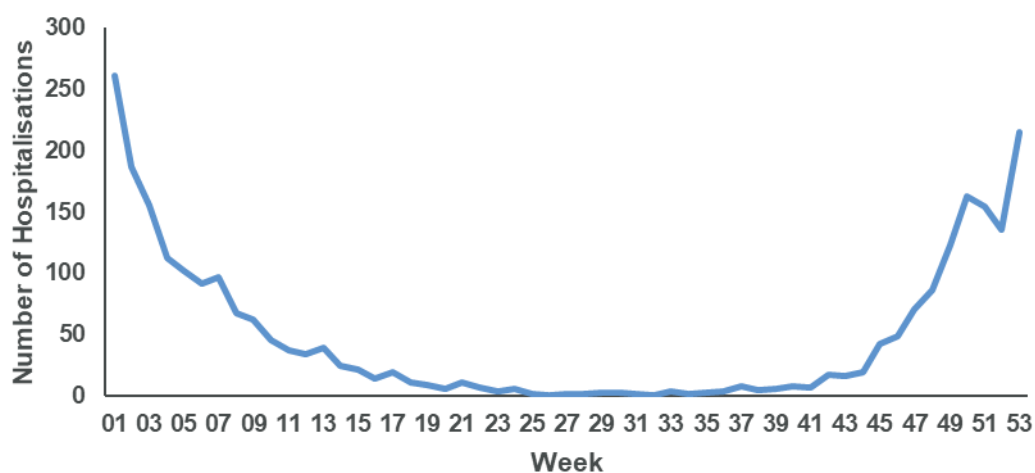
Table 11: Summary of Reported Health System Outcomes (2022-2025), Total Number by Age Subgroup				
	2022	2023	2024	2025
ED Visits				
65 - 69 years	85	93	48	69
70 - 74 years	98	107	55	119
75 - 79 years	141	155	80	135
80 years and over	317	347	179	290
Total	641	703	362	614
Hospitalisations				
65 - 69 years	91	100	52	79
70 - 74 years	143	157	81	124
75 - 79 years	176	193	100	152
80 years and over	448	491	253	386
Total	858	941	485	740
ICU Admissions				
65 - 69 years	0	2	1	1
70 - 74 years	0	3	2	2
75 - 79 years	0	4	2	3
80 years and over	0	10	5	7
Total	0	19	9	13
Deaths				
65 - 69 years	3	3	2	3
70 - 74 years	4	4	3	5
75 - 79 years	7	7	4	7
80 years and over	29	29	18	31
Total	43	43	27	46

Source: Forvis Mazars analysis of HPSC data

Seasonality and Winter Capacity Pressures

As demonstrated in Figure 2, which outlines weekly RSV hospitalisations in 2025, RSV is a highly seasonal respiratory infection in Ireland, with transmission typically increasing in the autumn, peaking during the winter months, and declining by early spring. Historically, the highest levels of RSV activity have been observed between October and March, with peak infection rates commonly occurring in December and January⁹.

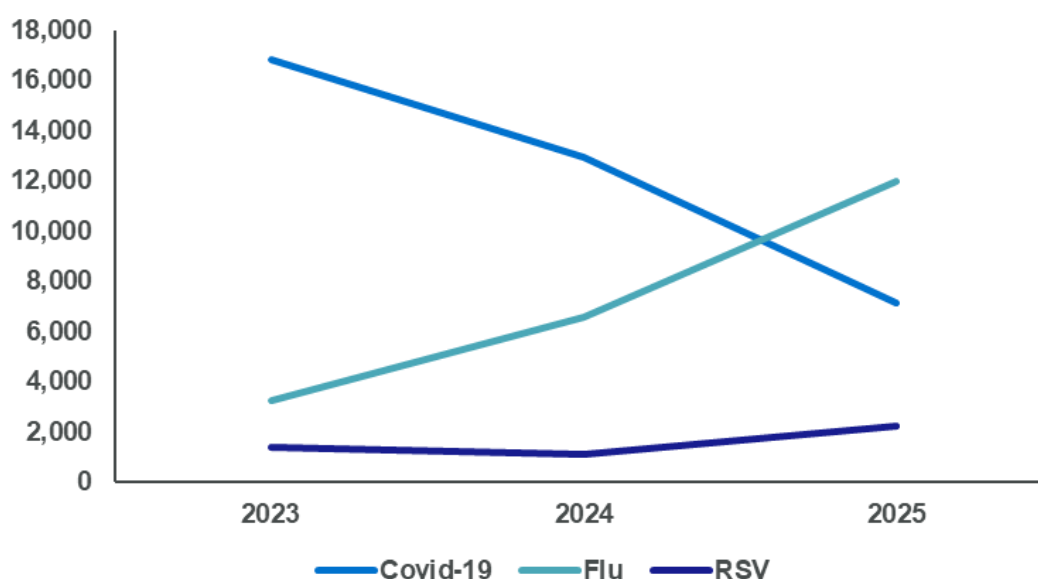
Figure 2: Number of Weekly RSV Hospitalisations, 2025



Source: Forvis Mazars analysis of HPSC data

This seasonal pattern coincides with periods of peak demand across acute hospitals, when influenza, COVID-19, and other respiratory illnesses are also circulating. Consequently, RSV contributes to substantial pressure on emergency departments, inpatient wards and critical care services, before considering the impacts of under-ascertainment of the illness. Additional admissions contribute to occupancy pressures, delayed patient flow, increased length of stay, and reduced availability of beds for elective procedures. RSV outbreaks in nursing homes and other long-term care facilities may also generate further hospital referrals and place additional strain on community and acute care services¹⁹.

Figure 3: Number of Notified Cases per Winter Respiratory Virus, 2023-2025



Source: Forvis Mazars analysis of HPSC data

00	00	01	02	03	04	05
Plain summary	Technical summary	Context	Current burden	Future burden	Impact	Findings

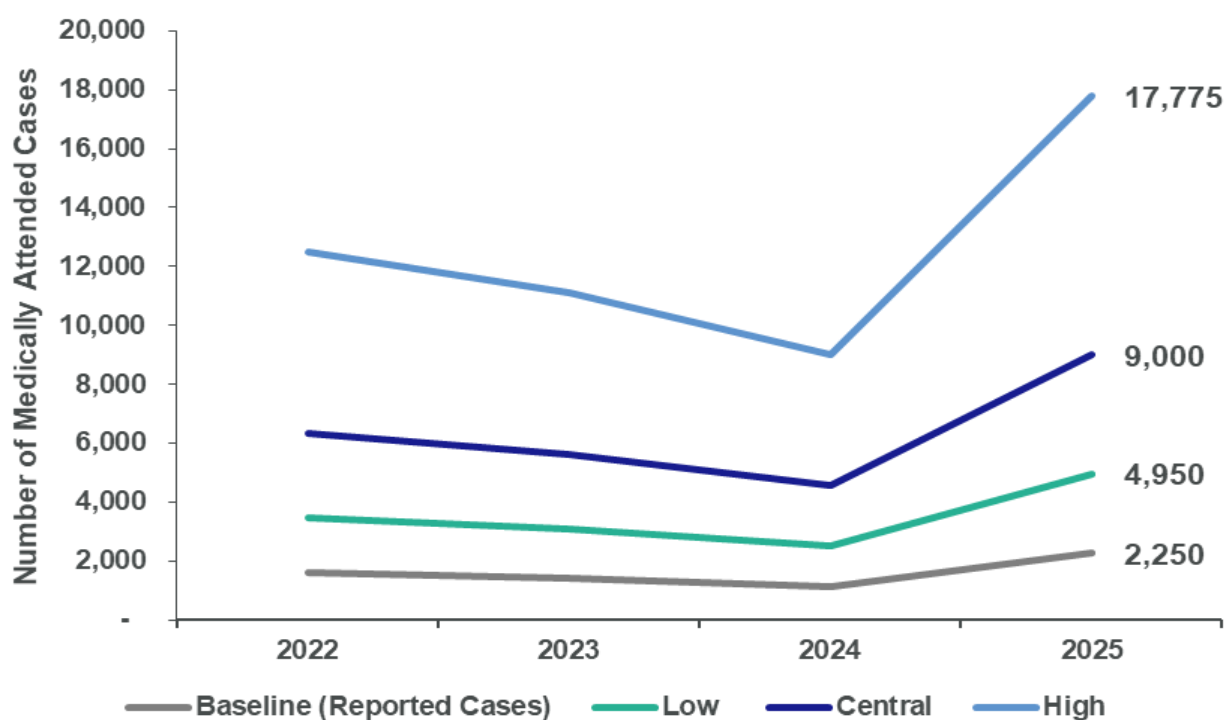
Medically Attended Cases – Scenario Analysis

Due to the aforementioned issues regarding the under-ascertainment of notified cases, the burden of RSV in older adults in Ireland is likely to be significantly higher. Our analysis therefore explores how alternative assumptions regarding under-ascertainment may affect estimates of healthcare utilisation and capacity burden under low-, central- and high- scenarios and provides more reasonable range estimates for the true clinical burden of RSV in the older adult population. These scenarios have been informed by a detailed literature review examining previous studies which estimate the potential *true* population incidence of RSV in older adults, and therefore reflect the range of plausible under-ascertainment factors.

Our low scenario applies an under-ascertainment factor of 2.2 to reported cases, while our central scenario applies an under-ascertainment factor in line with HIQA's HTA and central estimates from the literature review, i.e., 4. Some studies however suggest that this figure could be much higher, and therefore our high scenario applies an under-ascertainment figure of 7.9.

2,250 reported cases of medically attended RSV were reported in older adults (65+) in 2025, however, scenario analysis suggests the actual figure is likely to be closer to 9,000 (as under the central scenario in our analysis), but could be as high as 17,775 (as under the high scenario in our analysis).

Figure 4: Number of RSV Medically Attended Cases by Scenario, 2022-2025



Source: Forvis Mazars analysis of HPSC data

Table 12, meanwhile, further stratifies by age the estimates of medically attended RSV cases in the 65+ age group, across the modelling scenarios. The table demonstrates that, among adults aged 65 and over, it is the oldest subgroup – those aged over 80 – that are most acutely affected by RSV.

Table 12: Summary of Number of Medically Attended Cases of RSV by Age Subgroup and Scenario, 2022-2025				
	2022	2023	2024	2025
Baseline (Reported Cases)				
65 - 69 years	164	146	118	233
70 - 74 years	274	243	197	389
75 - 79 years	316	281	228	450
80 years and over	827	735	597	1,178
Total	1,581	1,405	1,140	2,250
Low				
65 - 69 years	361	321	260	514
70 - 74 years	602	535	434	857
75 - 79 years	695	618	501	989
80 years and over	1,820	1,618	1,313	2,591
Total	3,478	3,091	2,508	4,950
Central				
65 - 69 years	656	583	473	934
70 - 74 years	1,095	973	789	1,558
75 - 79 years	1,264	1,123	911	1,798
80 years and over	3,310	2,941	2,386	4,710
Total	6,324	5,620	4,560	9,000
High				
65 - 69 years	1,296	1,152	934	1,844
70 - 74 years	2,162	1,921	1,559	3,077
75 - 79 years	2,496	2,218	1,800	3,552
80 years and over	6,536	5,809	4,713	9,302
Total	12,490	11,100	9,006	17,775

Source: Forvis Mazars analysis of HPSC data

ED Visits, Hospitalisations, ICU Admissions and Deaths – Scenario Analysis

Table 13 summarises the number of ED visits, hospitalisations, ICU admissions and deaths linked to RSV in adults aged 65 and over, when credible alternative assumptions regarding the under-ascertainment and underdiagnosis of the disease are considered. As outlined in Section 1, due to the underlying methodological structure of the baseline data, as well as assumptions regarding clinical pathways, different under-ascertainment factors are applied in the case of ED visits, hospitalisations and ICU admissions.

