

# Funding Universal Health and Social Care in Ireland: Ageing, dying, and affordability.

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## Introduction

The history of research on health care and health care finance, from Arrow (1963) onwards, has seen a focus on why health and health care are 'different'. Much of the focus has been on various aspects of technical market failures, especially concerning uncertainty, asymmetric information and tendencies to monopolies. While these issues are important (Normand 1992), they provide only partial explanation of why, to a very great extent, allocation of health resources is taken out of the normal market mechanisms in all developed countries, including in those with a large role for private finance and provision. The main issues really come from two linked difficulties - the problem of timing and the need for inter-temporal transfers of rights to resources, and the inability of some people in society ever to afford access to effective care.

While it is argued above that the key motivation for collective action to provide access to care comes from problems of affordability at the time of needs (and for some people at any time) this does not fully justify a 'free at the point of use' approach – alternative voucher schemes and similar mechanism could work. However, another important part of the puzzle is that there is good evidence (as outlined in detail in the Ruane Report, Department of Health 2010) that fees disincentives both useful and less useful access to care – the conclusion is that the use of fees to ration does not usefully divert the less important use of care without doing exactly the same for more important use.

Whatever the mechanism for paying for care, on average we all pay in what we get out – the key issues are when we pay. Although it will be shown below that ageing is not in itself a very important driver of health care costs, it remains the case that heavy use of health services is clustered in the periods before people are working and after they are retired. Thus ability to pay is concentrated in the period of least need and need is concentrated in the period of least ability to pay. Additionally, since need for care is very varied, but is in many cases quite predictable, insurance in the conventional sense does not work well. Since most care is for the management of established and chronic conditions, by its nature it is not very uncertain or risk based. As understanding of disease patterns and aetiology increases, the insurability of services decreases.

An analysis of Irish health policy documents (DoHC 2001) (and indeed of health policy documents from many countries) provides some broad statements about health policy

objectives. While the detail is limited, the statements indicate that the main objectives are access to good quality services based on need and not ability to pay. It is difficult to see the link between the objectives stated and the subsequent reform programme, which did not significantly change entitlement or availability of services, and, at least in the short run, did not improve quality of care. It is arguable that at least some of the reason for this is that the concepts were too general to be operational, so that the reform programme focused on the 'comfort zone' of system reconfiguration, based on the simple logic that the reason for poor performance of organisations were organisational. Smith has shown that a range of different concepts of equity are used in Irish health policy documents and that the idea of equity is used inconsistently (Smith and Normand 2009, Smith and Normand 2011).

There are good reasons why clear and operational statements of policy are avoided. While a good intellectual argument can be made for many desirable changes, there are always losers as well as winners, and losers tend to argue more strongly than winners. Take two simple examples. First, good care requires that some services are provided in large scale, specialist centres, but local hospitals are often the source of secure and pensionable employment. While this need not be a real constraint, efforts to reconfigure services have tended to centralise but fail to decentralise those activities that can efficiently and safely be provided locally. Second, limited resources and effectively infinite demands require some form of rationing. Politically it is easier to do this without explicit rules, allowing for the myth that there is no rationing.

For the purposes of the argument in this paper, an economic (and logical) perspective is taken. The objective should be to provide access without significant barriers to all health and social care that is cost-effective. Clearly there is scope for argument about what we mean by cost-effective, but in many respects it is simple – we aim to improve life expectancy and we aim to improve quality of life, and we should prioritise those services that do the most to achieve improvements in these. While there are significant problems in tools such as Quality Adjusted Life Years (QALYs), especially in areas of complex care for complex needs (Normand 2012), and there are clearly areas in which we need to account for wider benefits from health improvements to, for example, parents of young children, the underlying logic holds. A typical threshold for inclusion of new treatments for simple conditions is around €45,000 per QALY, which reasonably closely reflects what is currently available and what is not. This is not to argue that there is never a good reason to break this barrier, although the arguments for do so are often advanced with support from providers of treatments priced (not costed) above this level.

