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PRICING AND REIMBURSEMENT SYSTEMS IN EUROPE

The Irish 'health basket': a basket case?

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Abstract The Irish health care system is typically described as complex and inequitable and yet the source of the complexity is difficult to identify. This paper examines and documents the way in which the structure of the Irish system is complicated when compared with other countries. Analysis is conducted in the context of the 'health basket' framework. A health basket describes which health care services, and which individuals, are covered by public funding, and to what extent. The Irish health basket is outlined along three dimensions of breadth, depth, and height, and compared with the health baskets of the United Kingdom, Canada, Australia, Sweden and France. Results indicate that it is in the combination of breadth and height that distinguishes the Irish basket from others. The majority of Irish health care services are run on a cost sharing basis; user fees are higher than in other countries particularly in primary care; and the structure of entitlement restrictions are complex. It is difficult to identify other countries in which all these factors operate within one system. In addition, the way in which the Irish health basket is delivered in practice introduces further complexities into the breadth and height of coverage.

Keywords Health basket · Health system · Health structure · Entitlement · Complex system · Ireland

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Introduction

The Irish health care system is typically described as complex and inequitable and yet the source of the complexity is difficult to identify [1, 2]. As in most countries, the Irish system is financed by a mix of public and private resources. Other systems also have complex user charge structures and allow private care to take place within public hospitals, as is the case in Ireland. This paper aims to examine and document the way in which the structure of the Irish health care system is complicated when compared with other countries.

Recent work by the European Health Management Association (EHMA *Health*BASKET project [3]) on identifying 'health baskets' for a range of countries, provides a useful framework for comparing health care systems. The health basket describes which health care services, and which individuals, are covered by public funding, and to what extent. A health basket is outlined along three separate dimensions of breadth, depth, and height (described below). This paper applies the health basket structure to the Irish health care system and to other national systems that are typically compared with the Irish system. Cross-country comparisons along the dimensions of breadth and height help to unpick the sources of complexity in the Irish system that distinguish it from others.

An introduction to the health basket framework is followed by a description of how it applies to the Irish context, outlining the origins and structure of the Irish health basket. The Irish basket is then discussed in the context of other national systems.

Background—definition of a health basket

As outlined in the literature, in the context of increasing European Union (EU) integration, individual health systems can no longer be regarded as operating in isolation from other EU member states. However, patient flows from one country to another, to avail of publicly funded services not provided in the home country, are limited. This has been attributed partly to lack of information on what services are available and at what price [4]. The EHMA *Health*BASKET project introduced a useful framework for comparing the spectrum of publicly funded health care benefits across Europe.

A health benefit basket is defined as that which includes all "services, activities, and goods" [4: S2] covered by public funding in a given country. There are three dimensions to this basket: breadth, depth, and height. Breadth refers to the extent of the covered population; depth refers to the number and character of the services covered; and height refers to the extent of the costs of the services covered. Services/activities/goods that are not covered (i.e. co-payment of 100%) are not considered to be part of the benefit basket. Within the benefit basket, individual benefit catalogues can define in more detail the different components of the basket.

Using this general framework, the EHMA *Health*BASKET project has examined the content of the health basket in a range of European countries [3].[1] Overall, the definition of the basket varies widely across the sample, and harmonisation is unrealistic in the short-to-medium term. Cross-country comparisons in this sample have focussed on the depth of service coverage. In all countries, the benefit catalogue is divided broadly into hospital in-patient care, primary care (including out-patient, general and specialised care), pharmaceuticals, and other (preventive services, allied professional care, etc.). Within those broad areas, varied methods are used to define the specific catalogues of benefits. Positive lists (itemising included goods/services) are widely used in pharmaceuticals. Remuneration schemes (e.g. fee catalogues) are increasingly used as implicit benefit catalogues. The models of taxonomy used in these lists and schemes range from alphabetical lists (e.g. of pharmaceuticals) to medical speciality codes (e.g. ICD categories).

