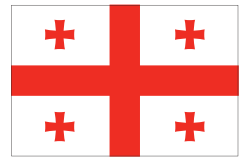


Health Systems in Action

# Georgia



## Keywords

DELIVERY OF HEALTH CARE

EVALUATION STUDIES

FINANCING, HEALTH

HEALTH CARE REFORM

HEALTH SYSTEM PLANS – organization and administration

GEORGIA



Health Systems in Action

# Georgia



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This edition of the Health Systems in Action Insight for Georgia was written by Erica Richardson.

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The Insights for each country are intended to:

- provide core information and data on health systems succinctly and accessibly
- outline the country health system context in which WHO Europe's Programme of Work is set
- flag key concerns, progress and challenges health system by health system
- build a baseline for comparisons, so that member states can see how their health systems develop over time and in relation to other countries.

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This Health Systems in Action Insight was written at the behest of the WHO Regional Office for Europe and in the context of the European Programme of Work. It captures for Member States outside the EU core information on their health systems; flags key issues; and allows comparison across countries and over time.

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This edition of the Health Systems in Action Insight for Georgia was written by Erica Richardson.

# HEALTH SYSTEMS IN ACTION: GEORGIA

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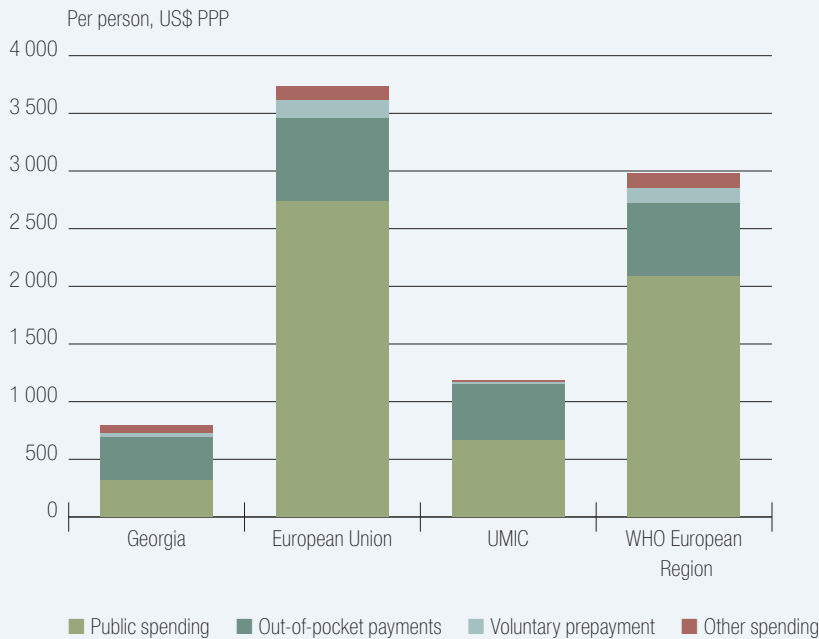
## Key points

- Since 2013 Georgia has been striving to provide universal health coverage through a package of publicly funded benefits and increased public investment in health.
- Although public spending on health remains low by international comparison (at 2.8% of GDP in 2018), it has increased as coverage has expanded and out-of-pocket spending on health has fallen considerably.
- However, coverage policy is extremely complex and there are substantial co-payments. The high cost of outpatient medicines is the biggest barrier to accessing care for the lowest income households. Richer households spend more out of pocket on inpatient care.
- Most health care providers are private, including approximately 80% of hospital beds.
- There is a very large number of doctors per capita, but an acute shortage of nurses.
- Gatekeeping in primary care is weak and there is a strong patient preference for accessing the system at more specialized levels of care.
- A policy focus has been on strengthening primary care by efforts to integrate and improve key vertical programmes (such as on early childhood development, hypertension and mental health); increase digital health services; invest in the workforce; and harmonize rural and urban primary care programmes.
- Access to essential services has improved, especially for HIV, MDR-TB and hepatitis C (HepC). Georgia has a well-developed HepC elimination programme, with over 70% of the adult population of Georgia screened as of December 2020.
- Communicable disease control is a longstanding priority and Georgia has achieved high coverage rates for routine childhood vaccinations.
- There is a large gap between male and female life expectancy (8.6 years in 2019).
- The smoking rate among male Georgians was among the highest in Europe in 2018, whereas the female smoking rate was among the lowest.
- Tobacco control is a public health priority and indoor smoking and tobacco advertising bans have been robust.
- Noncommunicable diseases account for most of the country's burden of morbidity and mortality. The overall mortality rate in Georgia is high, with stroke the leading cause of death.
- Georgia's health sector's response to the COVID-19 pandemic was relatively well coordinated and extensive preparedness efforts have been put in place.

This report looks at the action Georgia is taking to strengthen its health system; to achieve the Sustainable Development Goals; to address the priorities of the European Programme of Work 2020–2025; and to ensure that no one is left behind.

# 1 ORGANIZING THE HEALTH SYSTEM

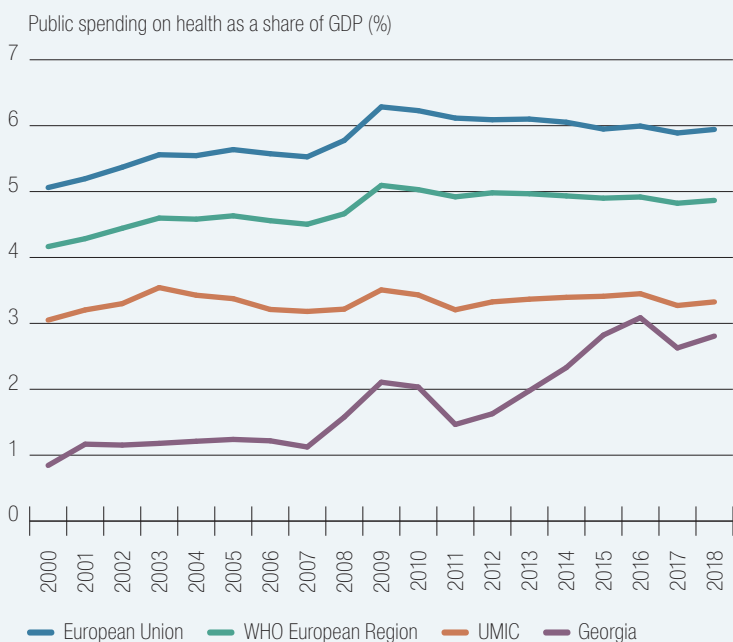
**Fig. 1**  
Health spending per capita is low in international comparison



**Notes:** 2018 data. UMIC: upper middle-income countries in the WHO European Region; PPP: purchasing power parity.

**Source:** WHO, 2021a.

**Fig. 2**  
Although public expenditure on health as a proportion of GDP is low, it has increased



**Notes:** GDP: gross domestic product; UMIC: upper-middle-income countries in the WHO European Region.

**Source:** WHO, 2021a.

## The main focus of health reforms since 2013 has been on improving access to publicly funded health services

Since 2013 Georgia has been striving to provide universal health coverage through health care programmes financed from the central budget. Previously, public financing was fragmented between competing private insurance companies and various national programmes, but in 2013 the Social Services Agency (SSA) became the sole purchaser of services. In February 2013 the Universal Health Care Programme (UHCP) was introduced and people who had not been covered previously were entitled to a 'minimum benefits package' after registering with a primary care facility of their choice. This was expanded in July 2013 to include elective surgery, cardiac surgery, chemo-, hormone and radiotherapy, and childbirth. The new 'basic package' was available to any legal resident who had no form of health insurance coverage. In September 2014 almost all state-funded health insurance programmes were united under the UHCP administered by the SSA. A new National Health Agency (NHA) was established in 2020 to administer the UHCP and most other health care programmes.