As noted in the baseline reporting (Table 11) the data shows how these more severe medical outcomes are disproportionately impactful for the 80 years and over age group.

Table 13: Summary of Total Number of RSV-Related Medical Outcomes for 65+ Age Group, Scenario Analysis				
	2022	2023	2024	2025
Baseline (Reported Cases)				
ED Visits	641	703	362	614
Hospitalisations	858	941	485	740
ICU	0	19	9	13
Deaths	43	43	27	46
Low				
ED Visits	769	843	435	736
Hospitalisations	1,030	1,130	582	888
ICU	0	23	11	16
Deaths	51	52	32	55
Central				
ED Visits	1,601	1,756	905	1,534
Hospitalisations	2,146	2,354	1,213	1,850
ICU	0	48	22	33
Deaths	107	108	66	115
High				
ED Visits	2,114	2,318	1,195	2,025
Hospitalisations	2,832	3,107	1,602	2,443
ICU	0	64	30	43
Deaths	141	143	87	152

Source: Forvis Mazars analysis of HPSC data

Capacity Burden – Bed Days and Length of Stay

The data presented thus far has demonstrated that the clinical burden of RSV is disproportionate among older adults (particularly those aged 80 or over), who account for two-thirds of RSV discharges and experience the longest lengths of stay, resulting in a disproportionately large consumption of hospital bed capacity. The oldest population have the longest length of stay on average, thereby requiring more bed days and increasing resource consumption.

Table 14: Average Length of In-Patient Stay by Age Subgroup 2022-2024, Number of Days				
	2022	2023	2024	Average
65 years and over	9.2	14	9.3	10.8
65-69	5.9	5.5	5.5	5.6
70-74	7.4	7.4	7.6	7.5
75-79	10.9	7.4	5.6	8.0
80 years and over	10	16	11.1	12.4

Source: HIQA HTA analysis of HPSC data

In turn, this combination of higher hospitalisations and longer length of stay among older adults, particularly those aged 80 and over, leads to a higher level of bed day occupation within the older adult population. In 2025, reported data suggests approximately 6,507 acute bed days and 57 ICU bed days could be attributable to RSV. However, given known issues around the under-ascertainment of RSV, our central scenario suggests this figure is more likely to be around 18,300, but could be as high as 30,477, for acute bed days. For ICU bed days, once estimates are adjusted for likely under-ascertainment in RSV-related ICU admissions, the central scenario suggests around 142 bed days per annum, with an upper bound of 187. Given the highly seasonal nature of RSV, this demand for bed days will be most concentrated across the winter period. In demonstrating the likely increase in health system burden, including bed capacity that RSV in older adults will bring, it is important to acknowledge that future expansions in bed capacity under existing health planning policy are planned. Under the Acute Hospital Inpatient Bed Capacity Expansion Plan 2024–2031, the government plans to provide an additional 4,656 acute hospital beds by 2031.

Table 15: Summary of Total Number of RSV-Related Bed Days for 65+ Age Group, Scenario Analysis					
		2022	2023	2024	2025
Acute Bed Days	Baseline (Reported Cases)	7,996	10,998	4,267	6,507
	Low	9,595	13,198	5,120	7,808
	Central	19,989	27,495	10,666	18,374
	High	26,385	36,293	14,079	30,477
ICU Bed Days	Baseline (Reported Cases)	1	84	39	57
	Low	1	100	47	68
	Central	1	209	97	142
	High	2	276	128	187

Source: Forvis Mazars analysis of HPSC data

00	00	01	02	03	04	05
Plain summary	Technical summary	Context	Current burden	Future burden	Impact	Findings

Summary of Key Findings

Analysis of HPSC surveillance data indicates that more than 2,250 medically attended cases of RSV, 740 hospitalisations, 13 ICU admissions and 46 deaths were reported among adults aged 65 and over in 2025. Recent years have also seen substantial variation in reported RSV activity, reflecting changes in testing practices, surveillance arrangements and awareness of RSV in adults. While reported medically attended cases increased from 1,140 in 2024 to 2,250 in 2025, evidence suggests that notified cases capture only a proportion of the true burden. Applying under-ascertainment assumptions broadly consistent with the literature indicates that the actual number of medically attended RSV cases in older adults may be several times higher than reported figures.

The most important finding from a health-system perspective relates not simply to case numbers, but to the capacity burden generated by severe RSV infection. Hospitalisations are heavily concentrated among older age groups, particularly adults aged 80 years and over, a group which accounts for more than half of RSV hospitalisations and which experiences the longest average lengths of stay. Reported data show that average hospital stays among adults aged 80 years and over can exceed 11 days and have reached as high as 16 days in some recent years. As a result, the oldest age groups consume a disproportionate share of acute hospital bed capacity.

00	00	01	02	03	04	05
Plain summary	Technical summary	Context	Current burden	Future burden	Impact	Findings

This burden is amplified by the strongly seasonal nature of RSV. Hospitalisations peak during the winter respiratory virus season, coinciding with periods of intense demand associated with influenza, COVID-19 and other respiratory infections. Consequently, RSV-related admissions and bed occupancy occur at the same time as acute hospitals face the greatest operational pressures, contributing to reduced bed availability, delayed patient flow, emergency department crowding and challenges in maintaining elective activity.

When adjusted for potential under-ascertainment, the estimated capacity burden becomes substantially larger. Under the central scenario, approximately 18,374 acute hospital bed days and 142 ICU bed days were attributable to RSV in adults aged 65 and over in 2025, compared with 6,507 acute bed days and 57 ICU bed days based on reported data alone. These findings suggest that the operational burden of RSV on the healthcare system may be much greater than is apparent from surveillance data alone. While uncertainty remains regarding the precise magnitude of under-ascertainment, overall, the evidence indicates that RSV already represents a meaningful source of hospital and critical care demand among older adults in Ireland.

Moving forward, the combination of demographic ageing, concentration of disease among adults aged 80 years and over, prolonged hospital stays and pronounced winter seasonality means that RSV's impact on healthcare capacity is only likely to increase further, thereby increasing the burden on the health system. This evidence provides the platform on which our forecasting model in section 3 is built.

3. Forecast of RSV Burden in Older Adults in Ireland (2026-2031)

Methodology

In this section, we forecast the burden of RSV in older adults in Ireland, and the subsequent health system impacts. To do so, we combined two primary datasets as the core foundation for the model:

- HPSC Respiratory Virus Notification Hub⁵.
- CSO Population Projections 2023-2042⁷.

Due to the highly variable nature of RSV reporting to date, it was decided that a **static forecasting** model was most appropriate. An average of the reported annual cases between 2023 and 2025 provided our baseline forecasting data. In order to forecast the different medical outcomes and health system impacts, we calculated the incidence rates from reported cases, per 100,000 people, across each age subgroup. These rates are summarised in Table 16.

Table 16: Summary of Estimated Reported Incidence Rates per 100,000 people, Medical Outcome and Age Subgroup, Average 2023-2025				
	Cases	Hospitalisations	ICU Admissions	Deaths
65 - 69 years	66.1	30.8	0.6	0.9
70 - 74 years	128.6	56.3	1.1	1.8
75 - 79 years	187.8	88.2	1.7	3.7
80 years and over	416.5	189.9	3.6	13.2
Total 65+	191.0	87.0	1.7	4.6

Source: Forvis Mazars analysis of HPSC data

These incidence rates were then applied to the relevant forecast population across age subgroup, as per CSO forecasts, to provide estimates for the number of persons per health system outcome. Therefore, by integrating RVN Hub data with CSO Population Projections, we can specify the overall forecasting model:

$$RSV_Outcome_{i,t} = Population_t * RSV_Incidence\ Rate_{i,2023-2025}$$

Where i refers to different medical outcomes (i.e., cases, hospitalisations, ICU admissions and deaths) and t refers to each year from 2026 to 2031.

00	00	01	02	03	04	05
Plain summary	Technical summary	Context	Current burden	Future burden	Impact	Findings

Scenario Analysis

As discussed, the baseline data, as published by the HPSC, is likely to significantly under-ascertain the true burden of RSV within older adults. To reflect this, and to better estimate the true future impact of RSV on older adults, we again integrate low-, central- and high- scenario analyses into our forecasts as outlined previously. These are compared against the baseline (reported cases) scenario, which forecasts RSV-attributable health system outcomes based on *reported cases only* (i.e., no under-ascertainment correction).

Estimation of System Capacity Burden

To inform our capacity burden modelling, we applied estimates regarding the average length of stay in a hospital bed per age group. These estimates are summarised in Table 17.

In the case of hospitalisations, we used HPSC data⁵ on the mean length of stay by age group between 2022 and 2024. Our baseline scenario (based on reported cases) applied the 2024 lengths of stay, our low scenario used the lowest mean length of stay per age between 2022 and 2024, while our high scenario used the highest mean. Our central scenario uses an average across the 3 years.

Table 17: Average Length of Stay Per Medical Outcome		
		Hospitalisation (# days)
Baseline	65 - 69 years	5.5
	70 - 74 years	7.6
	75 - 79 years	5.6
	80 years and over	11.1
Low	65 - 69 years	5.5
	70 - 74 years	7.4
	75 - 79 years	5.6
	80 years and over	10.0
Central	65 - 69 years	5.6
	70 - 74 years	7.5
	75 - 79 years	8.0
	80 years and over	12.4
High	65 - 69 years	5.9
	70 - 74 years	7.6
	75 - 79 years	10.9
	80 years and over	16.0

Source: HIQA HTA, using HPSC data

In the case of ICU admissions, data on the average length of stay is less readily available. In this instance, we used findings from a recent paper by Liang et al (2026)³² which estimated a weighted average mean length of ICU stay in older adults at 4.3 days. This figure is applied consistently across all scenarios.

To estimate the weekly burden by means of examining specific seasonal peaks, we calculated the average weekly distribution (as a proportion of total annual cases) of RSV-attributable hospitalisations and ICU admissions across 2023, 2024 and 2025 and applied this distribution to our forecast numbers.