The Irish 'health basket'

Establishing and shaping the Irish health basket

Similar to the countries in the *Health*BASKET project, the general framework for the Irish health basket is established by national legislation. Specifically, rules on eligibility for publicly funded health care are outlined in legislative acts (e.g. the Health Acts of 1947, 1970, 2005, etc.). This follows the trend observed in countries with social-insurance-based health systems whereby the basket is defined in terms of entitlements of the covered individuals. This is in contrast to National Health Service (NHS) systems (where coverage is universal), whose baskets are defined in terms of the duties and obligations of the health services [4]. A broad benefit catalogue is indicated in the Irish Health Acts, and services are divided into similar categories as found in other countries: in-patient and out-patient services; general practitioner (GP) services; drugs, medicines and appliances; home nursing; home help services; dental, ophthalmic and aural services; rehabilitation services. etc. [5].

In other countries, further shape to the basket is given at a second, more detailed level, in the form of benefit catalogues, identifying specific services to be provided in each area of health care outlined in the basket. In the Irish context, it is more difficult to identify specific benefit catalogues. There is no publicly available list of in-patient and out-patient treatments/procedures included in the public health basket. For primary care, reimbursement guidelines for primary care contractors (e.g. GPs, dentists, optometrists/ophthalmologists) and public information documents (e.g. web pages) provide general descriptions of the publicly funded services available. To illustrate, under the Dental Treatment Services Scheme, participating dentists are reimbursed for specific 'above the line' (e.g. examination, restoration etc.) and 'below the line' treatments (e.g. prosthetics) administered to eligible patients [6]. For community care services (e.g. public health nursing, physiotherapy, occupational therapy, home help, etc.), the benefit catalogue can vary across regions, and in many cases depends on service availability in that region.

The most explicit benefit catalogue is found in the area of pharmaceuticals. The Primary Care Reimbursement Service (PCRS) prepares a positive (alphabetical) list of reimbursable medicines and other non-drug items [7]. Pharmacists are reimbursed for items on this list administered to eligible individuals (eligibility outlined below).

Breadth, depth, and height of Irish health basket

In the Irish system, the breadth dimension can be split into two categories of eligibility. Category I, which covers <29% of the population, refers to individuals who are issued with a medical card. Full medical cards are granted to those earning an income below a specified threshold level [8] and, between 2001 and 2008, to all individuals aged 70 and over (regardless of income). A small number of full medical cards are issued on the basis

[1] Denmark, England, France, Germany, Hungary, Italy, Poland, Spain, the Netherlands.

Table 1 Breadth, depth and height of Irish Health Basket. *PCRS* Primary care reimbursement service

	Breadth	Depth	Height	
			Category I	Category II
GP care	Category I (plus GP visit card holders)	In-hours visits Out-of-hours visits Home visits Special procedures (e.g. suturing, vaccinations)	100%	0%
Prescriptions	Categories I & II	PCRS reimbursement list Long-term illness scheme High-tech drug scheme	100%	Excess above €100 per month
Public hospital in-patient	Categories I & II	Not published	100%	€75 per night (and €750 per annum)
Public hospital out-patient	Categories I & II	Not published	100%	€100 per self-referred visit (100% in the case of referred visits)[a]

[a] For self-referred out-patient visits (excluding visits to an Emergency Department) actual height is likely to be 100% in practice due to the absence of revenue collection mechanisms in public hospital out-patient departments

of ill-health (discretionary). In 2005 a new ‘GP (family doctor) Visit’ medical card was introduced and has been granted to just over 76,000 people to date (<2% of the population) [9]. Eligibility for the GP Visit card is means-tested where the income thresholds are higher than specified for the full medical card. From 2009, automatic entitlement to a medical card for individuals aged 70+ has been removed and means-testing applies. A separate set of income thresholds applies for this age group.[2]

The GP Visit card provides public cover for GP care only; for all other services these individuals are included under Category II. Category II refers to the non medical card group and covers the rest of the population (71%).

As outlined above, the public sector finances hospital and primary care, pharmaceuticals, and a range of community care services. The shape of the Irish health basket is more easily identified if the breadth, depth, and height of public coverage are presented separately for each of these care areas (see Table 1).