## The package of benefits is broad but extremely complex, substantial co-payments are required and coverage of outpatient medicines is very limited

Since May 2017 services provided under the UHCP have been stratified by income and other priority groups. In 2020 the UHCP provided about 90% of the resident population with some degree of coverage. About 9% of the population was covered by private health insurance and less than 1% of the population did not have any form of coverage (UHCP or private health insurance). The highest income households (around 1% of the population; defined as households earning over GEL 40 000 or US\$ 12 300 a year) have been excluded from most UHCP benefits since 2017 but are still entitled to some services offered through vertical programmes. They are expected to purchase private health insurance. Eligibility for the UHCP and the level of co-payment covered is income-based for those who do not have private insurance. There are also 23 vertical national health programmes which cover the whole population for specific diseases or treatments which tend to be high cost or high priority public health programmes, but with differing co-payments to cover a proportion of the cost.

The level of co-payments is based on priority grouping, stratified by income, age or other criteria. The main priority group by income covers households living below the poverty line. Other priority groups are children aged 0–5 years, children in foster care, students,



pensioners, people registered as disabled, veterans, settled internally displaced people, teachers, and public artists (laureates). Households living below the poverty line and veterans (about 12% of the population in 2020) are exempt from co-payments for medical services, but prescribed outpatient medicines are only covered to 50% unless they are for specific chronic conditions. Higher income groups still eligible for the UHCP (41% of the population in 2020) get free visits to family doctors in primary care, emergency intensive care and childbirth, but pay in full for visits to specialists and prescribed outpatient medicines. The only UHCP benefits available to the 1% of highest earners, regardless of private insurance status, are childbirth (100% covered) and treatment for infectious diseases (80% covered).

There are ceilings on the amount the government covers (usually in any given year). For example, childbirth costs are covered for all, but only up to GEL 500 (US\$ 162) for a vaginal delivery and GEL 800 (US\$ 259) for a caesarean section. A hip replacement, as elective surgery, would be covered at 100%, 90%, 80%, 70% or 0% depending on priority group, but only up to a ceiling of GEL 15 000 (US\$ 4855). There are no caps on the charges paid by patients and no caps on the prices hospitals can charge patients. Consequently, out-of-pocket spending on medical services remains high (see Section 2). This weakens the gatekeeping function of primary care, as self-referral to specialized care may not cost more than accessing specialized care with a referral from primary care.

## The health system is dominated by private providers, and there is a strong patient preference for accessing the system at more specialized levels of care

Nearly all providers at all levels of the system are independent of government in terms of ownership and management and the health system is dominated by private, for-profit entities, the key exception being rural ambulatories. Reforms enacted between 2008 and 2012 heavily deregulated the health system and the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs (MoIDPLHSA) is now working to strengthen the quality management system to ensure that the quality of care provided is adequate and better aligned with the health needs of the population. The financial incentives in the system still strongly favour emergency and inpatient care, which accounts for half of all spending through the UHCP. Under this programme, all beneficiaries must register with a primary care provider but because primary care is funded by capitation and hospitals by fee-for-service, the integrated providers make more money treating patients in hospital than in primary care. Cover for emergency care is also more generous than cover for non-emergency care, which encourages patients to be treated as emergency cases. Patients can access specialist services directly without a referral if they are not being reimbursed under the UHCP, and most do.

# 2 FINANCING AND ENSURING FINANCIAL PROTECTION

## Health spending remains low in international comparison, but has increased as coverage has expanded

Average health expenditure per capita in the WHO European Region in 2018 was US\$ 2982 per person when adjusted for purchasing power. In Georgia it was US\$ 796, lower than the average for upper middle-income countries in the WHO European Region (Fig. 1).

Through most of the 2000s public spending as a share of GDP was very low in Georgia, at around 1.2%, but it increased to 2% with the introduction of reforms to provide a comprehensive package of benefits to those living below the poverty line in 2008. When this scheme was expanded to cover almost all the population from 2013, public spending increased further as more health expenditure was covered from general taxation rather than being paid for out of pocket, reaching 3% in 2016 (Fig. 2). In 2018 public expenditure on

### Box 1

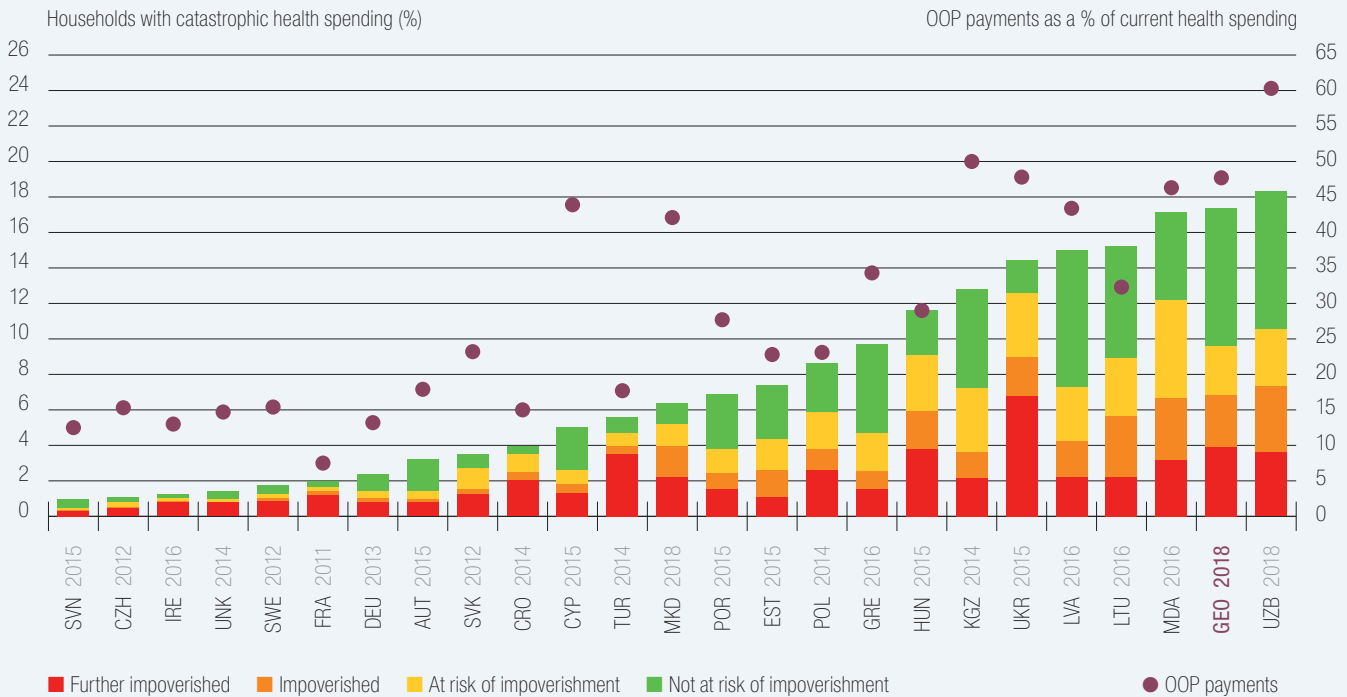
Even though increased public spending on health remains low, there is pressure for efficiency gains