Medically Attended Cases

Table 18 summarises the range of RSV-related medically attended cases between 2026 and 2031 for the older adult age group, under each modelling scenario specification. Under the baseline specification, where no adjustment is made for known under-ascertainment issues, the number of medical attendances could reach over 2,000 by 2031 – compared to an average of 1,600 between 2023 and 2025. More realistic estimates should consider the impacts of under-ascertainment of RSV. As such, the number of medically attended cases in the central scenario is more likely to be between 7,000 and 8,000 per annum in the coming years, but could be as high as 16,000 by 2031 as under the high scenario.

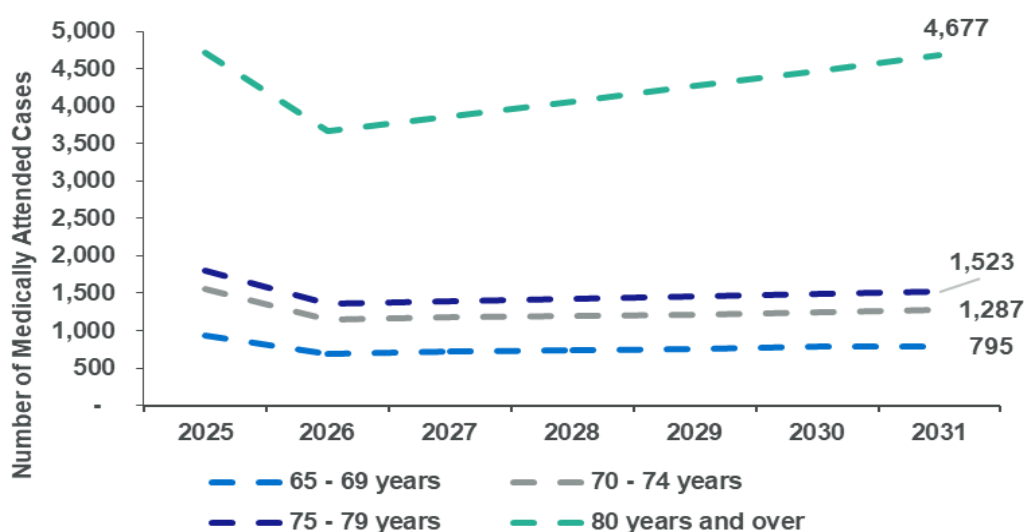
Table 18: Summary of Forecast Number of RSV-Related Medically Attended Cases in 65+ Age Group, Scenario Analysis, 2025-2031							
	2025	2026*	2027	2028	2029	2030	2031
Baseline (Reported Cases)	2,250	1,718	1,785	1,854	1,925	1,998	2,070
Low	4,950	3,779	3,927	4,079	4,235	4,396	4,555
Central	9,000	6,871	7,141	7,417	7,700	7,993	8,281
High	17,775	13,569	14,103	14,649	15,207	15,786	16,355

Source: Forvis Mazars analysis of HPSC data

** Note that 2026 estimates reflect an average of 2023-2025 figures, with 2025 representing a high-case year.

Figure 5 shows the further breakdown of these forecast medical attendances under the central scenario, where the oldest age group (80 years and over) represents the majority of cases (over 50%).

Figure 5: Forecast Number of Medically Attended Cases, 2025-2031, Central Scenario



Source: Forvis Mazars analysis of HPSC data

Emergency Department Attendances

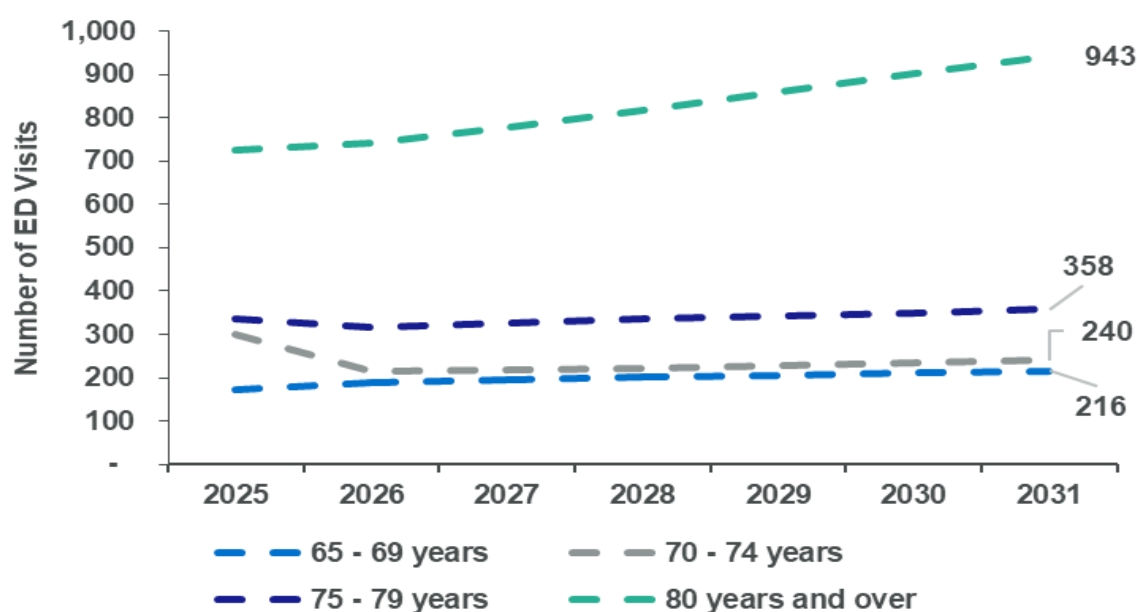
RSV-related emergency department (ED) visits among adults aged 65 and over are projected to increase steadily between 2025 and 2031 across all scenarios. Under the central scenario, annual ED visits are forecast to rise from 1,534 in 2025 to 1,757 in 2031 (a 14.5% increase), while the high scenario suggests that the burden could exceed 2,300 visits annually by 2031.

	2025	2026	2027	2028	2029	2030	2031
Baseline (Reported Cases)	614	585	607	631	654	679	703
Low	736	702	729	757	785	815	843
Central	1,534	1,462	1,518	1,577	1,636	1,697	1,757
High	2,025	1,930	2,004	2,081	2,159	2,240	2,319

Source: Forvis Mazars analysis of HPSC data

The projected increase in RSV-related ED visits is driven primarily by adults aged 80 years and over, whose ED attendances are expected to rise from approximately 725 in 2025 to 943 in 2031 under the central scenario. While ED visits increase across all age groups, the oldest age subgroup accounts for the largest share of attendances throughout the forecast period, reflecting the growing contribution of population ageing to RSV-related healthcare demand.

Figure 6: Forecast Number of ED Visits, 2025-2031, Central Scenario



Source: Forvis Mazars analysis of HPSC data

Hospitalisations

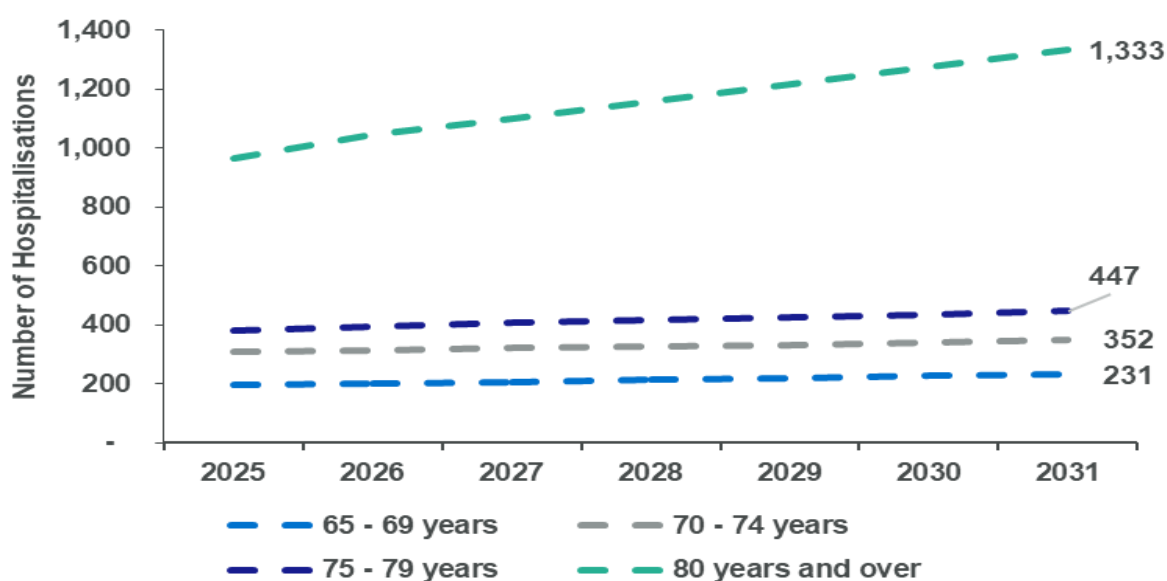
Table 20 summarises the forecast number of RSV-related hospitalisations under each of the four modelling scenarios. In our baseline specification, the number of hospitalisations is anticipated to increase from 740 to 945. However, once accounting for the known under-ascertainment of RSV, our central scenario indicates that hospitalisations could reach over 2,300 by 2031, while the high scenario suggests this figure could be over 3,100.

Table 20: Summary of Forecast Number of RSV-Related Hospitalisations in 65+ Age Group, Scenario Analysis, 2025-2031							
	2025	2026	2027	2028	2029	2030	2031
Baseline (Reported Cases)	740	784	815	847	879	912	945
Low	888	941	978	1,016	1,055	1,095	1,134
Central	1,850	1,961	2,038	2,117	2,198	2,281	2,363
High	2,443	2,588	2,690	2,794	2,901	3,011	3,119

Source: Forvis Mazars analysis of HPSC data

Figure 7 presents the distribution of forecast hospitalisations by age sub-group under the central scenario. As noted previously, the 80 years and over age group represents the majority of hospitalisations, and we forecast that this share will only increase (56% of all hospitalisations in 2031) due to the rapid growth rate in this age group.