Individuals in both categories (universal breadth) are entitled to public hospital care. This covers in-patient and out-patient care including day case and Emergency Department care. Detailed catalogues of procedures/treatments that are either included or excluded are not available. The height of public coverage varies by entitlement status. Category I individuals (excluding GP Visit card holders) are granted free access to public hospital care while Category II individuals (with some exceptions) are required to pay statutory charges. The standard daily charge for public in-patient care is €75 up to an annual maximum of €750 [10]. The out-patient charge is €100, including attendance at an Emergency Department, for all self-referred cases.

For primary care, public coverage for GP care is almost fully restricted[3] to Category I individuals (including those with a GP Visit card). The depth of coverage can be identified from remuneration schedules for participating GPs. The benefits include visits to GP clinics (in-hours and out-of-hours), home visits, and a range of consultation services (e.g. suturing, vaccinations etc.). These services are provided free of charge to the eligible individuals and thus height of coverage is 100%. For Category II individuals, GP care is not included in the benefit basket. The full-price charge imposed on this group is complicated by uncertainty around the pricing level. Private charges for GP visits vary by GP, but can also vary by visit and are hard to predict in advance [11]. Published estimates of GP charges for private patients range from €35 to €36 [11]. However, anecdotal estimates suggest the average charge ranges from €40 to €60 in current prices, with charges in Dublin higher than in the rest of the county. Analysis of expenditure data (2004 data) indicates that non medical card holders spend on average €130 per annum on GP care [12].

Public cover for prescribed medicines and appliances is universal. The depth of coverage is identified from three different sources: the positive list of reimbursable items

[2] Thus, there are now three sets of income thresholds to determine eligibility for Category I entitlement: for full medical card entitlement; for full medical card entitlement if aged 70+; for GP Visit medical card entitlement.

[3] Exceptions include specific resource flows to GPs for services provided free of charge to all individuals (e.g. GP maternity and infant care services; the Heartwatch programme; the Methadone Treatment Scheme; services provided under the Health Amendment Act (1996) for those who have contracted hepatitis C from the use of human immunoglobulin-anti D/other blood product or transfusion).

issued by the PCRS[4] [7]; the Long Term Illness Scheme, which covers the cost of prescription medicines for specified long-term illnesses (e.g. diabetes); and the High-Tech Drugs Scheme, which covers the cost of expensive high-technology medicines that are usually only prescribed/initiated in hospital (e.g. anti-rejection drugs for transplant patients or medicines used in conjunction with chemotherapy or growth hormones). The height of coverage varies by entitlement status and by scheme. For individuals in Category I (excluding GP Visit card holders), the height of public coverage is 100% for prescribed medicines included in the PCRS list. For individuals in Category II, prescription costs above a monthly threshold (currently €100) are covered for medicines included in the PCRS list (the Drugs Payment Scheme). Although 100% coverage for costs in excess of €100 per month is relatively generous, the threshold level of expenditure is high. This is illustrated by the small proportion of non medical card holders availing of the scheme (less than 20% in 2006 [13, 14]), indicating that allocation of public resources under this scheme is skewed within the non medical card population. For individuals eligible for the Long-Term Illness or High-Tech Drugs Schemes, the height of public coverage is 100%.

Public coverage for dental, ophthalmic, and aural services is restricted mainly to Category I individuals (excluding GP Visit card holders). The depth of coverage is outlined in positive reimbursement lists for the practitioners, and these include routine dental treatments, eye examinations and spectacles/appliances. The height of public coverage for eligible individuals is 100%. Category II individuals can avail of subsidisation from the Treatment Benefit Scheme for specific dental, optical, and aural services. This scheme is funded from a national social insurance fund and individuals are eligible to receive subsidisation once they have made requisite contributions to the fund. The height of public coverage under this scheme varies by treatment.[5]

Community care services include public health nursing, home help services, physiotherapy, chiropody, occupational therapy etc. The breadth, depth, and height vary by service and by region [15]. In general, public coverage of these services is restricted to Category I and has a height of 100%.

Additional complications

It is important to note that the focus of this paper is on outlining and comparing the structure of the Irish health basket as identified in legislation and policy documents. Practical implementation of the basket of health care services introduces other complications that further distinguish the Irish system from that of other countries.