In 2020 responsibility for purchasing was transferred to the National Health Authority (NHA). There is renewed focus on referral and encouraging the utilization of primary care services instead of specialist care with the launch of PHC reforms in 2021. These reforms pursue a stepwise implementation strategy from 2021 to 2025, implementing a revised benefits package and integrating priority service packages into primary care. The roadmap envisions a gradual transition towards networks of multidisciplinary primary health care teams, with an increased role for nurses and social workers.

So far, the system still incentivizes providers to treat patients at the most specialized levels of the system or in emergency care. Pharmaceutical policies strengthening prescription requirements since 2017 support more rational pharmaceutical consumption, but these policies have faced resistance from patients and pharmaceutical companies that do not want to see reduced consumption. In 2021 a new Law on Medicinal Products (ready for discussion in Parliament) was developed by local experts under WHO guidance. It creates a framework for price regulation and quality assurance of essential medicines. The cost of medicines in Georgia remains high and out-of-pocket spending on pharmaceuticals is the main factor behind catastrophic health care costs for households. So far, there is no policy to encourage the use of generic medicines.

**Fig. 3**

Share of households with catastrophic health spending by risk of impoverishment and out-of-pocket payments as a share of current spending on health



**Notes:** The data on OOP payments are for the same year as the data on catastrophic health spending. A household is impoverished if its total spending falls below the poverty line after OOP payments; further impoverished if its total spending is below the poverty line before OOP payments; and at risk of impoverishment if its total spending after OOP payments comes within 120% of the poverty line. The poverty line used here is a relative line reflecting basic needs (food, housing, utilities). AUT: Austria; CRO: Croatia; CYP: Cyprus; CZH: Czechia; DEU: Germany; EST: Estonia; FRA: France; GEO: Georgia; GRE: Greece; HUN: Hungary; IRE: Ireland; KGZ: Kyrgyzstan; LVA: Latvia; LTU: Lithuania; MDA: Republic of Moldova; MKD: North Macedonia; POL: Poland; POR: Portugal; SVK: Slovakia; SVN: Slovenia; SWE: Sweden; TUR: Turkey; UNK: United Kingdom; UKR: Ukraine; UZB: Uzbekistan.

**Sources:** WHO, 2019 (catastrophic health spending); WHO, 2021a (out-of-pocket payments).

health as a share of GDP was 2.8%, still below the averages for upper middle-income countries (3.3%), the WHO European Region (4.8%) and the EU (5.9%).

### Out-of-pocket spending on health has fallen considerably as a result of government policy

Public spending on health in Georgia accounted for 39% of current health expenditure in 2018, an increase from 19% in 2012, before the UHCP was introduced. As health has become more of a political priority, public spending on health as a proportion of total government spending has increased, from 5.5% in 2012 to 10.3% in 2018, as did pressure to contain costs (see Box 1). Consequently, the share of out-of-pocket spending as a proportion of current health expenditure fell from a high of 73.4% in 2012 to 47.6% in 2018. Voluntary health insurance is encouraged for very high-income households and many employers provide coverage as part of remuneration packages, but it accounted for only 4.3% of current health spending in 2018.

When the package of benefits was expanded in 2013, the use of inpatient health services increased significantly, as financial barriers for people who were previously not covered were reduced (Goginashvili, Nadareishvili & Habicht, 2021). Improved access has increased catastrophic health spending, however, driven largely by an increase in out-of-pocket spending on outpatient medicines, which were not the focus of the 2013 reform (Goginashvili, Nadareishvili & Habicht, 2021). In 2018 just over 17% of households experienced catastrophic levels of spending on health (Fig. 3). Catastrophic health spending has increasingly been driven by spending on outpatient medicines, particularly among poorer households (Box 1). The value of the Georgian Lari has fallen since 2016, pushing up the price of imports, including medicines, and Georgia has very limited domestic production capacity. The administrative procedure and overall complexity of the benefits package was a major barrier to patients in accessing entitlements for outpatient pharmaceuticals under the UHCP, but it was simplified in 2020. For the richest households, the main driver of catastrophic spending is inpatient care costs. The highest income households are those that pay higher co-payments or are excluded from most benefits under the UHCP (see Section 1).

### 3 GENERATING RESOURCES, PROVIDING SERVICES AND ENSURING ACCESS

#### Georgia has an increasing number of hospital beds, most of which are in private ownership

Georgia used to have a low number of hospital beds in international comparison (Fig. 4), but numbers have increased in recent years across the country. In 2019 there were 470 hospital beds per 100 000 population (NCDC, 2020). The Georgian health system has been extensively privatized and about 80% of all hospital beds are private, as are almost all primary care providers and outpatient specialists. Only a handful of single-profile hospitals (such as for emergency care, psychiatry, TB and HIV, and the national immunology centre) remain in the public sector. There are also approximately 20 publicly owned service providers to maintain access in mountainous and remote rural areas where there are insufficient financial incentives for private providers to operate. In November 2019 the Emergency Preparedness and Urgent Assistance Agency (EPUAA) assumed responsibility for the coordination and financing of rural primary care providers; with this move, individual contracts with rural providers ended and as of 1 January 2020 they became employed by the state on a fixed salary. Rural ambulatories are owned by the local government or the state-owned company that is accountable to the MoDPLHSA, and which also owns the medical centres in difficult-to-reach areas.

The purchase of medical equipment is not limited by statutory controls and, as most hospitals are for-profit enterprises, they take the decision to purchase new equipment autonomously. Current regulations do not set a national ceiling of units per population for high-technology equipment. As a result, there is a significant proliferation, particularly of CT and MRI scanners, in urban areas (Richardson & Berdzuli, 2017).

Waves of deregulation, decentralization and privatization have meant that private providers have developed a mix of health information solutions. Implementing integrated IT systems within the health sector has been a priority for the MoDPLHSA, particularly for strengthening service purchasing through the Social Services Agency.