Figure 7: Forecast Number of Hospitalisations, 2025-2031, Central Scenario



Source: Forvis Mazars analysis of HPSC data

ICU Admissions

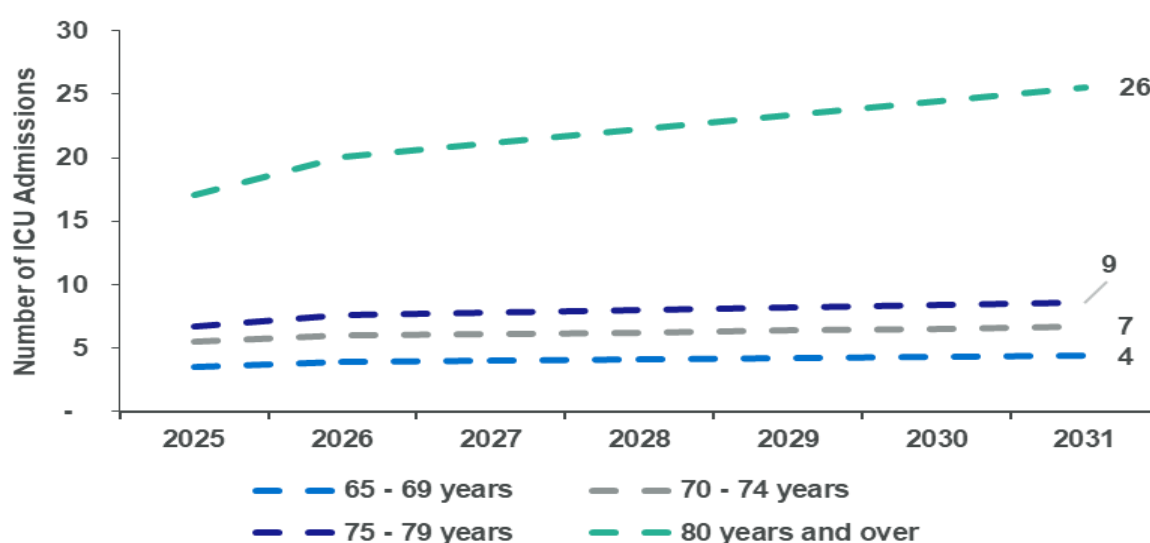
Table 21 summarises the forecasts for the number of RSV-related ICU admissions under our modelling specifications, across each of the scenarios discussed. Reflecting the narrower definition of an ICU admission in reported data, and literature suggesting a higher proportion of ICU admissions relative to cases, higher under-ascertainment figures (ref. Table 9) were applied in these scenarios ¹⁹. Across all scenarios, the number of ICU admissions in the 65+ age group is expected to increase.

Table 21: Summary of Forecast Number of RSV-Related ICU Admissions in 65+ Age Group, Scenario Analysis, 2025-2031							
	2025	2026	2027	2028	2029	2030	2031
Baseline (Reported Cases)	13	15	16	16	17	18	18
Low	16	18	19	19	20	21	22
Central	33	38	39	41	42	44	45
High	43	50	52	54	56	58	60

Source: Forvis Mazars analysis of HPSC data

Figure 8 provides an estimate of how these ICU admissions are likely to be distributed across smaller age groups under the central scenario. As before, the 80+ age group is likely to continue to be disproportionately affected *and* continue to grow at the highest rate. This age group also has the highest average length of stay – a combination of factors which will only serve to increase the number of bed days and overall system pressure.

Figure 8: Forecast Number of ICU Admissions, 2025-2031, Central Scenario



Source: Forvis Mazars analysis of HPSC data

Deaths

RSV-related deaths among adults aged 65 and over are projected to increase steadily between 2025 and 2031 across all scenarios, reflecting both population growth and ageing within older age subgroups. Under the central scenario, annual RSV-related deaths are forecast to increase from 115 in 2025 to 129 in 2031 (+12%), while the high scenario suggests the burden could rise to 170 deaths annually by 2031. Even under conservative assumptions, the mortality burden is expected to increase steadily through to 2031.

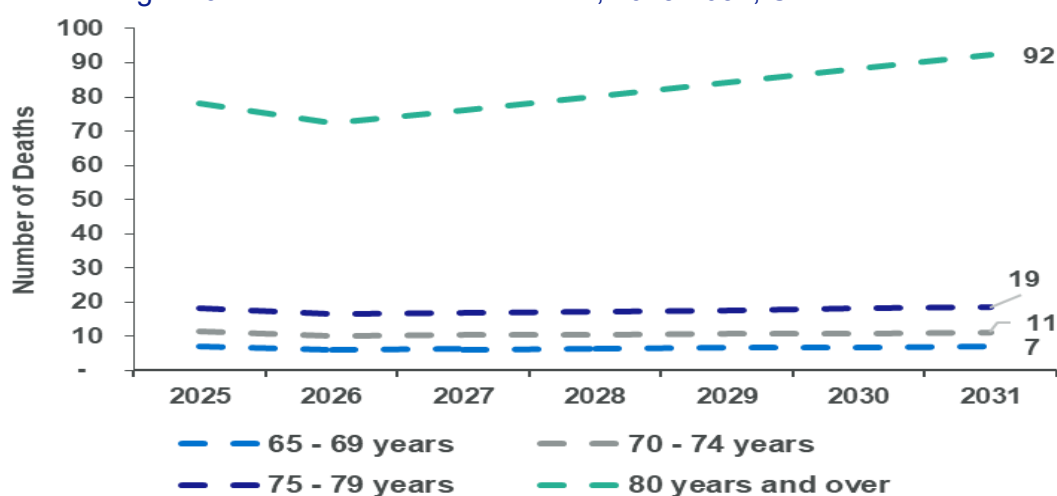
Table 22: Summary of Forecast for RSV-Related Deaths in 65+ Age Group, Scenario Analysis, 2025-2031

	2025	2026	2027	2028	2029	2030	2031
Baseline (Reported Cases)	46	42	44	46	48	50	52
Low	55	50	53	55	57	60	62
Central	115	105	110	114	119	124	129
High	152	139	145	151	157	164	170

Source: Forvis Mazars analysis of HPSC data

The pressure that population ageing will continue to place on the health system is illustrated in Figure 9 which shows that, under the central scenario, around 129 people over the age of 65 may die due to RSV by 2031, all else equal. Of these, around 92 (or 72%) will be over the age of 80, as this age subgroup is growing at the fastest rate, while also being most vulnerable to the most negative impacts of RSV.

Figure 9: Forecast Number of Deaths, 2025-2031, Central Scenario



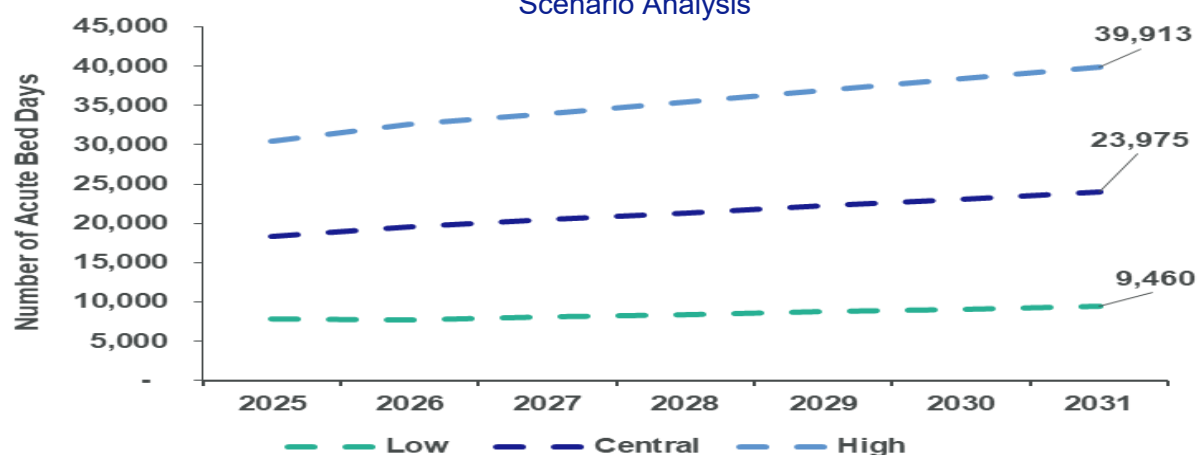
Source: Forvis Mazars analysis of HPSC data

Capacity Burden – Acute Bed Days

Explicitly modelling the number of bed days attributable to RSV more accurately demonstrates the likely burden on the system. RSV-related acute bed day utilisation among adults aged 65 and over is projected to increase steadily between 2025 and 2031 under all scenarios, reflecting growth in RSV-related hospitalisations and the increasing number of older adults at highest risk of severe disease. Under the central scenario, annual acute bed day utilisation is projected to rise from approximately 18,374 bed days in 2025 to 23,975 bed days by 2031, an increase of around 30%. Depending on assumptions regarding average length of stay, annual RSV-related bed day requirements could range from 9,460 bed days under the low scenario to 39,913 bed days under the high scenario by 2031. As well as reflecting under-ascertainment estimates, our scenarios also consider alternative assumptions regarding average length of stay. As a result, they illustrate the potential impact that prolonged hospital stays, particularly among the oldest and most clinically vulnerable patients, may have on overall hospital capacity requirements.

These findings are particularly important in the context of the Irish health system, where acute hospital bed capacity remains under significant pressure and demand routinely exceeds available capacity during winter months³⁶. RSV activity is strongly seasonal, with the majority of admissions occurring during the winter respiratory virus season when hospitals are simultaneously managing increased demand associated with influenza, COVID-19 and other respiratory infections⁹. Consequently, the projected growth in RSV-related bed occupancy is likely to be concentrated over relatively short periods, amplifying its impact on patient flow, emergency department crowding and care delivery.

Figure 10: Forecast Number of Acute Bed Days Occupied Due to RSV, 2025-2031, Scenario Analysis



Source: Forvis Mazars analysis of HPSC data

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Plain summary	Technical summary	Context	Current burden	Future burden	Impact	Findings

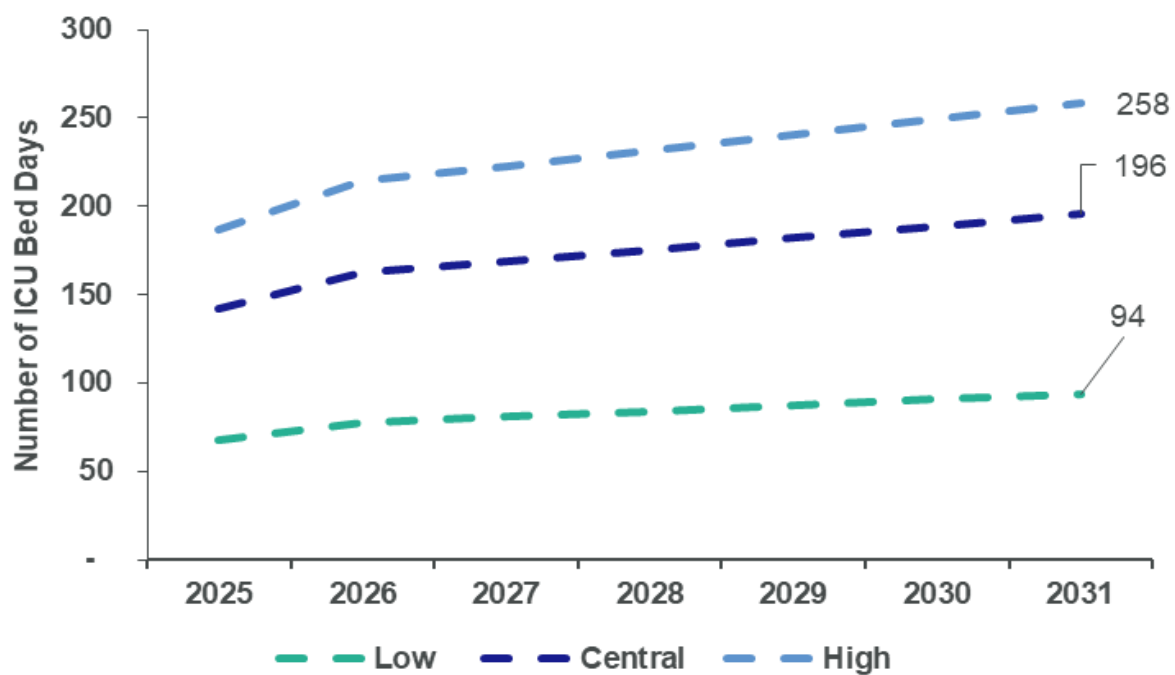
Capacity Burden – ICU Bed Days

RSV-related ICU bed day utilisation among adults aged 65 and over is projected to increase steadily between 2025 and 2031 across all scenarios, reflecting the growing burden of severe RSV disease in an ageing population. Under the central scenario, annual ICU bed days are forecast to rise from approximately 142 in 2025 to 196 by 2031, representing an increase of around 38%. Under the low scenario, ICU bed day utilisation is projected to increase more modestly to 94 days by 2031, while the high scenario projects that ICU demand could reach almost 258 bed days annually.