Apart from the role of fees to raise funds (which in many cases they do effectively), and to discourage frivolous use of services (which they do badly), there is a tendency to believe there is some intrinsic usefulness in some fees, if only to make people aware of the costs (which they fail to do unless the full cost is charged) or to make people appreciate and value the services. This enthusiasm for fees has no basis in evidence. Where there is interesting evidence is on the use of partial fees – the argument is that we cannot afford

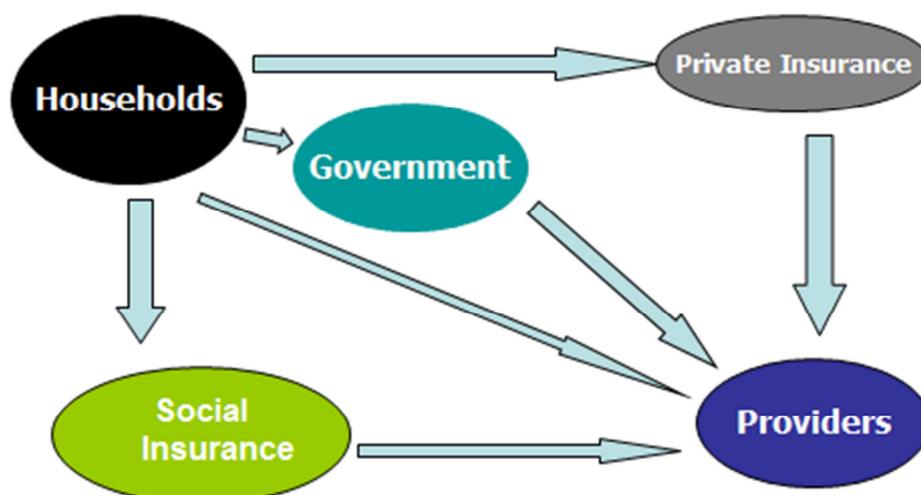
collectively to fund the full cost but we can fund part of the cost (Chang et al 2009). In the early experience in Korea, the national health insurance covered half of the cost of services. This paradoxically led to subsidy of the relatively rich (who could afford the other half) by the relatively poor (who could not). The lesson is that, in general, it is better to give full subsidy on some services than to give partial subsidy on all.

It will be argued below that this approach to defining the scope of health care entitlements, along with a better understanding of the drivers of health care need and appropriate incentives for efficient delivery of care make it feasible in the long run to have universal health care (as conceptualised above).

### Health Care Funding – nothing comes from nothing

The diagram below provides a simplified description of the flow of funds in health care finance. The simple, but key point is that all health care resources start from households, and therefore the only ways in which different systems of finance change the burden of paying is through differences in who pays and who gets access to care. If we are committed to universal health care as characterised above, then the questions become simpler – how we raise the funds affects who pays how much, and how much does it cost to raise and manage the funds. As suggested above the level of funding is defined by the cost of providing all cost-effective interventions, but it is also sometimes argued (based on some reasonable evidence) that the acceptability of paying for services is increased by more transparent mechanisms of funding (Thomas et al 2008).

### Health Finance – the flow of funds



What is known is that costs of transactions vary widely across health systems, with levels being as low as 7-8% in tax funded systems to around 25-30% in complex mixed funding models such as the USA.

### **Funding what – the need for clear rationing principles**

The proposition in this paper is that what is meant by universal health care is the provision without serious barriers of all services that are cost-effective. As the term suggests, this requires information on both cost and effectiveness. Costs of care depend on how efficiently care is provided and the prices paid to the staff and other care inputs, and there are well established tools for assessing system efficiency (Papanicolas and Smith 2013). Studies in Ireland (Lordan 2007, Lordan 2009) have shown that if the performance of all providers were at the level of the best there would be improvements in efficiency. Taking the evidence from across the OECD the potential improvements may be 10-20% (OECD 2010). Thus basing access to care on cost-effectiveness has to consider that this will increase as efficiency of delivery increases. Obviously in principle the cost of care is the cost of care provided efficiently. Additionally, there is some evidence that it is possible through technical progress (including incremental technical progress) to increase efficiency in the hospital sector by 2-3% per year. This means that there is some scope over time to offset any growth in needs with growth in efficiency, and that there is a stock of inefficiency that can, over time, be used to reduce costs and release resources.