Fig. 4

Georgia had a relatively low number of hospital beds per 100 000 population in 2014, but numbers have increased since then



Note: Hospital beds per 100 000 population; internationally comparable data only available up to 2014.

Sources: WHO, 2021b; NCDC, 2020 for Georgia.

#### Georgia has a large number of doctors per capita, but an acute shortage of nurses

Extensive capacity in the Georgian health system extends to the number of doctors available. Since 2006 Georgia has consistently had a large number of active doctors per capita, but the rate has increased significantly, from 541 per 100 000 population in 2015 to 789 in 2019 (NCDC, 2020). This is much higher than elsewhere in the WHO European Region (Fig. 5). There are three times as many doctors in Tbilisi than there are in other regions, and recruiting and retaining staff to work in remote and rural areas is a significant challenge. The distribution of general practitioners (GPs) across the country is a particularly acute problem.

The number of nurses working in the Georgian health system has been on the rise since 2013, but it remains very low in comparison to other countries in the region, at just 542 per 100 000 population in 2019. According to the latest available data, the ratio of physicians to nurses was 2.5 in the European Union and 2.3 in the WHO European Region as a whole, but in Georgia it has not exceeded 0.8 since 2014 (NCDC, 2020). Most health staff work in inpatient facilities – in 2019 this included 52% of all physicians and 71% of all nurses and midwives.

**Fig. 5**

The ratio of physicians to nurses in Georgia is one of the most imbalanced in Europe



**Notes:** 2014 data for the European Union and the WHO European Region, 2015, or latest available for countries; 2019 data for Georgia.

**Sources:** WHO, 2021b; national sources for Georgia.

## High out-of-pocket payments are the most significant barrier to accessing care

By far the most significant barriers to accessing care in Georgia are financial and are being tackled. Waiting time is not a major barrier to access, and geographical access has improved. More facilities have been built in both rural and urban areas, and better road and transport links have improved access to more specialist services. Improvements in the accessibility of care are indicated by the increase in utilization since the introduction of the UHCP. For example, the utilization of outpatient services has almost doubled, from 2.1 visits per capita in 2012 to 4.0 in 2019.

Findings from the latest health, utilization and expenditure survey (HUES) show that 82% of people consulted health care providers when ill in 2017 compared to 75% in 2010 and 79% in 2014. Reductions in unmet need were particularly strong for those income groups that were uninsured prior to 2013 (when the UHCP was introduced), and between 2014 and 2017 inequalities between people living in rural and urban areas declined (Goginashvili, Nadareishvili & Habicht, 2021). The main factor determining unmet need in 2017 was income level. The trend is towards greater coverage for services and medicines for all groups, but in 2017, 15% of the poorest households did not purchase prescribed medicines due to cost (down from 22% in 2010). Consequently, the basic benefits package for people registered as living below the poverty line was expanded to cover outpatient medicines for four major chronic

conditions (heart disease, chronic obstructive pulmonary disease, type 2 diabetes and thyroid conditions) in 2017, and in 2019 medicines for Parkinson's disease and epilepsy were added and the medicines programme was extended to all pensioners, albeit with ceilings on the amount covered annually (see Section 1).

## Georgia has achieved high coverage rates for routine childhood vaccinations and communicable disease control is a longstanding priority

Immunization is a public health priority and government allocations for vaccination programmes increased from GEL 4 million in 2012 to GEL 22.8 million in 2019. The vaccination schedule was expanded to include pneumococcal vaccination from 2013, Rota virus vaccination from 2014 and the roll-out of HPV vaccination nationally in 2019. Immunization coverage rates for routine childhood vaccinations are high, with 99.8% of infants receiving the first dose of vaccine against measles, mumps and rubella (MMR) in 2019, and 97.3% receiving the second (compared to 91% in the WHO European Region). This followed a measles outbreak in 2018 in Georgia resulting from previous weaknesses in the immunization programme that left some cohorts insufficiently immunized. Routine childhood vaccinations are free of charge and provided at birth in maternity hospitals and subsequently by primary care providers. There have also been

targeted campaigns in response to outbreaks to provide additional vaccinations for the population aged 20–40 to overcome persistent gaps in coverage.

Communicable disease control more broadly became a political priority even prior to the COVID-19 pandemic. An innovative hepatitis C (HepC) programme was rolled out that aimed to achieve a 90% reduction in prevalence by 2020. Georgia had a high prevalence of HepC infection in 2015, with an estimated 7.7% of the adult population living with HepC (Richardson & Berdzuli, 2017). Over 70% of the adult population (2.3 million people) has been screened for HepC and as of December 2020, 72 811 patients have been enrolled in HCV treatment with 98.9% treatment effectiveness. Nevertheless, in 2019, 8671 new HepC cases were registered, of which 749 were children (NCDC, 2020). A new ambitious HepC elimination strategy covers the period 2021–2025.

### Although tuberculosis remains a serious public health issue, the situation is improving

Tuberculosis (TB) incidence has more than halved since 2009 as a result of concerted policy efforts, from 129 per 100 000 population in 2009 to 58 in 2019. Georgia is still among the 18 high-priority countries for TB in the WHO European Region, but it no longer belongs to the group of 30 countries with a high burden of MDR-TB

**Fig. 6**

Effective TB treatment coverage is higher than in the EU



**Note:** Proportion of TB cases detected and successfully treated (estimate).

**Source:** WHO, 2021c.

**Fig. 7**

More people need to know their HIV status to benefit from access to HIV treatment



**Abbreviation:** ART: antiretroviral therapy.

**Source:** UNAIDS, 2020.

(WHO, 2020). Georgia has ensured universal access to first- and second-line treatments for TB and, with the assistance of the Global Fund, the country has managed to introduce effective treatments for MDR patients. New anti-TB drugs are available under a national programme, accompanied by a new drug-safety monitoring system. A new remote version of directly observed treatment (DOTS) has been successfully piloted in Tbilisi using video links (VOT) to improve geographical access to treatment. Effective treatment coverage is not as high as it has been previously, but in 2017 it was above the average for EU countries (Fig. 6), and national data put the effective treatment rate at 83% (NCDC, 2020).