Although the absolute number of ICU bed days is lower than acute hospital bed day utilisation, ICU capacity is a particularly constrained healthcare resource, meaning even relatively small increases in demand may have important operational implications. The growing ICU burden is partially driven by increases in severe RSV-related illness among older adults, particularly within the oldest age groups who are at greatest risk of complications. The divergence between scenarios highlights the uncertainty surrounding the true burden of RSV-associated critical illness, particularly given the restrictive surveillance definition used for RSV-related ICU admissions. Overall, the findings suggest that RSV is likely to contribute to increasing pressure on critical care services over the forecast period, with ICU resource requirements expected to rise in line with broader demographic ageing trends.³⁶

Taken together, the analysis suggests that the burden of RSV on the healthcare system extends beyond the number of hospitalisations alone. Even modest increases in average length of stay can generate substantial additional bed day requirements, highlighting the importance of considering hospital capacity impacts alongside clinical outcomes and healthcare costs when assessing the future burden of RSV in older adults.

Figure 11: Forecast Number of ICU Bed Days Occupied Due to RSV, 2025-2031



Source: Forvis Mazars analysis of HPSC data and Liang et al (2026)³²

Capacity Burden – Increased System Pressure

RSV-related acute bed occupancy (hospitalisation and ICU) among adults aged 65 and over is projected to increase from an average of 51 beds occupied per day in 2025 to around 66 beds per day by 2031, representing an increase of around 31%. This growth is driven primarily by adults aged 80 years and over, who account for approximately two-thirds of all RSV-related bed utilisation and who experience the longest average lengths of stay following hospitalisation. The projected increase in RSV-related activity translates into a requirement for the equivalent of 15 additional acute hospital beds occupied every day by 2031.

Table 23: Summary of Forecast Estimated Daily Average Combined Inpatient and ICU Bed Usage, Central Scenario							
	2025	2026	2027	2028	2029	2030	2031
65 - 69 years	3.1	3.2	3.3	3.4	3.5	3.6	3.6
70 - 74 years	6.4	6.5	6.6	6.7	6.9	7.1	7.3
75 - 79 years	8.4	8.8	9.0	9.2	9.4	9.6	9.9
80 years and over	32.9	35.7	37.5	39.5	41.5	43.5	45.5
Total	50.7	54.1	56.4	58.8	61.3	63.8	66.2

Source: Forvis Mazars analysis of HPSC data

Table 24: Forecast Number of RSV-Attributable Acute Bed Days Required During Winter Respiratory Virus Season, 2026-2031, Central Scenario						
	2026	2027	2028	2029	2030	2031
Total Annual RSV-Attributable Bed Days	19,595	20,430	21,291	22,174	23,083	23,975
In-Season Bed Days Required	19,183	20,001	20,844	21,709	22,598	23,472
Bed Days Required in 10-Week Peak	12,618	13,156	13,710	14,279	14,864	15,439

Source: Forvis Mazars analysis of HPSC data

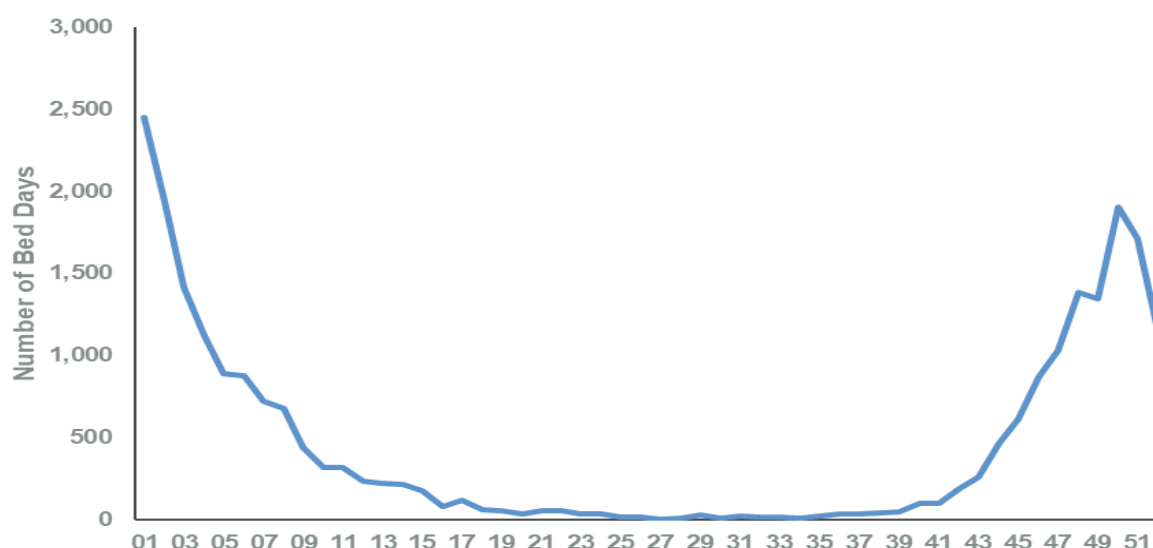
Meanwhile, it is forecast that 97% of ICU bed days are required in-season, with 81% of the bed-requirement concentrated in the 10-week peak.

Table 25: Forecast Number of RSV-Attributable ICU Bed Days Required During Winter Respiratory Virus Season, 2026-2031, Central Scenario						
	2026	2027	2028	2029	2030	2031
Total Annual RSV-Attributable Bed Days	162	169	175	182	189	196
In-Season Bed Days Required	158	164	170	177	183	190
Bed Days Required in 10-Week Peak	128	133	138	144	149	154

Source: Forvis Mazars analysis of HPSC data

Capacity Burden – Increased System Pressure

Figure 12: Forecast Weekly Number of Inpatient Bed Days, 2031, Central Scenario



Source: Forvis Mazars analysis of HPSC data

The burden of RSV is also amplified by demographic ageing. As shown in Table 26, while hospitalisations are projected to increase steadily over the forecast period, acute bed day utilisation is projected to grow faster than admissions themselves. This reflects the increasing contribution of the oldest age groups, particularly adults aged 80 years and over, whose longer lengths of stay result in disproportionately higher consumption of hospital resources.

Table 26: Forecast Comparison of Growth in Hospitalisations vs Growth in Bed Days, Central Scenario, 2026-2031

	2026	2027	2028	2029	2030	2031
Hospitalisations	5.96%	3.93%	3.88%	3.81%	3.80%	3.60%
Acute Bed Days	6.64%	4.26%	4.22%	4.15%	4.10%	3.87%

Source: Forvis Mazars analysis of HPSC data

Taken together, these findings suggest that RSV should be viewed not only in the context of increasing additional hospital admissions, but also as a growing driver of winter hospital capacity pressures. Even modest increases in RSV burden may translate into significant operational challenges through increased bed occupancy, crowded emergency departments, reduced surge capacity, delayed patient flow and greater pressure on already constrained acute hospital services.

Summary of Key Findings

Table 27 summarises the forecasts for each health system outcomes – number of cases, ED visits, hospitalisations, ICU admissions and deaths – across the 65+ age group between 2025 and 2031 and across each modelling scenario. The picture borne out by the data is clear: the clinical burden of RSV in older adults aged 65 and over will continue to increase. Furthermore, this impact is most acutely felt in the oldest age sub-group, i.e., those aged 80 years and over. When we consider the fact that the 65+ age group is growing at the fastest rate across the whole population – and the 80+ age subgroup growing at the fastest of all ^{7 8} – the policy implications are clear: the number of medically attended cases, hospitalisations, ICU admissions and deaths (each requiring bed days) will only continue to increase as a result of population ageing, and this will place further strain on an already overburdened healthcare system.

Table 27: Summary of Forecast Number of RSV-Related Health System Outcomes for 65+ Age Group, Scenario Analysis							
	2025	2026*	2027	2028	2029	2030	2031
Baseline (Reported Cases)							
Cases	2,250	1,718	1,785	1,854	1,925	1,998	2,070
ED Visits	614	585	607	631	654	679	703
Hospitalisations	740	784	815	847	879	912	945
ICU Admissions	13	15	16	16	17	18	18
Deaths	46	42	44	46	48	50	52
Low							
Cases	4,950	3,779	3,927	4,079	4,235	4,396	4,555
ED Visits	736	702	729	757	785	815	843
Hospitalisations	888	941	978	1,016	1,055	1,095	1,134
ICU Admissions	16	18	19	19	20	21	22
Deaths	55	50	53	55	57	60	62
Central							
Cases	9,000	6,871	7,141	7,417	7,700	7,993	8,281
ED Visits	1,534	1,462	1,518	1,577	1,636	1,697	1,757
Hospitalisations	1,850	1,961	2,038	2,117	2,198	2,281	2,363
ICU Admissions	33	38	39	41	42	44	45
Deaths	115	105	110	114	119	124	129
High							
Cases	17,775	13,569	14,103	14,649	15,207	15,786	16,355
ED Visits	2,025	1,930	2,004	2,081	2,159	2,240	2,319
Hospitalisations	2,443	2,588	2,690	2,794	2,901	3,011	3,119
ICU Admissions	43	50	52	54	56	58	60
Deaths	152	139	145	151	157	164	170

Source: Forvis Mazars analysis of HPSC data

* Note that 2026 estimates reflect an average of 2023-2025 figures, with 2025 representing a high-case year

00	00	01	02	03	04	05
Plain summary	Technical summary	Context	Current burden	Future burden	Impact	Findings

Summary of Key Findings

However, explicitly modelling the number of bed days attributable to RSV provides a more nuanced picture of the likely burden on the system. RSV-related acute bed day utilisation among adults aged 65 and over is projected to increase steadily between 2025 and 2031 under all scenarios, reflecting growth in RSV-related hospitalisations and the increasing number of older adults at highest risk of severe disease.

The burden of RSV is also amplified by demographic ageing. While hospitalisations are projected to increase steadily over the forecast period, **acute bed day utilisation is projected to grow faster than admissions themselves**. This reflects the increasing contribution of the oldest age groups, particularly adults aged 80 years and over, whose longer lengths of stay result in disproportionately higher consumption of hospital resources.