The assessment of effectiveness needs to move beyond efficacy. Take the example of prostate cancer. Of men who die over the age of 80 more than half have prostate cancer, but only some of these have disease that will harm them. Recent work on breast cancer screening shows that some people whose cancers are detected and treated would have had no symptoms or adverse consequences if the disease had been left undiagnosed (but we do not know which people). The advantage of using QALYs or similar measures is that this focuses on the changes in survival and quality of life, and not simply on disease presence or absence. While accepting the shortcomings of such measure in practice, this approach can go a long way to sorting out what treatments should be available and for whom.

There are good reasons *not* to use implicit rationing, such as use of waiting times to ration care. While appearing in some sense fair, the fact that a person waits for treatment effectively destroys some of the outputs. Take the simple example of cataract surgery. The output is years of good vision. Delay in treatment may reduce this by the time from when benefits could exist till the time they do.

The issues in explicit rationing tend to come in cases where there are tragic outcomes for those not treated, but where the available treatment is usually relatively ineffective or very expensive. There are good reasons why we should not allow this problem to get in the way of moves towards more explicit rationing. First, such problems are rare, and we can take a case by case approach. Where the treatment is very expensive (as in the recent cases of drugs for people with cystic fibrosis), to an extent what is observed is a negotiation between

the funders and the drug company. Especially with rare diseases the cost of developing drugs can be very high and companies aim to recoup this with high prices within the patent period. It should be understood that there is no such thing as the price of drugs for rare diseases – there is a negotiation between a monopoly supplier and a (normally) monopsony buyer. Where the evidence is that treatment is seldom effective different issues arise, but it can be appropriate in such cases to fund treatments within well specified research studies, since there may be potential to increase the efficacy in well managed care, and we may be able to identify more clearly who will benefit. While explicit rationing will always be contentious, and will never be perfect, using this general approach, and applying judgment and compassion, it should be possible at any time to have a concept of what is included in cost-effective care. With increasing national wealth this can expand. As always the trade-offs are with other useful public programmes and with benefits from lower taxes or contributions and higher private spending.

### **Ageing and dying – the complex effects of ageing and demographic changes**

There are many myths around ageing and health care costs. The evidence is quite clear (Zweifel et al 1999, McGrail et al 2000). The main reason that costs are higher for people who are older is that they are closer to death. Additionally, there is evidence that the cost of dying declines with age. What is also clear is that the balance of costs changes with age, with people needing more social and primary care as they get older, but with no equivalent increase in the costs of acute care. When proximity to death is taken into account there is little or no effect of ageing on costs of acute care. Recent work shows the same pattern for community prescribing – the effect of ageing disappears when proximity to death is taken into account, and the cost of dying decreases with age (Moore et al 2014).

The implications of this evidence for future health care costs are obvious. Projections that are based solely on population age structure are likely to exaggerate significantly the effects of ageing on costs of care particularly costs of hospital care.

However, evidence also shows that older people are getting more access to care, probably as a result of greater assertiveness and more availability of services (Layte 2009). The Demographic Change project demonstrates that the growth in use of services is driven more by changes in access for existing needs than by changes in the levels of needs. This suggests that the effect of informal rationing of access to care is weakening, and that there is an increasing recognition that many interventions are cost-effective for older people (Lamping et al 2000). Research shows that access to care tends to be uneven even when in principle it is available on the basis of need alone (Langham et al 2003). It is likely that there will be a continuing tendency for use of services to increase where there are clear benefits and where it is hard to justify previous rationing.

Recent research (Wren 2014, presentation at iHEA conference, Dublin) confirms the general findings on the relative unimportance of ageing on health care costs, but also raises another

important complexity in the relationship of ageing and health care costs. It is well established that a main source of caring for older people is other older people, and a particularly strong role is played by spouses and partners. Ageing is not only increasing life expectancy in general, but is also closing the life expectancy gap between men and women. This has the effect of increasing the proportion of older people who are living in households of 2 or more people. Wren demonstrates that countries with more rapid convergence in life expectancy have slower growth in health care costs. As with all relationships between ageing and health care costs, the pattern is complex, and the effect of convergence is particularly important as ageing increases. Wren also explores the effects of female labour force participation – while it is clear that comparing countries those with lower rates have more care provided within the family, the growing labour force participation does not appear to be associated with higher costs. A recent study on palliative care reinforces this finding that the carers for older people tend to be other older people (Brick et al 2015).