### Georgia has a low prevalence of HIV/AIDS and good access to treatment

Georgia has a relatively low HIV/AIDS prevalence rate, but cases have increased over the past couple of years (16.7 new cases were recorded in 2019 per 100 000 population, up from 9.3 in 2009). In response, a voluntary testing programme was scaled up in 2019 to cover all pregnant women, incarcerated people and specific groups at higher risk of infection (such as men who have sex with men (MSM) and commercial sex workers). In terms of the 90:90:90 target set by UNAIDS for 2020, 87% of people who knew their status were on antiretroviral medication in 2019 and of these 91% had achieved viral suppression. Access to antiretrovirals is publicly financed, co-funded by the Global Fund and

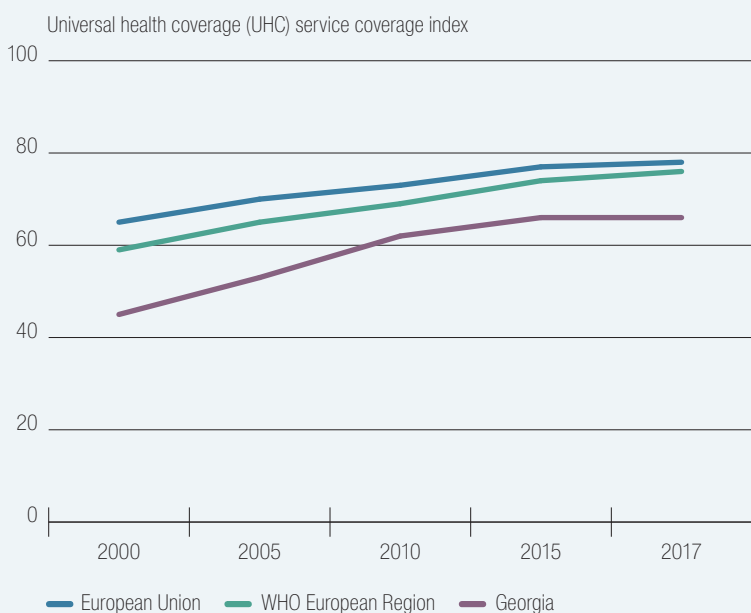
the government, and the country has a 'treatment for all' strategy rather than setting particular thresholds for treatment eligibility. Pre-exposure prophylaxis (PrEP) with ART has been available to MSM since 2017 through a pilot programme. However, the country did not meet the UNAIDS target of ensuring 90% of people living with HIV know their status. Indeed, 30.4% of new HIV cases in 2019 were diagnosed once the person had already developed AIDS. Stigma is a major barrier to reaching the groups most at risk of HIV infection for testing.

### Georgia has improved access to essential services, especially for infectious diseases

In terms of the universal health coverage service coverage index, access to essential services increased from 45 (out of 100) in 2000 to 66 in 2017, although this was still below the averages for the European Union and the WHO European Region (Fig. 8). Gains in access to treatment for infectious diseases such as HIV, TB and HepC have been particularly notable. After a successful pilot programme, from 2020 the decentralization and integration of vertical HepC/HIV/TB services into primary care has been implemented countrywide. However, considerable challenges remain for access to treatment for chronic conditions and preventive treatments for cardiovascular diseases – particularly for outpatient medicines. Spending on outpatient medicines remains the main contributor to out-of-pocket spending despite the implementation of policies to expand access to specific medicines for the prevention and treatment of certain chronic conditions (see Section 1).

Fig. 8

Service coverage has improved but remains low in international comparison



**Note:** The universal health coverage service coverage index is defined as the average estimated coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health; infectious diseases; noncommunicable diseases; and service capacity and access; among the general and the most disadvantaged population.

**Source:** WHO, 2021c.

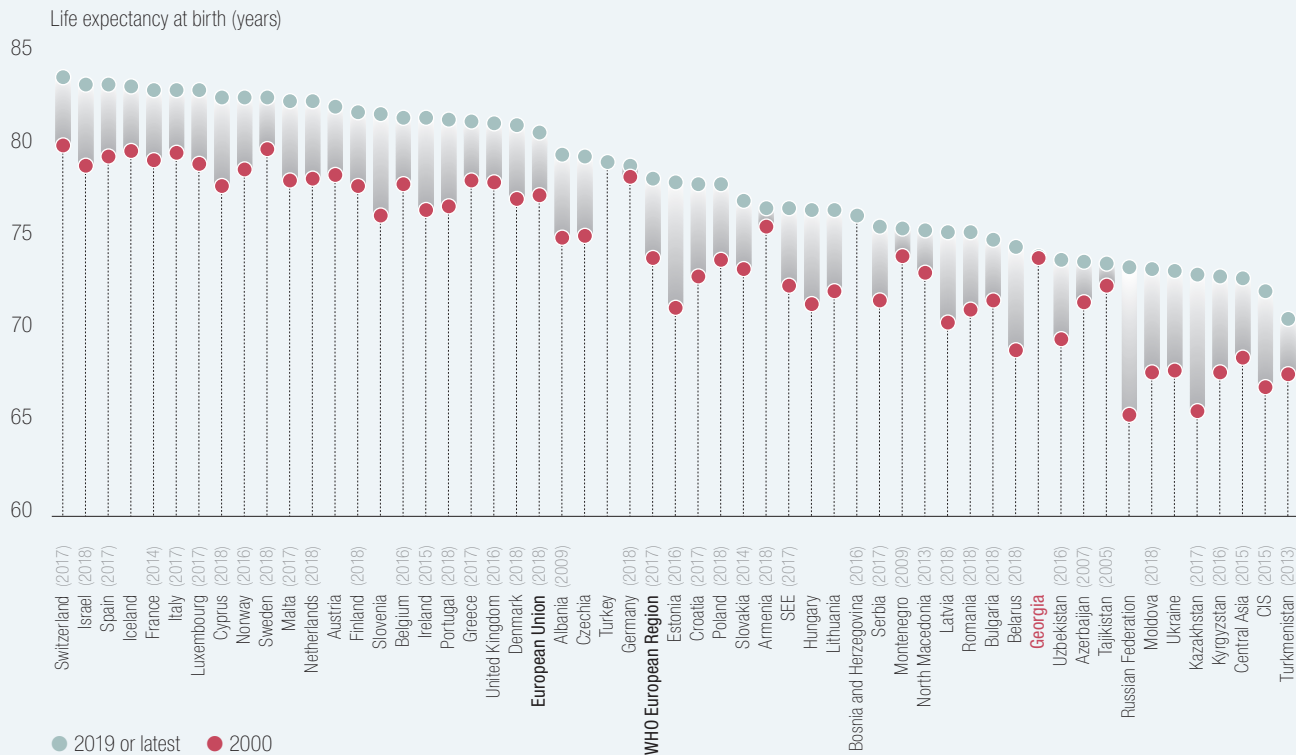
## 4 IMPROVING THE HEALTH OF THE POPULATION

### There is a large gap between male and female life expectancy

Prior to the COVID-19 pandemic, life expectancy at birth in Georgia had been hovering at around 74 years (reaching 74.1 in 2019), which is relatively low compared with the average for the WHO European Region (Fig. 9). The apparent lack of change could, however, be due to changes in the methodology used to estimate population numbers in 2000. The overall figure masks a wider gender gap in life expectancy at birth between males and females, which has increased from 6.9 years in 2000 to 8.6 years in 2019, while the gap in the WHO European Region as a whole has narrowed from 7.7 in 2000 to 6.3 in 2017. This runs counter to the trends seen in many post-communist countries, which have seen rapid improvements in male life expectancy. While mortality data are not sufficiently reliable to unpick cause of death between males and females in Georgia

Fig. 9

Life expectancy at birth in Georgia remains low in comparison to the average of the WHO European Region



**Note:** Data are for 2019 or latest available year (shown in brackets). CIS: Commonwealth of Independent States; SEE: South Eastern European countries (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Montenegro, North Macedonia, Romania, Serbia).