4. Estimating the Socio-Economic Impact of RSV in Older Adults

Direct Healthcare Costs

To estimate the direct economic impact of RSV in older adults, forecast activity levels for each healthcare outcome were combined with average associated cost estimates derived from Irish healthcare data sources. The modelling considers four main categories of healthcare utilisation: GP visits, Emergency Department (ED) visits, hospitalisations and ICU admissions. The objective of this socio-economic modelling analysis is not to undertake a full cost-effectiveness assessment, but rather to quantify the scale of direct healthcare expenditure likely to be associated with the forecast RSV burden between 2026 and 2031.

Table 28 summarises the average cost assumptions applied in the analysis. Consistent with the broader modelling framework, costs are estimated separately by age subgroup where data is available. Aligned with HIQA's HTA¹⁶, GP consultation costs are based on standard Irish primary care cost estimates (multiplied by the average number of GP visits required given a notified case). Emergency Department costs are based on HPO estimates of the average cost of an ED attendance. Age-specific hospitalisation costs are based on estimates drawn from HIQA's Health Technology Assessment (HTA) of RSV immunisation in older adults, which utilised Healthcare Pricing Office (HPO) and Hospital In-Patient Enquiry (HIPE) data to estimate the average cost of RSV-related admissions. Lastly, an incremental cost was applied for ICU admissions to reflect the additional resource intensity associated with critical care treatment. 2018 data from the HPO suggests that the total average annual running cost of a critical care bed was €747,000³⁷, or just over €2,000 per day, which corresponds to around €2,521 in 2025 values³⁸.

Direct Healthcare Costs

Table 28: Estimated Average Costs per Health System Outcome, Age Subgroup				
	Cost of GP Visits (€)	Cost of ED Visit (€)	Cost of Hospitalisation (€)	Incremental Cost of ICU Admission (€)
65 - 69 years	€130	€474	€8,621	€2,521
70 - 74 years	€130	€474	€9,466	€2,521
75 - 79 years	€260	€474	€8,817	€2,521
80 years and over	€260	€474	€8,791	€2,521

Source: HIQA HTA, using HPO and HIPE data

To estimate overall costs, for each scenario and forecast year, the projected number of GP visits, ED visits, hospitalisations and ICU admissions were multiplied by the corresponding unit costs shown in Table 28. Total costs were subsequently aggregated across age groups and across the 2026-2031 period to derive an estimate of the overall direct healthcare costs attributable to RSV under these assumptions.

This approach ensures consistency with the health system burden projections presented in the report while maintaining alignment with Irish healthcare costing methodologies. As highlighted elsewhere in this report, the economic burden should be considered alongside the wider hospital capacity burden associated with RSV, particularly the substantial demand for acute and critical care bed capacity generated by older adults experiencing prolonged lengths of stay. Hospitalisations account for the largest share of total direct healthcare costs in every scenario, reflecting both the high volume of admissions and the relatively high cost per hospital episode. Under the central scenario, RSV-related hospitalisations are estimated to generate approximately €115.1 million in healthcare costs between 2026 and 2031, compared with €46 million under the baseline scenario which considers reported cases only. The economic burden is heavily concentrated among adults aged 80 years and over, who account for the largest share of costs across all healthcare settings due to higher rates of severe disease, hospitalisation and ICU utilisation.

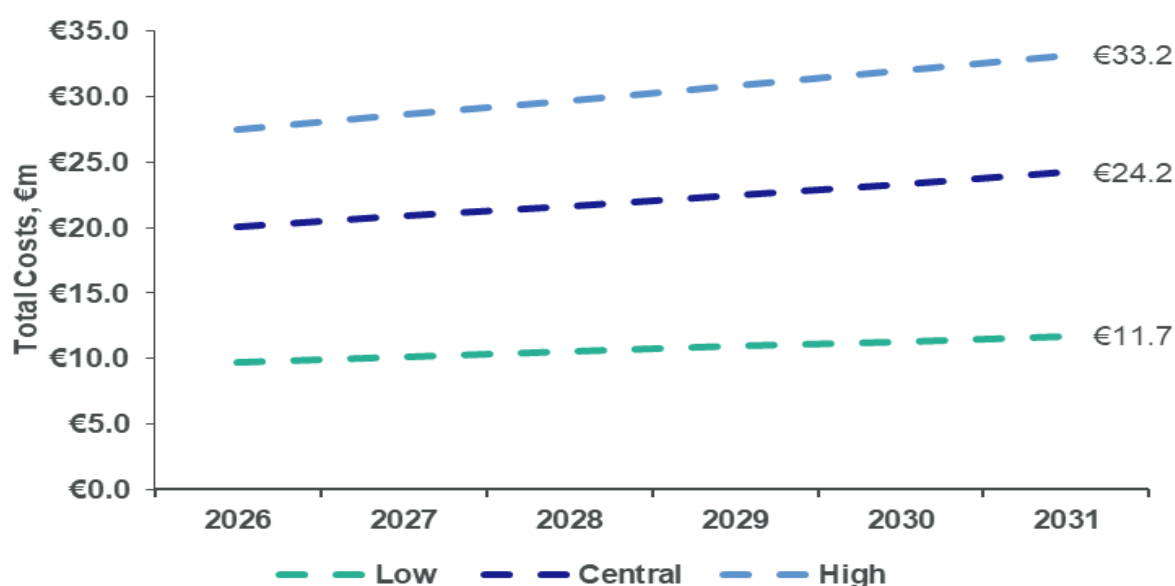
Table 29: Summary of Total Forecast Estimated Economic Impact of RSV-Related Medical Outcomes, 2026-2031, (€m)

	Cost of GP Visit (€m)	Cost of ED Visit (€m)	Cost of Hospitalisation (€m)	Cost of ICU Admission (€m)
Baseline (Reported Cases)	€2.6	€1.8	€46.0	€1.1
Low	€5.7	€2.2	€55.2	€1.3
Central	€10.3	€4.6	€115.1	€2.7
High	€20.3	€6.0	€151.9	€3.6

Source: Forvis Mazars analysis of HIQA, HPO and HIPE data

Figure 13 shows the total estimated healthcare costs by combining each cost outlined above. Direct healthcare costs associated with RSV are projected to increase each year across all scenarios, driven primarily by growth in healthcare utilisation among older adults and the increasing size of the 80+ population.

Figure 13: Total Forecast Healthcare Costs Attributable to RSV Health System Outcomes, €m, 2025-2031



Source: Forvis Mazars analysis of HIQA, HPO and HIPE data

Table 30 summarises the estimated economic impact of each RSV-related medical outcome, for each year from 2026 to 2031.

Table 30: Annual Forecast Estimated Economic Impact of RSV-Related Medical Outcomes, 2026-2031, (€m)							
	2026	2027	2028	2029	2030	2031	Total (2026-2031)
Baseline (Reported Cases)							
Cost of GP Visits (€m)	€0.4	€0.4	€0.4	€0.4	€0.5	€0.5	€2.6
Cost of ED Visit (€m)	€0.3	€0.3	€0.3	€0.3	€0.3	€0.3	€1.8
Cost of Hospitalisation (€m)	€7.0	€7.2	€7.5	€7.8	€8.1	€8.4	€46.0
Cost of ICU Admission (€m)	€0.2	€0.2	€0.2	€0.2	€0.2	€0.2	€1.1
Low							
Cost of GP Visits (€m)	€0.9	€0.9	€0.9	€1.0	€1.0	€1.0	€5.7
Cost of ED Visit (€m)	€0.3	€0.3	€0.4	€0.4	€0.4	€0.4	€2.2
Cost of Hospitalisation (€m)	€8.4	€8.7	€9.0	€9.4	€9.7	€10.1	€55.2
Cost of ICU Admission (€m)	€0.2	€0.2	€0.2	€0.2	€0.2	€0.2	€1.3
Central							
Cost of GP Visits (€m)	€1.5	€1.6	€1.7	€1.7	€1.8	€1.9	€10.3
Cost of ED Visit (€m)	€0.7	€0.7	€0.7	€0.8	€0.8	€0.8	€4.6
Cost of Hospitalisation (€m)	€17.4	€18.1	€18.8	€19.5	€20.3	€21.0	€115.1
Cost of ICU Admission (€m)	€0.4	€0.4	€0.4	€0.5	€0.5	€0.5	€2.7
High							
Cost of GP Visits (€m)	€3.1	€3.2	€3.3	€3.4	€3.6	€3.7	€20.3
Cost of ED Visit (€m)	€0.9	€1.0	€1.0	€1.0	€1.1	€1.1	€6.0
Cost of Hospitalisation (€m)	€23.0	€23.9	€24.8	€25.8	€26.7	€27.7	€151.9
Cost of ICU Admission (€m)	€0.5	€0.6	€0.6	€0.6	€0.6	€0.7	€3.6

Source: Forvis Mazars analysis of HIQA, HPO and HIPE data

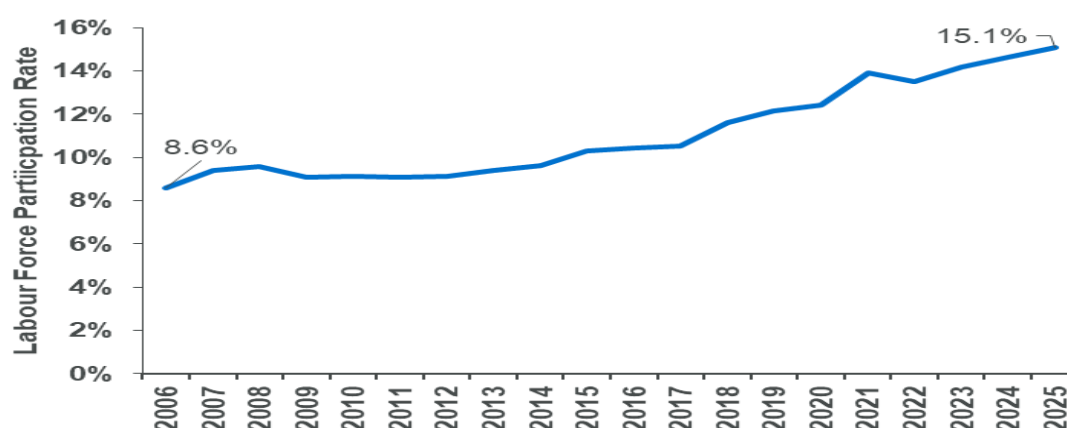
Indirect Socio-Economic Costs

While the main focus of this report has been in quantifying the substantial direct healthcare costs of RSV-related hospitalisations, bed occupancy and ICU admissions, a broader range of indirect costs are also likely to arise as RSV incidence increases among Ireland's growing older adult population.

A key societal impact is the loss of life and reduced life expectancy associated with severe RSV infection. Although this report has not explicitly estimated the societal cost of excess mortality, it cannot be overstated the extent to which mortality attributable to RSV represents a loss of economic and social value that is not captured through hospital costing alone.