Supply side factors can influence who actually benefits from public health care funding. In public hospital care, although the breadth of coverage is universal, in practice a range of incentives favour the treatment of private patients over public patients. This has given rise to concerns about a two-tier system in hospital care, with private patients receiving priority over, and crowding out, public patients [2, 12]. One of the stated primary incentives for purchasing private health insurance is to obtain greater access to hospital care [16].[6] The extent to which the public system subsidises private care within public hospitals interferes with the breadth and height of public coverage for secondary care. At the community care level, while some services have universal entitlement, in practice, supply is limited so that medical card holders are granted priority access [15].

The system of two-tier access to public hospital care has implications for quality of care and long waiting lists for public patients have been central to policy debates in the Irish health care sector. In addition, there is concern that there is two-tier quality of care for those who gain access. There is a perception that private patients expect and receive care directly provided by the hospital consultant[7] while public patients are more likely to receive consultant-led care (i.e. care by more junior professionals under the supervision of a consultant) [2, 18].

Tax reliefs also complicate the shape of the health basket. The Irish Government grants tax relief on private health insurance premiums (at the standard tax rate), and on a range of medical expenses that are not otherwise covered by a medical card or by private health insurance. The medical expenses relief is granted at an individual's marginal tax rate on expenses above an annual threshold of €125 (or €250 for a family claim). Together, these reliefs increase the height of public coverage for specific individuals for specific services.[8]

[4] This list includes some medicines that are also available over-the-counter (e.g. mineral supplements, pain reliefs etc.). If prescribed, these over-the-counter medicines are eligible for public coverage.

[5] e.g. 100% for oral examination, scaling and polishing; 100% for eye examination and specified spectacles; 50% for contact lenses; 50% for hearing aid [15].

[6] Demand for private health insurance is high in Ireland, covering 50% of the population. Private insurance covers mainly hospital care although private health insurance companies have recently begun to offer primary care benefits, usually with high deductibles [17]. The majority of people with private health insurance have Category II eligibility, but a small proportion of individuals with Category I eligibility (i.e. medical card holders) also hold private health insurance (3–4% of the population).

[7] Specialist hospital doctor.

[8] Tax relief on private health insurance premiums reflects the Government intention to promote the private health insurance market [19] but there has been limited evidence of a strong link between the relief and demand for private health insurance.

International comparisons

Previous international comparisons in this area have focussed mainly on the depth dimension, identifying the content and structure of detailed benefit catalogues for different health care services. In the Irish system, focussing on the depth of coverage risks overlooking information on the other dimensions of care that are important for comparison purposes. This section assesses the key features of the whole Irish health basket in the context of health care systems that are typically used as comparators to the Irish system.[9] These include the United Kingdom (UK), Canadian, Australian, Swedish, and French systems.[10]

The UK NHS covers GP care, prescription medicines, hospital based care, and other professional care (e.g. dental care, optical services etc.) and is similar in depth to Irish public cover. Controlling for depth, the health basket in the UK provides a direct contrast to the Irish system in terms of breadth and height. Most health care in the NHS covers all the population and is free at the point of use. Even where user fees do apply, the exemptions are "extensive" [20: S75]. Dentistry, optical services, and prescription charges are the three main areas where user fees have been introduced. For prescriptions, a fixed-rate deductible (STG £7.10 in 2008) is payable on each item [21]. The rate is fixed regardless of the cost of the prescription and thus a high proportion of actual prescription costs are covered by public funding. It is also estimated that approximately half of the population (including those on low incomes, elderly, school children etc.) are exempt from this charge [20], and in practice this covers more than half the number of prescriptions that are dispensed [22].

The Canadian system covers physician (including some dental surgery), hospital, and diagnostic services.[11] Services not included in the benefit basket, and which are funded from private health insurance and out-of-pocket payments, include pharmaceuticals prescribed outside of hospitals, most dental and vision care, and long-term care. As in the UK system, Canadian residents are eligible to receive free at the point of delivery almost all physician, hospital, and diagnostic services [23]. This indicates universal breadth, and 100% cost coverage (height) for these services. Pharmaceutical drug costs (prescription and non-prescription) constitute the second largest category of health expenditure in the Canadian health system, and recent recommendations for reform include measures to protect against high cost drug charges [23, 24].[12]

The Australian benefit basket includes public hospital, GP and specialist services, and essential pharmaceuticals. Coverage for these services is universal (i.e. all individuals covered) with high cost coverage. Medical treatment is free for public hospital and the majority of GP and specialist services,[13] and essential pharmaceuticals are subsidised [25]. Private payments are required for pharmaceutical cost sharing, other medicines not covered under the subsidisation scheme, dental care, and any gap between doctors' fees and reimbursements from the government health insurance system. Pensioners are granted concessions or free treatment.