**Source:** WHO, 2021b.

over time, differences in risk factors such as tobacco and alcohol consumption, as well as mortality from external causes, follow strongly gendered patterns that would explain much of the difference (see below).

## Although the infant mortality rate has improved dramatically, the maternal mortality rate remains comparatively high

According to WHO estimates, the infant mortality rate per 1000 live births in Georgia has fallen by almost 75% between 2000 and 2019, from 31.9 to 8.5. This indicates a dramatic improvement in infant survival and the rate is now approaching the average for the WHO European Region (7.5 in 2018), compared to 2000 when it was nearly double the average (17.1 deaths per 1000 live births).

The WHO estimated that the maternal mortality rate in Georgia was 25 per 100 000 live births in 2017, which was almost double the average for the WHO European Region (13.1 in 2017). In 2000 there were an estimated 31 maternal deaths per 100 000 live births, but the maternal mortality rate peaked at 43 in 2009.

While the absolute numbers of births and maternal deaths are low in Georgia (which means fluctuations in the maternal death rate are to be expected), improvements since 2009 appear to be sustained.

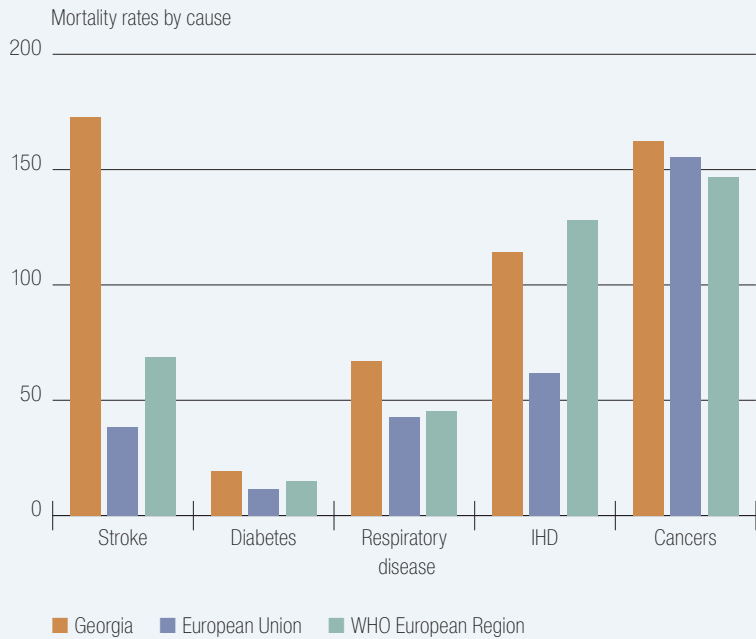
Addressing the relatively high maternal mortality rate has been a political priority for many years, and detailed examinations of the factors contributing to maternal deaths in Georgia have been conducted. The most recent national Reproductive Age Mortality Study combined medical records with verbal autopsy diagnoses and detailed investigations of all maternal deaths in Georgia for 2014–2015 (Berdzuli et al., 2021). The findings showed that improvements in the quality of care would have prevented 87% of early maternal deaths and 67% of late maternal deaths due to direct obstetric causes (Berdzuli et al., 2021).

## The overall mortality rate in Georgia is high and the leading cause of death is stroke

Problems with the collection of mortality data in Georgia mean that, until recently, while most deaths were registered, for more than a quarter of deaths the cause of death was unknown. There were also

**Fig. 10**

The mortality rate for stroke is far above European averages



**Notes:** 2018 data for the European Union and the WHO European Region, 2019 data for Georgia. IHD: Ischaemic Heart Disease.

**Source:** WHO, 2021b.

concerns about the accuracy of cause of death data being recorded, as many individuals tasked with recording this information were not medically qualified. The data gaps – both in breadth and level of detail available – mean that it is not possible to discuss trends in the leading causes of death over time. However, concerted efforts have improved the completeness of mortality data since 2018. For 2019 the total mortality rate was very high in international comparison – 964 per 100 000 population in Georgia compared with 547 in the EU and 690 in the WHO European Region. Cardiovascular diseases (ischaemic heart disease (IHD) and particularly stroke) are the main causes of death, closely followed by mortality from all cancers (Fig. 10).

## Noncommunicable diseases account for most of the country's burden of disease

Hypertension, ischaemic heart disease and stroke result in both high mortality and high morbidity. Overall, the burden of premature mortality from noncommunicable diseases is so high as to constitute a threat to the country's sustainable development (Fig. 11). A survey conducted in 2016 found that 37.7% of the population have high blood pressure (up from 33.4% in 2010), a factor which considerably increases the risk of stroke if left unmanaged. Similarly, the number of people living with type 2 diabetes is also increasing. Other important risk factors include tobacco and, to a lesser extent, alcohol consumption (Fig. 12). Smoking prevalence in 2018 was 27.1% of all people aged over 15 years, but the gender differences were significant. The male smoking rate was the highest in the WHO European Region, at 52.6% of all males aged over 15 years, whereas the female smoking rate, at 4.8%, was among the lowest. The country has recognized the importance of strengthening tobacco control measures (Box 2).

## Social determinants shape health outcomes significantly

The poverty ratio in Georgia fell sharply between 2010, when 37.3% of the population was living below the national poverty line, and 2019, when this share stood at 19.5% (see country data in Section 7). Poverty is associated with the immediate risk factors (such as unhealthy diet, smoking and reduced access to health services) discussed above, but also exposure to non-optimal temperatures and indoor air pollution. Air pollution, including both outdoor and household air pollution, was estimated to account for 9.7% of all deaths in 2019.

### Box 2

Tobacco control is a priority and implementation has been robust

Implementing all provisions of the Framework Convention on Tobacco Control (FCTC) is more difficult where smoking rates are high, but the Parliament of Georgia made significant progress toward the FCTC in 2017 when it passed advanced legislation on tobacco control. The law introduced a series of advanced measures including: a comprehensive ban on tobacco advertising, promotion and sponsorship; a ban on smoking in enclosed public spaces, workplaces and public transport; an extensive ban on the display of tobacco products at point of sale; a ban on tobacco vending machines; and standardized packaging to be rolled out in stages from December 2022. Compliance with the smoke-free policy is over 97% in cafés and restaurants and tobacco advertising in public has disappeared. In addition, taxes on tobacco products were also increased.

As a result of successful implementation of the policy, smoking prevalence has decreased by 10%, consumption of tobacco among smokers has dropped by 15% and tobacco-related air pollution decreased by 90% in public places.