RSV also generates important productivity losses, both directly and indirectly. Though many older adults are retired, labour force participation among people aged 65 and over continues to increase in Ireland. Indeed, as shown in Figure 14, the average labour force participation rate for adults aged 65 and over in 2025 was 15.1% - compared to 10.3% in 2015 and 8.6% in 2006. This is reflective of a labour force population in the 65 and over group of over 130,000 in 2025. Assuming this labour force participation rate remains the same, the labour force population in the 65 and over group in 2031 will be around 156,000. Based on our estimated hospitalisation rates for adults aged 65-69 (since most older adults in the labour force are likely to be in this age bracket) under the central scenario, this means that by 2031 almost 120 older adults may be out of work for a period of time due to the impacts of RSV-based hospitalisation. Severe RSV infection can therefore lead to temporary or permanent withdrawal from paid employment, volunteering and informal community activities.

Figure 14: Labour Force Participation Rate, Adults Aged 65+, 2006-2025



00	00	01	02	03	04	05
<u>Plain summary</u>	<u>Technical summary</u>	<u>Context</u>	<u>Current burden</u>	<u>Future burden</u>	<u>Impact</u>	<u>Findings</u>

In addition, productivity losses are often borne by family members who reduce working hours, take leave from employment or forego economic activity to provide care during illness and recovery.

A further cost arises from the increased requirement for informal and formal caregiving following discharge. Older adults recovering from RSV frequently experience prolonged weakness, reduced mobility, deterioration in underlying chronic conditions and overall reductions in quality-of-life³⁹. As well as impacting the quality of life of RSV patients, this prolonged impact may also increase dependence on spouses, adult children and community services for several weeks or months after infection. For some individuals, RSV-associated functional decline may accelerate the need for home-care support packages, rehabilitation services or long-term residential care. Such impacts are particularly relevant in Ireland given demographic ageing and existing pressures on home-care and long-term care capacity. Recent research from the ESRI, for example, suggests that long-term residential care and home support requirements will increase by at least 60% by 2040 due largely to the increase in the size of the older population⁴⁰.

As well as direct healthcare and social care costs, RSV may impose substantial opportunity costs on informal caregivers. Family members frequently provide assistance and support with daily living activities including medication management, transport to medical appointments, household tasks and general recovery management. Time devoted to caregiving may require reductions in paid employment due to curtailed working hours, absenteeism from work, diminished productivity while at work, or the loss of leisure and unpaid activities⁴². These indirect costs are often omitted from healthcare payer perspectives but represent a genuine economic burden faced by households and society. Evidence from a recent systematic review of caregiver burden associated with influenza and influenza-like illness found that caregivers commonly experienced work productivity losses, reductions in health-related quality of life, and missed work, with greater impacts observed when illness severity increased or hospitalisation occurred⁴¹. Productivity losses are therefore likely to impact not just patients of RSV themselves, but also caregivers who may be needed to support the patients after discharge.

00	00	01	02	03	04	05
Plain summary	Technical summary	Context	Current burden	Future burden	Impact	Findings

Finally, RSV outbreaks can contribute to wider societal costs through increased pressure on nursing homes, community healthcare services and carers. Evidence indicates that RSV is a significant cause of outbreaks in residential care settings and that disease burden rises with advancing age and comorbidity^{44 45 46}.

As the population aged over 65 continues to grow between 2026 and 2031, these indirect costs – though difficult to quantify – are likely to represent a meaningful component of the total economic burden of RSV, beyond the direct costs already captured through hospital resource utilisation.

Although evidence specific to RSV in older adults remains limited, the consequences may be even more significant because recovery is often prolonged and can be accompanied by ongoing functional decline. Reviews of RSV burden in older adults have highlighted that assessments restricted to acute healthcare utilisation are likely to underestimate the true impact of infection by failing to capture post-discharge disability, loss of independence and increased reliance on informal care. Branche et al (2022) finds that *“Older adults hospitalized with RSV demonstrate acute functional decline that may become prolonged.”*⁴³ In sum, the economic value of RSV prevention may extend beyond avoided hospitalisations and medical costs to include reductions in caregiver time, productivity losses and demands on formal social care services. In an ageing society such as Ireland, where many caregivers are themselves older adults or working-age family members, these opportunity costs may represent a substantial component of the overall socio-economic burden of RSV.

5. Summary of Key Findings

- Respiratory syncytial virus (RSV) is a common seasonal respiratory virus transmitted through airborne respiratory droplets. Each year, RSV, together with other winter respiratory viruses (primarily flu and COVID-19), puts significant capacity pressure on the Irish health system.
- International evidence suggests that data can significantly underestimate (under-ascertain) the true burden of RSV, due to infrequent routine testing, issues with test sensitivity, atypical symptoms and details around surveillance. In estimating the true burden of RSV in older adults, it is important to include an under-ascertainment factor.
- RSV is projected to place an increasing burden on the Irish healthcare system between 2026 and 2031, driven primarily by growth in the older adult population, particularly those aged 80 years and over.
- Accounting for under-ascertainment, under a central scenario examining trends in medical attendance as well as population growth and ageing, by 2031 over 8,000 adults over the age of 65 are likely to require medical attendance due to RSV per annum.
- This clinical burden is most acute for older adults, who have the highest share (over 50%) of RSV among adults over the age of 65.
- While RSV-related hospitalisations are projected to rise steadily over the forecast period, demand for hospital capacity is expected to increase even more rapidly, with acute bed day utilisation growing faster than admission volumes.
- Although RSV-related bed occupancy averages 66 beds per day in 2031, demand is concentrated within the winter respiratory virus season, meaning that peak bed requirements are likely to be substantially higher than annual averages suggest. Our analysis shows that 98% of the total annual acute bed day requirement occurs during the RSV season (32 weeks, or 62%, of the year).
- Furthermore, in the 10-week peak spell (between weeks 48 through to 4) where RSV is most prevalent, we expect that 66% of the bed-requirement will be concentrated, showing the burden that RSV has on the health system, when operational capacity is at its most constrained.

00	00	01	02	03	04	05
Plain summary	Technical summary	Context	Current burden	Future burden	Impact	Findings

- For ICU bed days, 81% of the annual bed-requirement is concentrated in the 10-week peak period.
- Adults aged 80 years and over account for the majority of RSV-related bed occupancy and are expected to drive most future growth in hospital resource utilisation due to higher rates of severe disease and longer lengths of stay.
- The projected increase in bed occupancy highlights how RSV will continue to impact on winter capacity pressures, including reduced bed availability, increased patient flow challenges, and greater demand on acute hospital services.
- Direct healthcare costs are projected to increase over the forecast period; however, bed day utilisation and occupied-bed requirements indicate that the operational impact of RSV on the health service may extend beyond financial costs alone.
- Further indirect socio-economic costs arise outside of the health system, including the increase in productivity loss and increased burden on caregivers. Productivity loss is expected to increase, given the increase in the labour force participation of adults aged 65 and over.
- **Overall, the findings suggest that the future burden of RSV in Ireland will be characterised not only by increasing numbers of cases and hospitalisations, but also by a growing demand for acute hospital capacity, with the greatest impact concentrated among adults aged 80 years and over.**

Appendices

A1: Abbreviations and Glossary of Terms

A2: Data Definitions

A3: References

Appendix 1: Abbreviations and Glossary of Terms

Abbreviation	Definition
CHF	Congestive Heart Failure
CIDR	Computerised Infectious Disease Reporting System
COPD	Chronic Obstructive Pulmonary Disease
CSO	Central Statistics Office
ED	Emergency Department
GP	General Practitioner
HIPE	Hospital In-Patient Enquiry System
HIQA	Health Information and Quality Authority
HPO	Healthcare Pricing Office
HPSC	Health Protection Surveillance Centre
HSE	Health Service Executive
HTA	Health Technology Assessment
ICU	Intensive Care Unit
ICU LOS	Intensive Care Unit Length of Stay
LOS	Length of Stay
NIAC	National Immunisation Advisory Committee
OECD	Organisation for Economic Co-operation and Development
RSV	Respiratory Syncytial Virus
RVN	Respiratory Virus Notifications

Appendix 2: Data Definitions

Our modelling has been informed by data sourced from the HPSC's Respiratory Virus Notification (RVN) Hub, which draws on statutory notifications of RSV cases extracted from the Computerised Infectious Disease Reporting (CIDR) system. The health system outcomes, under this system, are defined as follows:

- **Medically attended cases:** a confirmed case of RSV meets both clinical and laboratory criteria.
 - **Clinical criteria:** Any person presenting with a compatible clinical illness. Primary infection with respiratory syncytial virus (RSV) manifests clinically as pneumonia, bronchiolitis, tracheobronchiolitis or upper respiratory tract infection (often accompanied by fever and otitis media). The infection is rarely asymptomatic.
 - **Laboratory criteria:** At least one of the following four: - Isolation of respiratory syncytial virus (RSV) in tissue cell culture from respiratory secretions - Identification of RSV RNA in respiratory specimens by RT-PCR or other nucleic acid testing technique - Identification of RSV-specific viral antigen in respiratory specimens - 4 fold or greater rise in RSV antibody titre in paired acute and convalescent sera.
- **Hospitalised case:** Hospital in-patients with a laboratory confirmed RSV test.
- **ICU case:** Cases notified to the Computerised Infectious Disease Reporting system (CIDR) at HPSC who are in ICU with laboratory confirmed RSV whose RSV infection was the primary or contributing cause for their ICU admission.
- **RSV Deaths:** The definition of RSV death currently used by HPSC (for surveillance purposes) is any death where RSV is listed anywhere on the death certificate as the cause of death or when HPSC are notified of a death in laboratory confirmed RSV case by a clinician.