In the above examples, for most of the services included in the benefit basket there is universal breadth and height of 100%. There are other countries that are more like Ireland where the height of cost coverage is not 100% (i.e. free at the point of use) and user fees are imposed on a wide range of services for large proportions of the population. However, when compared with Ireland, the rates of cost sharing in other countries tend to be lower and exemption strategies are transparent and simple. The Swedish health care system relies on a combination of proportional income tax and user charges to finance health services. User charges apply in primary and secondary care and for prescription medicines. The system is similar to that in Ireland where the major health services are provided on a cost sharing basis (i.e. height $< 100\%$) for a large proportion of the population. In the Swedish structure, individuals aged under 20 years are exempt from the user fees for GP and hospital care (in all but a small number of county council areas). There are maximum limits for user fee payments in all services, except in-patient care, to protect individuals from high costs. Approximate charges are as follows: €11–€17 per primary care visit; €22–€32 per out-patient consultation; €9 per in-patient day; subsidisation of prescription charges in excess of €200 per annum[14] [26].

Three features distinguish the structure of the Swedish health basket from the Irish structure on these breadth and height dimensions. First, the breadth of public cover is standardised across health services. The user charge exemption for individuals under the age of 20 applies

[9] As the focus is on comparing the whole basket, investigation of depth is limited to the broad taxonomy of care that disaggregates by primary, secondary, community care etc.

[10] Health baskets have been documented in the literature for the French and UK systems [3].

[11] In Canada, the precise shape of the health basket varies by province. The focus here is on the baseline basket, outlined in the Canada Health Act, that provinces must provide.

[12] Private resources account for 56% of expenditure on prescription medicines [24].

[13] Most GPs opt to bulk bill the government health insurance system, 'Medicare Australia', in which case the service is effectively free to the patient. Alternatively, GPs charge the patient a higher amount and the patient can claim an 85% rebate on the schedule fee from Medicare Australia. For out-of-hospital specialist consultations, Medicare Australia reimburses 85% of the schedule fee [25].

[14] Patients pay the full cost for prescribed drugs up to €100, after which the level of subsidy increases to 100%. The annual maximum co-payment is €200 [26].

uniformly for GP, out-patient and in-patient care. This is transparent and non-arbitrary, in contrast to the complex way in which breadth of coverage in Ireland changes from one health care service to another. Second, maximum payment limits are imposed on most health payments in the Swedish system. In the Irish system these only apply to public in-patient hospital charges and to drug payments. In-patient charges are levied up to an annual maximum of €750. In the Drugs Payment Scheme, all prescription costs above a monthly threshold are reimbursed. There is no high-cost protection for GP or other care for non medical card holders (i.e. more than 70% of the population). Third, absolute values of the user fees are lower in Sweden than in Ireland, using 2004 rates: €11–€17 vs. €40–€50 per primary care/GP visit; €22–€32 vs. €45 per out-patient consultation; €9 vs. €45 per public in-patient day; subsidisation of prescriptions in excess of €200 per annum vs. €78 per month [26]. In Sweden, total out-of-pocket per capita payments were estimated to be €250 (in 2004 prices) while 40% of the population paid no charges [27]. Detailed analysis of total health expenditure patterns indicate that mean out-of-pocket payments in the Irish system (using 2004 data) were more than €600 for non medical card holders [12]. Interpretation of such cross-country comparisons is hindered by the variation in data sources and service definitions but the general comparison suggests that out-of-pocket charges are relatively high in the Irish system.