**Sources:** WHO, 2018; NCDC, 2021; FCTC Monitoring and Implementation Center in Georgia, 2021.



## 5 SPOTLIGHT ON COVID-19

### Georgia was reasonably well prepared for a health emergency in 2019

Based on the International Health Regulations (IHR), Georgia recorded below-average scores for most indicators of self-reported capacity to detect and manage public health risks in areas including legislation and financing, national health emergency framework, surveillance, human resources and health service provision (Fig. 13). There was particular concern in the areas of risk communication (20 in Georgia, compared with 66 on average in the WHO European Region) and points of entry (40 versus 60). Nevertheless, Georgia scored itself above average on IHR requirements for laboratory capacity (93 compared with a WHO European Regional average of 81) and similar to the WHO European Regional average for IHR coordination (around 80). The country was quick to recognize the threat posed by COVID-19 in January 2020 and was able to implement a comprehensive testing programme at scale very rapidly once the first cases were detected.

The independent Joint External Evaluation (JEE) of IHR capacities conducted in Georgia in June 2019 largely reflected the scores of the self-assessment. The IHR capacities that were rated lowest were risk communication, points of entry and response capacities to chemical events.

**Fig. 11**

Premature mortality from noncommunicable diseases is high



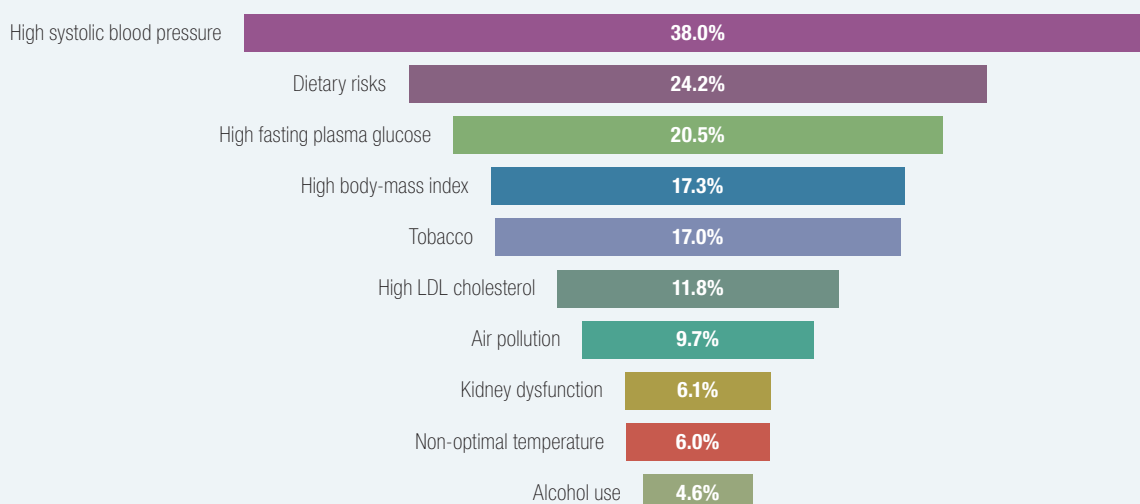
**Notes:** 2017 data for WHO European Region, 2018 for the European Union, 2019 for Georgia; Premature mortality (in people aged 30–69 years) from major noncommunicable diseases (cardiovascular diseases, cancer, diabetes mellitus and chronic respiratory diseases).

**Source:** WHO, 2021b.

**Fig. 12**

High blood pressure is the biggest risk factor as a share of all deaths in Georgia

#### Top 10 risk factors as a share of all deaths

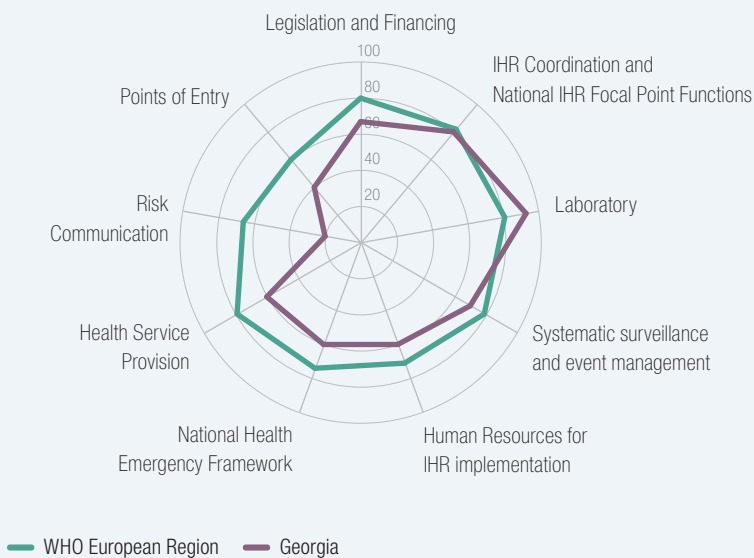


**Note:** Shares overlap and therefore add up to more than 100%.

**Source:** IHME (2019).

**Fig. 13**

Before the COVID-19 pandemic Georgia had strong laboratory capacity but weak risk communication



**Note:** Country self-assessment score (0–100) on selected core capacities for the implementation of the International Health Regulations.

**Source:** WHO, 2021c (data refer to 2019).

**Fig. 14**

Georgia has been severely affected by the COVID-19 pandemic

### WHO European Region

6 454 cases  
per 100 000  
population

131 deaths  
per 100 000  
population

### Georgia

423 843  
confirmed  
cases

5 876  
deaths

10 625 cases  
per 100 000  
population

147 deaths  
per 100 000  
population

**Note:** Data as of 3 August 2021.

**Source:** WHO, 2021a.

## Georgia responded to the COVID-19 pandemic with a comprehensive package of containment measures

Georgia implemented a multisectoral response led by the Prime Minister and coordinated by the MoIDPLHSA and the NCDC. On 23 January 2020 the Interagency Coordination Council was set up to respond to the outbreak and the Emergency Response Plan was adopted on 28 January 2020. This was seen as part of Georgia's responsibilities as a party to the International Health Regulations, guided by the recommendations of the WHO and ECDC.

Official advice regarding the necessary personal preventive measures against COVID-19 – such as hand hygiene, respiratory etiquette and social distancing – was issued in January 2020, before the first cases in Georgia were recorded on 26 February 2020. Laboratory testing and contact tracing capacity were scaled up rapidly and measures were put in place to enable the isolation of confirmed and suspected cases. In March 2020 a State of Emergency was declared and a broad package of measures was introduced, closing all education establishments, entertainment venues and non-essential shops, as well as curtailing movement around the country and internationally. Largely motivated by economic considerations, the State of Emergency ended on 23 May 2020 and the country began a staged reopening in the hope that the summer tourism season could still go ahead. However, continuing high infection levels across much of Europe meant that the borders remained largely closed.