A major source of uncertainty around need for healthcare is the increase in numbers of people who live with multiple health conditions. Again the evidence paints a complicated picture. Current research using data from TILDA has shown that people with multimorbidity are higher users of services than those with one or less conditions (McNamara et al 2013). However, preliminary evidence suggests that the relationship between number of conditions and use of services is not linear, and above a threshold the use of services changes only marginally. What seems to be happening is that in the early stages the focus is on trying to manage each condition, but as the needs become more complex it is understood that a more selective, holistic approach is better. Also there seems to be some element of scale economies – the same consultation can deal with more than one problem. This is an area where more and more detailed studies are needed, and it will be particularly important to ensure that a distinction can be made between good decisions not to treat (May et al 2014) and (often ageist) restrictions on access to care. For example, there was a rule in England that people with diabetes should not be started on dialysis in older age, but research showed that there was no direct link between having diabetes and poor dialysis outcomes (but there was a correlation driven by other associated diseases), (Lamping et al 2000). A recent study on palliative care in hospitals in the US (presented by Peter May at the 2014 iHEA conference in Dublin) has shown that the better decision making following a specialist consultation improves outcomes and reduces costs of hospital care, especially for people who have multiple health conditions, suggesting that there is some overtreatment of these patients. There remains considerable uncertainty about the characteristics of the ‘new’ old, who may include more people who survive despite chronic disease, while traditionally the very old tended to be people who have largely escaped (multi) morbidity. What is clear is that the care needs of older people will not overwhelm the health system, and any increase will be more a glacier than an avalanche (Barer et al 1995).

### **System capacity and the plausibility of universal health care**

There is some evidence that satisfaction with health systems can be higher with higher costs (contributions or taxes) and better access to care (Mossialos 1998). What is also clear is that there is considerable resistance to paying more unless this is also a better service and this is reflected in the analysis of the recent public consultation on universal health insurance in Ireland (Department of Health 2014<sup>1</sup>). Analysis of the current capacity in the Irish health system shows significant gaps in the availability of services (even for people who have medical cards and private health insurance). The key issues are that there are too few primary care doctors and other professionals to shift care out of hospitals and to provide for needs to manage chronic disease (Teljeur et al 2013). There are particular shortages in some allied health professions, and for some it is not easy to get access even as a private patient. While there is probably adequate capacity in the hospital sector, much of this is not available due to delayed discharge of patients whose treatment is complete, some is of poor quality, and some is in the wrong places. Additionally for historical reasons and as a result of the restrictions on recruitment the staffing of acute hospitals is in many cases out of balance. It is a simple point, but any serious move towards universal access to care will require that additional financial resources can mobilise additional service delivery (of the right kinds in the right places). The difficulty is that the planning of increases in service availability must run in parallel with the increases in funding, and this has been difficult to achieve in the past.

### **Dealing with legacy issues**

Irish health policy makers have had a complex relationship with private medical insurance, and this has remained a barrier to coherent thinking. The current changes to the rules on community rating (Department of Health 2014<sup>2</sup>) (which incentivise people at younger ages to buy insurance) directly contradict the plan to move to a single tier universal insurance system within the next few years (Department of Health 2012). Recent moves further confuse matters by trying to widen the coverage from private insurance into primary and community services. The recent decline in private health insurance has exposed the underlying problem. Private insurance was originally needed to provide access to hospital care for those who were not entitled to state services, and was regulated to remove risk rating and subsidised in various ways. The model that emerged following widening of access to hospital care to the whole resident population retained the community rating and much of the subsidy, and was very good value for most people, leading to coverage for more than half of the population.

The rising price of private insurance and the decline in uptake posed risks to the viability of the system. The trend has been very clear. While overall the numbers with private insurance has fallen, the numbers of older people with private insurance has increased (TILDA 2014). The people who chose to drop their insurance were very low users of services and were, actuarially, losers. This raises the average risk level and increases premiums. Along with a decline in subsidies and a widening of services for which hospitals could charge

meant that premiums were rising rapidly. In effect the government response has been to increase subsidies again (by lowering charges in public hospitals) and to allow some *de facto* risk selection through the introduction of life time community rating.