Ireland is not alone in the complexity of entitlements to publicly funded care. The French social health insurance system outlines a range of medical goods and services that qualify for reimbursement, including hospital care, specialist and GP care, and specified pharmaceutical products. The system of reimbursement is complex and the level of reimbursement varies. On the breadth dimension, there are exemptions from cost sharing that are linked to health status and other factors (e.g. disabled children etc.). Complementary coverage of voluntary health insurance is provided to all individuals on low incomes, thereby offering exemption from cost sharing. In terms of height, cost sharing rates are higher for out-patient care and medicines than for hospital treatment. It is difficult to determine specific estimates of height, but on average the reimbursement rate is 75% for GPs and specialists, 90.2% for hospital care and 61.5% for medicines. One estimate indicates an average annual cost sharing burden of €310 (before voluntary insurance coverage—in 2004 prices) [28]. Measures to contain costs in the French system have in the past included increases in the rates of cost sharing but these have not been considered in more recent reforms given competing objectives of improving equity in the system [28]. Thus, although breadth and height are difficult to disentangle in the French system, with the free voluntary health insurance for those on low incomes, the effective reimbursement rate for GP and hospital services is 100% for low income groups. The average rates of reimbursement for these services are more than 70% for the rest of the population.

Across the above countries, there are similarities with the Irish system in terms of the depth of publicly funded care. Public funding of GP, hospital, and prescription medicines is common to the systems identified here. Non-prescription medicines are less likely to be included in the publicly funded basket in many countries. Public funding for dental, ophthalmic and aural care is less consistent across these countries. More detailed comparison of depth across countries, in terms of benefit catalogues for different health care services, is complicated by the absence of detail on such catalogues in the Irish system, particularly for hospital-based care. Current research by the Irish Dept. of Health and Children on general eligibility issues[15] should fill some of these gaps in detail in future.

Within the broad taxonomy of services included in the benefit basket, breadth and height vary by health care service. This discussion compares countries on these latter dimensions, controlling for depth. Examination of the breadth and height dimensions highlights key points on the distinctiveness of the Irish health care system. Figure 1 illustrates the position of the above countries along the two dimensions for GP care. The breadth of public coverage for GP care in Ireland is narrow relative to the other countries. Cost sharing of 100% applies to GP care for more than 70% of the population (i.e. technically excluded from the health basket). In each of the other countries, breadth of GP coverage extends to the whole population. The height of public coverage is 100% in Ireland, as in the UK and Canada. In Australia, a minimum of 85% of GP costs are covered, but in most cases GPs bulk bill the government health insurance system in which case the service is free to the patient. In Sweden, the estimated height of public coverage for GP care is >87% [26, 29] but it can increase to 100% for those under the age of 20. In France, the estimated average rate of reimbursement is 75% while those on low incomes receive free insurance coverage.

Public coverage of secondary care in Ireland is broader than in primary care.[16] Figure 2 indicates the position of the

[15] Eligibility Review Division at the Department of Health and Children, http://www.dohc.ie/about_us/divisions/eligibility.html.

[16] It is important to note that the shape of the Irish health care basket has developed incrementally over time. The history behind the Irish health care system [18, 30] shows that the policy process has been influenced at different stages by a wide range of economic and non-economic factors, as well as by specific institutions and individuals. The bias in funding and attention paid to curative hospital care in the Irish health basket was influenced over time by a number of factors including: prestige of voluntary hospitals as places of learning and sources of private income; successful funding mechanism via the Irish Hospitals Sweepstakes (mid 1930s); strong opposition by Catholic hierarchy and the medical profession to expansion of Government role in primary care.

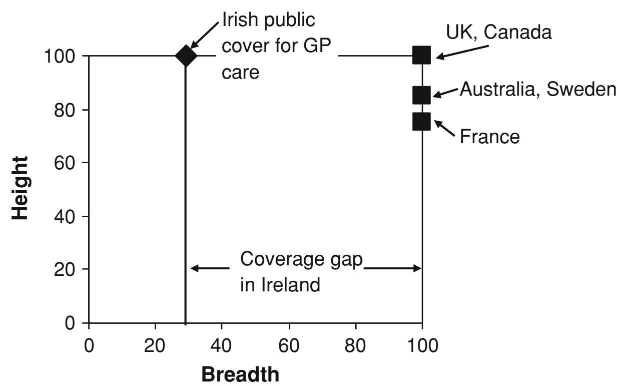

Fig. 1 Height and breadth dimensions of health baskets for general practitioner (GP) care (% coverage). Height of coverage is based on the most recent data available on cost sharing, where applicable (Sweden: 2004; France: 1999–2000)