While in other countries in Europe there was a series of 'waves' of infections, throughout most of 2020 infection rates in Georgia were largely contained and restrictions on socializing, mass events and travel were not fully lifted even over the summer of 2020. In the autumn of 2020 restrictions were reintroduced as infection rates surged as a result of the earlier relaxation of public health and social measures and the reopening of hotels, restaurants and public transportation, which resulted in the health system coming under pressure. Most of these restrictions stayed in place until March 2021. Since then, the number of registered cases and deaths has started to escalate again. Roll-out of the COVID-19 vaccination programme began in March 2021, with the aim of vaccinating 60% of the population by the end of 2021, although by the beginning of August 2021 less than 10% of the population had received at least one dose.

## Maintaining access to non-COVID services through the pandemic has provided valuable lessons for future health system strengthening

As the infection rate was initially kept comparatively low and spare hospital capacity was quite high, access to non-COVID-19 services could be maintained at its previous level until November 2020, when some elective care had to be postponed because a number of patients attending for planned surgeries were found to be infected with COVID-19. Longstanding issues with the quality of cause of death data mean that it will be important to look at both the number of excess deaths as well as the number of confirmed COVID-19 deaths, even though in 2020 reported infection and death rates from COVID-19 were not as high as elsewhere in Europe.

An important impact of the pandemic on non-COVID services in Georgia has been the restructuring of primary care across the country. The package of benefits has been expanded to cover more services, improve the coordination of care between primary and specialist providers, and optimize the use of diagnostic and specialist services. The revised design of primary care services envisions greater use of remote and digital services (the provision of which has expanded rapidly during the pandemic) to improve access for rural populations. The aim is to improve geographical equity and to better support people with noncommunicable diseases during the pandemic and beyond. The lesson learned through the COVID-19 pandemic is that greater investment in rural infrastructure, telemedicine equipment and better communication systems is needed to reach all populations (Domete & Zardiashvili, 2021).

## 6 EUROPEAN PROGRAMME OF WORK (EPW)

### Moving towards universal health coverage

Georgia has made major progress in recent years in moving towards universal health coverage. WHO supports these efforts by providing technical assistance to improve the coverage and quality of primary care, strengthen relevant legislation, improve strategic purchasing and financial protection, and improve access to quality services and medicines.

Despite pandemic-related disruptions, WHO contributed to a revision of the primary care benefits package and developed a new costing and payment model, and a phased implementation roadmap. The new Law on Medicinal Products (**Box 1**) was developed by local experts under WHO guidance and creates a framework for price regulation and quality assurance of essential medicines. Discussions are ongoing on revising the central procurement system for essential medicines and medical devices.

### Protecting against health emergencies

Supporting Georgia's response to the COVID-19 pandemic has been the primary focus of WHO work since early 2020. Under WHO leadership, and in close coordination with the MoDPLHSA, the Country Inter-Agency Preparedness and Response Plan was developed. WHO technical support was also provided to strengthen the capacity of the health workforce and designated health care facilities and laboratories, improve national response coordination mechanisms, and develop national case investigation and contact tracing protocols.

## COUNTRY DATA SUMMARY

	Georgia	WHO European Region	EU-28
Life expectancy at birth, both sexes combined <sup>a</sup>	74.1 (2019)	78.3 (2017)	81.2 (2017)
Estimated maternal mortality per 100 000 live births (2017)	25	13	6.1
Estimated infant mortality per 1000 live births <sup>a</sup> (2019)	8.5	7.5 (2018)	3.5 (2018)
Population size, in million (2019)	3.7	927.2	512
GDP per capita, PPP US\$ (2019)	15 655	36 813	46 699
Poverty rate at national poverty lines <sup>a</sup> (2019)	19.5	14.9 (2018)	17 (2018)

<sup>a</sup> Latest year for which data are available shown in brackets.

**Notes:** EU-28: 28 EU Member States until 2020; GDP: gross domestic product; PPP: purchasing power parity.

**Sources:** WHO, 2021b; World Bank, 2021.

WHO also helped to improve infection prevention and control in health care facilities, train epidemiologists involved in surveillance, and train laboratory staff to improve detection capacities, and support risk communication and community engagement efforts.

## Promoting health and well-being

WHO is assisting Georgia in its efforts to reduce the burden of noncommunicable diseases (NCDs). This has included updating the National NCD Prevention and Control Strategy and Action Plan, determining strategic priorities for 2021–2025, and implementing tobacco control legislation (**Box 2**). Environment and health has also become a priority area of collaboration between WHO and the Georgian authorities. Pollution is a major problem in Georgia, as legislation and implementation of existing regulations is weak, and air monitoring centres are inefficient. In 2020 WHO supported implementation of the National Environment and Health Action Plan (NEHAP), and supported the revision of the regulatory framework on Water, Sanitation and Health (WASH) in health care facilities, as well as adapting survey instruments to the local context. In 2021 a national network of healthy cities is being established and Tbilisi will become a member of the WHO European Network of Healthy Cities. In addition, a policy audit and development of the national action plan for physical activity is under way.

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## WHO Regional Office for Europe

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WHO is the authority responsible for public health within the United Nations system. The WHO Regional Office for Europe (WHO/Europe) covers 53 countries, from the Atlantic to the Pacific oceans.

To support countries, WHO/Europe seeks to deliver a new vision for health, building a pan-European culture of health, where health and well-being goals guide public and private decision-making, and everyone can make healthy choices. WHO/Europe aims to inspire and support all its Member States to improve the health of their populations at all ages. WHO/Europe does this by providing a roadmap for the Region's future to better health; ensuring health security in the face of emergencies and other threats to health; empowering people and increasing health behaviour insights; supporting health transformation at all levels of health systems; and by leveraging strategic partnerships for better health.

## European Programme of Work 'United Action for Better Health in Europe'

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The European Programme of Work (EPW) sets out a vision of how the WHO Regional Office for Europe can better support countries in our region in meeting citizens' expectations about health.

The social, political, economic and health landscape in the WHO European Region is changing. United action for better health is the new vision that aims to support countries in these changing times. "United", because partnership is an ethical duty and essential for success, and "action" because countries have stressed their wish to see WHO move from the "what" to the "how", exchanging knowledge to solve real problems. The WHO European Region's solidarity is a precious asset to be nurtured and preserved and, through the EPW, WHO/Europe supports countries as they work together to serve their citizens, learning from their challenges and successes.

## The European Observatory on Health Systems and Policies

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The European Observatory on Health Systems and Policies supports and promotes evidence-based health policy-making so that countries can take more informed decisions to improve the health of their populations. It brings together a wide range of policy-makers, academics and practitioners, drawing on their knowledge and experience to offer comprehensive and rigorous analysis of health systems in Europe. The Observatory is a partnership hosted by WHO/Europe. Partners include the governments of Austria, Belgium, Finland, Ireland, Norway, Slovenia, Spain, Sweden, Switzerland, the United Kingdom, and the Veneto Region of Italy (with Agenas); the European Commission; the French National Union of Health Insurance Funds (UNCAM), the Health Foundation; the London School of Economics and Political Science (LSE) and the London School of Hygiene & Tropical Medicine (LSHTM). The Observatory is based in Brussels with hubs in London (at LSE and LSHTM) and at the Berlin University of Technology.