Appendix 3: References

1. Health Service Executive (2023) RSV (respiratory syncytial virus): symptoms, causes, diagnosis and treatments. HSE. Available at: <https://www2.hse.ie/conditions/rsv/> (Accessed: 9 September 2026).
2. RSV and Me (n.d.) RSV and Underlying Conditions. Available at: <https://www.rsvandme.ie/rsv-and-underlying-conditions/> (Accessed: 9 September 2026).
3. Kenmoe S, Nair H. (2024) The disease burden of respiratory syncytial virus in older adults. *Current Opinion in Infectious Diseases*. 37(2):129-136.
4. Department of Health (2025) Delivering an Age-Friendly Health System – A Blueprint to Transform Health and Healthcare for Older Adults published. Department of Health, Government of Ireland. Available at: <https://www.gov.ie/en/department-of-health/press-releases/delivering-an-age-friendly-health-system-a-blueprint-to-transform-health-and-healthcare-for-older-adults-published/> (Accessed: 9 September 2026).
5. Health Protection Surveillance Centre (n.d.) RSV: Respiratory Virus Notification Data Hub. Available at: <https://respiratoryvirus.hpsc.ie/pages/rsv> (Accessed: 9 September 2026).
6. Lowry Lehnen T. (2025) In focus: RSV in adults. *Medical Independent*. Available at: <https://www.medicalindependent.ie/update/clinical-practice/in-focus-rsv-in-adults/> (Accessed: 9 September 2026).
7. Central Statistics Office (2025) Regional Population Projections 2023–2042. Central Statistics Office. Available at: <https://www.cso.ie/en/releasesandpublications/ep/p-rpp/regionalpopulationprojections2023-2042/> (Accessed: 9 September 2026).
8. Lynch C. (2025) Ireland's Ageing Population and the Challenge for Health and Social Care. TASC. Available at: <https://www.tasc.ie/blog/2025/07/02/irelands-ageing-population-and-the-challenge-for-h/> (Accessed: 9 September 2026).
9. Murray V. (2025) RSV: An overview. *Medical Independent*. Available at: <https://www.medicalindependent.ie/clinical-news/rsv-an-overview/> (Accessed: 9 September 2026).
10. RSV and Me (n.d.) RSV and Older Adults. Available at: <https://www.rsvandme.ie/rsv-and-older-adults/> (Accessed: 9 September 2026).
11. Central Statistics Office (n.d.) QLF18:CSO StatBank. Available at: <https://data.cso.ie/table/QLF18> (Accessed: 9 September 2026).
12. National Immunisation Advisory Committee (NIAC) (2025) Updated recommendations for vaccination against respiratory syncytial virus in older adults. NITAG Resource Centre. Available at: <https://www.nitag-resource.org/resources/updated-recommendations-vaccination-against-respiratory-syncytial-virus-older-adults> (Accessed: 9 September 2026).
13. Centres for Disease Control and Prevention (2026) Symptoms and Care of RSV. RSV | CDC. Available at: <https://www.cdc.gov/rsv/about/symptoms.html> (Accessed: 9 September 2026).
14. Organisation for Economic Co-operation and Development (2025) Health at a Glance 2025: Ireland, OECD Available at: https://www.oecd.org/en/publications/health-at-a-glance-2025_5c9722ad-en/ireland_769329ca-en.html (Accessed: 9 September 2026).
15. Health Protection Surveillance Centre (2026) Study published on impact of Ireland's national nirsevimab immunisation programme on RSV morbidity amongst infants. News Archive. Available at: <https://www.hpsc.ie/news/newsarchive/2026newsarchive/title-25254-en.html> (Accessed: 9 September 2026).
16. Health Information and Quality Authority (2024) Health Technology Assessment of RSV Immunisation, HIQA. Available at <https://www.hiqa.ie/reports-and-publications/health-technology-assessment/hta-rsv-immunisation> (Accessed: 9 September 2026).

17. Cong et al. (2023) Understanding the Age Spectrum of Respiratory Syncytial Virus Associated Hospitalisation and Mortality Burden Based on Statistical Modelling Methods: A Systematic Analysis. *BMC Medicine*, 21(1), 224. Available at: <https://doi.org/10.1186/s12916-023-02932-5>.
18. Rozenbaum et al. (2023) Low Levels of RSV Testing Among Adults Hospitalized for Lower Respiratory Tract Infection in the United States
19. Talbot and Falsey (2010) The Diagnosis of Viral Respiratory Disease in Older Adults, *Clinical Infectious Diseases*, 50:747-751
20. Korsten et al. (2022) World Health Organization Influenza-Like Illness Underestimates the Burden of Respiratory Syncytial Virus Infection in Community-Dwelling Older Adults, *The Journal of Infectious Diseases*, 226(S1):S71-S78.
21. Burkart et al. (2025) Respiratory Syncytial Virus-Attributable Hospitalizations Among Adults in High- and Middle-Income Countries: Application of the Global Burden of Disease Framework. *EClinicalMedicine*, 85, 103292. Available at: <https://doi.org/10.1016/j.eclim.2025.103292>.
22. Penders et al. (2025) Burden of Respiratory Syncytial Virus Disease in Adults with Asthma and Chronic Obstructive Pulmonary Disease: A Systematic Literature Review, *Current Allergy and Asthma Reports*, 25(1):14
23. Chan et al. (2025) Respiratory Syncytial Virus Infection in Older Adults in Asia: A Modified Delphi Expert Consensus on Surveillance, Diagnosis, and Prevention, *Pulmonary Therapy*, 11(4):677-704
24. Zhang et al. (2025) Estimating the Respiratory Syncytial Virus-Associated Hospitalisation Burden in Older Adults in European Countries: A Systematic Analysis. *BMC Medicine*, 23(1), 453. Available at: <https://doi.org/10.1186/s12916-025-04249-x>.
25. Marot et al. (2025) Incidence and Burden of Respiratory Syncytial Virus-Associated Hospitalizations Among People 65 and Older in France: A National Hospital Database Study. *Open Forum Infectious Diseases*, 12(9), ofaf528. Available at: <https://doi.org/10.1093/ofid/ofaf528>.
26. Havers et al. (2024) Burden of Respiratory Syncytial Virus-Associated Hospitalizations in US Adults, October 2016 to September 2023, *JAMA Network Open*, 7(11):e2444756
27. Krauer et al. (2024) Effectiveness and Efficiency of Immunisation Strategies to Prevent RSV Among Infants and Older Adults in Germany: A Modelling Study, *BMC Medicine*, 22(1)478
28. Robert Koch. Falman A, Schönfeld V, Flasche S, Günther F, Koch J, Kwetkat A, Lange B, Liese J, Meerpohl J, Röhl-Mathieu M, Sandmann F, Schlaberg J, Tabatabai J, Überla K, Vygen-Bonnet S, Weltermann B, Widders G, Berner R. (2024) Decision and Scientific Justification of the STIKO Recommendation for a Standard Vaccination against Respiratory Syncytial Virus (RSV) Disease for Persons ≥75 Years of Age and for the indication vaccination of persons aged 60 to 74 years with risk factors. *Epidemiological Bulletin*. 32:3-28.
29. Cozzolino et al. (2025) Estimation of the Respiratory Syncytial Virus Hospitalization Burden in Older Adults in the Veneto Region, Italy: A Modelling Study, *Infectious Diseases and Therapy*, 14(12):2719-2732
30. Osei-Yeboah et al. (2023) Estimation of the Number of Respiratory Syncytial Virus-Associated Hospitalizations in Adults in the European Union, *The Journal of Infectious Diseases*, 228(11):1539-1548
31. Savic M, Penders Y, Shi T, Branche A, Pirçon-J-7. (2022) Respiratory Syncytial Virus Disease Burden in Adults Aged 60 years and Older in High-Income Countries: A Systematic Literature Review and Meta-Analysis, *Influenza and Other Respiratory Viruses*. 2022;17(1):e13031
32. Liang C, Zhou Y, Kent M et al. (2026) Intensive Care Unit Stay and Mechanical Ventilation Among Adults with Respiratory Syncytial Virus-Related Hospitalizations by Age and Comorbidity Status, *Infect Dis Ther*. 2026;15:101-115

33. Abrams EM, Doyon-Plourde P, Davis P, Lee L, Rahal A, Brousseau N, Siu W, Killikelly A. (2025) Burden of Disease of Respiratory Syncytial Virus in Older Adults Considered at High Risk of Severe Infection, Canada Communicable Disease Report, 2025;51(1)26-34
34. Department of Health (2021) Acute Hospital Inpatient Bed Capacity Expansion Plan, Department of Health, Government of Ireland. Available at: <https://www.gov.ie/en/department-of-health/publications/acute-hospital-inpatient-bed-capacity-expansion-plan-2024-2031/>. (Accessed 3 September 2026).
35. Organisation for Economic Co-operation and Development (OECD) (2026) Hospital Beds, OECD Data Indicators. Available at: <https://www.oecd.org/en/data/indicators/hospital-beds.html> (Accessed 3 September 2026).
36. National Office of Clinical Audit (NOCA) (2025) Irish National ICU Audit Annual Report 2024 highlights strong outcomes despite sustained pressure on services. Available at: <https://www.noca.ie/news-events/irish-national-icu-audit-annual-report-2024-highlights-strong-outcomes-despite-sustained-pressure-on-services-2/> (Accessed: 9 September 2026).
37. Minister for Health (2021) Health Services: Parliamentary Question No. 1874, Dáil Éireann Debate, Houses of the Oireachtas. Available at: <https://www.oireachtas.ie/en/debates/question/2021-07-27/2983/> (Accessed 3 September 2026)
38. Central Statistics Office (n.d.) CPI Inflation Calculator. Central Statistics Office. Available at: <https://visual.cso.ie/?body=entity/cpicalculator> (Accessed: 9 September 2026).
39. Curran D, Cabrera ES, Bracke B, Raymond K, Foster A, Umanzor C, Goulet P, Powers JH III. (2022) Impact of Respiratory Syncytial Virus Disease on Quality of Life in Adults Aged ≥ 50 Years: A Qualitative Patient Experience Cross-Sectional Study, Influenza and Other Respiratory Viruses. 2022;16(3):462-473.
40. Walsh B, Kakoulidou T. (2025) Projections of National Demand and Bed Capacity Requirements for Older People's Care in Ireland, 2022-2040: Based on the Hippocrates Model, ESRI Research Series No. 214, Economic and Social Research Institute (ESRI), Dublin
41. Vaghela S, Welch VL, Sinh A, Di Fusco M. (2024) Caregiver Burden Among Patients with Influenza or Influenza-Like Illness (ILI): A Systematic Literature Review, Healthcare (Basel). 2024;12(16):1591
42. Keita Fakeye M, Samuel L, Drabo E et al. (2022) Caregiving-Related Work Productivity Loss Among Employed Family and Other Unpaid Caregivers of Older Adults, Value in Health. 2022;26:712-720.
43. Branche AR, Saiman L, Walsh EE, Falsey AR, Jia H, Barrett A, Alba L, Phillips M, Finelli L. (2022) Change in Functional Status Associated with Respiratory Syncytial Virus Infection in Hospitalized Older Adults, Influenza and Other Respiratory Viruses. 2022;16(6):1151-1160.
44. Gannon J, Fennell L, Woods J, O'Connell A, Murphy B, Donnelly T, Connolly M, Concannon C, Mullaney C, Conroy N. (2025) Acute Respiratory Infection Outbreaks in Residential Care Facilities, Irish Medical Journal. 2025;118(10):P167.
45. McGeoch L, Stoker K, Rome M, Carey C, Rose A, Dolan G, Cassell J, Watson C. (2026) What is the Burden of Respiratory Syncytial Virus Outbreaks in Care Homes? An Enhanced Surveillance Study in England, Winter 2024/25, Epidemiology and Infection. 2026;154:e99.
46. Nguyen-Van-Tam JS, O'Leary M, Martin ET, Heijnen E, Callendret B, Fleischhackl R, Comeaux C, Tran TMP, Weber K. (2022) Burden of Respiratory Syncytial Virus Infection in Older and High-Risk Adults: A Systematic Review and Meta-Analysis of the Evidence from Developed Countries, European Respiratory Review. 2022;31(166):220105

Dr Graham Love

Partner, Forvis Mazars

glove@mazars.ie

Eoin Monaghan

Senior Economist, Forvis Mazars

eoin.monaghan@mazars.ie