A puzzling part of this whole story is the relative unimportance of private health insurance in Ireland as a source of funds. Between 2006 and 2007 the *increase* in the public health budget was larger than the annual private insurance funding. The percentage of private insurance funding in total health care funding has been rising recently, largely due to reductions in public funding levels, but the percentage remains below that of private out of pocket spending. When the higher cost of private provision is taken into account, the cost of replacing private provision in public services would probably be around 5-7% of total health spending, or between 7 and 10% of current public revenue spending on health. While accepting that it is the right of citizens to buy private health insurance, and while it is the right of professionals and care delivery organisations to provide these services, it is difficult to justify the current focus on maintaining the private insurance funding given the effects on equity in access to care and the array of perverse incentives that it creates. Community rating is increasingly undermined by the complexity of the policies on offer and the difficulty in devising risk equalisation across the diverse offerings. The irony is that private health insurance is popular largely because it conflicts with the public policy objective of a single tier of access to care.

There are other important legacy issues to address. Although access to GP care has been free for a high proportion of service use, the majority of people still pay per visit. This has undermined the objective of shifting care into (more appropriate) community settings, and has reduced the incentives to develop continuity of care.

### **Towards affordable universal coverage.**

There is no correct level of health care expenditure. Universal health care (as conceptualised above) can be compatible with a range of different levels of spending, and what should be clear is that universal care does not mean anything that produces a benefit, however small. Countries that have more universal systems than Ireland spend between 8 and 12% of GNI on health care, in many cases with less favourable demographics. Controlling overall spending is important not narrowly to increase sustainability (since this is not really a useful concept). It can also sustain support for a system that has those able to pay paying, and those in need receiving care. It is important that services are provided efficiently and that collective funding is not used for interventions of little value.

A further and important complication is that the value of interventions tends to vary hugely between individuals, so that exclusion of access should properly be *for some people for some services* rather than *for some services*. Essentially the mechanisms for optimal rationing are bottom up – defined clinical pathways determine eligibility. This contrasts with the more common approach that access to particular services free, at a subsidised

price or at full price. This means that to an extent there will always be grey areas – the choice to give or not to give free access to care may not be completely fair since an element of judgement is needed. However, it will certainly be better than crude rationing by waiting or by ability to pay.

Once the principles for defining universal care are in place it is possible to envisage a more mature debate on levels of funding to allow the threshold to change. Since it is clear that the demographics should be possible to accommodate within the natural growth in the economy, the debate is really around the extent to which we wish to meet currently unmet needs. Insofar as the current rationing is unfair it may practically be possible only to level up access, which would imply higher shares of GNI.

However, since good versions of universal care are affordable, we can envisage a situation in which we collectively opt not to change the share of GNI to health with a growing economy, exploiting efficiency gains at perhaps 2% per year to supplement 2-3% growth in revenues for wider economic progress. Some efficiency gains are easy to achieve, but many will require significant changes in the way care is delivered. Moves out of hospital settings will be important, and some industrialisation of care will be useful.

However, the real challenges will come in the growing pressures around long term care provision. Despite some obvious shortcomings, the underlying approach in Fair Deal (<http://health.gov.ie/blog/policy/n/nursing-homes-support-scheme-a-fair-deal/>) offers some possible ways forward. Long term care insurance has little prospect – it is not inherently very insurable, and few are likely to take out insurance at a time when it could be afforded. It is not unreasonable that people should pay at least what it costs to stay at home when in long term care. Few people have significant financial assets except in the value of pensions and the value of owner occupier housing. As with all attempts to tax inheritance, taxing the equity value in housing can encourage tax avoidance behaviour, and is strongly resisted by those who hope to inherit (and those who wish to provide inheritance). In principle it can be quite equitable since the tax on equity in housing can be higher where housing is more valuable, but the reality is that the choice is between some approach of this sort or paying the full cost of long term care (net of charges to account for any lower costs at home).

It is important to recognise that good versions of universal health care are affordable, especially where the service is provided efficiently. Collectively we have choices on how universal it should be (not in the sense of who gets cover but in what is covered). Experience suggests that access use of free care by richer people along with equitable revenue raising is better than a two tier system. Titmus (1974 - <http://rszarf.ips.uw.edu.pl/welfare-state/titmuss.pdf>) was probably right that a welfare system for the poor tends to become a poor system.

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