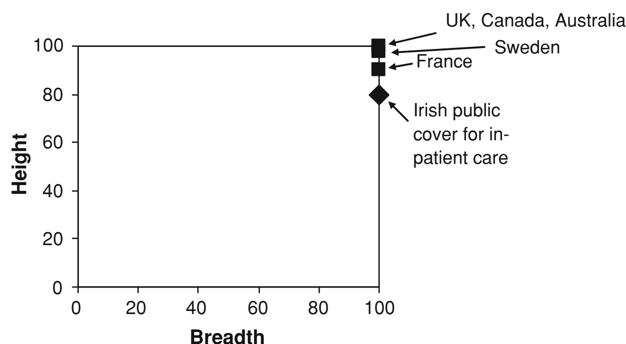

Fig. 2 Height and breadth dimensions of health baskets for public hospital in-patient care (% coverage). Height of coverage is based on the most recent data available on cost sharing, where applicable (Sweden: 2004; France: 1999–2000)

sample of countries on the breadth and height dimensions for public hospital in-patient care based on available data. In all countries, public funding for public in-patient care is available for all individuals (universal breadth). Care is provided free of charge in the UK, Canada and Australia (100% height). The average height of coverage in Sweden is estimated to be >97%, increasing to 100% for most individuals under the age of 20 [26, 29]. As outlined earlier, average reimbursement for public care in France is more than 90%. As with GP care, coverage can reach 100% for individuals on low incomes. The rate of public coverage in Ireland is more difficult to assess and, as discussed earlier, in practice it varies depending on whether or not the individual is treated privately. Analysis of public hospital resource allocations estimates that for public, non medical card patients, public resources cover approximately 80% of in-patient costs [31], while those with a medical card are eligible for free care.

The Irish system is also distinguished by the complexity in the entitlement structures. Entitlement to medical card cover and other types of public cover include a mix of socio-economic[18] and health need factors. These complexities reduce transparency in the system, which in turn risks lowering public support for the system. Yet there are other countries where entitlement patterns are complex. In the French system it is difficult to generate accurate estimates of average reimbursement rates and exemptions are granted on a range of criteria. However, even within this system, the breadth of coverage by the social health insurance system is large and the average reimbursement rates are high.

Similarly, there are other countries (e.g. Sweden) where the height of public coverage is not 100% and cost sharing applies to a wide range of services, as in Ireland, but the height of cost coverage in Ireland is distinctively low (i.e. high user charges).

Conclusions

This paper has demonstrated how the health basket provides a useful framework for describing and examining the main features of a health care system. Cross-country comparisons in the *Health*BASKET project have focussed on variations in depth and the content of detailed benefit catalogues. Analysis in this paper shows how the basket framework is also useful for across-country comparisons in terms of who is eligible to receive what public services (i.e. breadth), and at what price (i.e. height). The response of the Irish health care system to questions of how a health service should be financed, who should have access to it, and at what price, has been described as "complex" [1: 111]. Until now, less attention has been paid to unpicking and documenting the nature of that complexity and the health basket has facilitated this process.

Holding depth constant, comparison across a sample of countries has illustrated that it is the combination of breadth and height that distinguishes the Irish health basket from other health care systems. The majority of the Irish health care system is run on a cost sharing basis (e.g. as in Sweden); user fees are higher than in other countries, particularly in primary care, where GP fees are charged at full price for the majority of the population; and the structure of entitlement restrictions are complex (e.g. as in France). It is difficult to identify other countries in which all these factors operate within one system.

Finally, it is important to remember that the way in which health care systems function in practice can diverge from their intended structures. As discussed earlier, in the Irish case, complications in how the health basket is

[18] Further complicated by the use of three separate sets of income thresholds for full medical cards, full medical cards for individuals aged 70+, and GP Visit cards, as noted earlier.

actually delivered introduce further complexities in the breadth and height of coverage. International comparisons of health baskets need to take into account this divergence between intention and implementation.

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