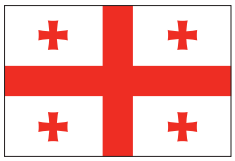
2024 Edition

Health Systems in Action

Georgia



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GEORGIA

Health Systems in Action (HSiA) Insights

Georgia

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Editorial Team

This edition of the Health Systems in Action Insight for Georgia was written by Erica Richardson, Mari Tvaliashvili, Kakha Gviniadze and Tomas Roubal.

The Health Systems in Action series

The Health Systems in Action Insights series supports Member States in the WHO European Region that are not in the European Union. 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; and
- build a baseline for comparisons, so that Member States can see how their health systems develop over time and in relation to other countries.

The series is co-produced by the WHO Regional Office for Europe and the European Observatory on Health Systems and Policies. It draws on the knowledge and understanding of the WHO Country Offices and of the Division of Country Health Policies and Systems (CPS), the WHO Barcelona Office for Health Systems Financing and other WHO/Europe technical programmes; as well as the Health Systems in Transition series and the work of the European Observatory on Health Systems and Policies.

The Insights follow a common template that provides detailed guidance and allows comparison across countries. The series is publicly available on the websites of the WHO Regional Office for Europe and the European Observatory on Health Systems and Policies (eurohealthobservatory.who.int).

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HEALTH SYSTEMS IN ACTION INSIGHTS: GEORGIA

Key points

- Since 2013, Georgia has been striving to provide universal health coverage (UHC) through a steadily expanding package of publicly funded benefits and increased public spending on health.
- However, coverage policy is complex and there are substantial co-payments. The high cost of outpatient medicines has been the biggest barrier to accessing care for the lowest income households and the main target for policy changes to improve access.
- Recent reforms have sought to limit co-payments at certain thresholds for different groups of beneficiaries to improve financial protection for households and improve clarity on how much patients need to co-pay.
- Although public spending on health remains low by international comparison (at 3.1% of GDP in 2022), it has increased as coverage has expanded and out-of-pocket (OOP) spending on health has fallen considerably.
- Most health care providers are private, including approximately 80% of hospital beds.
- There is a strong patient preference for accessing the system at more specialized levels of care and there is scope to strengthen the role of primary care in the system and improve allocative efficiency.
- Georgia has improved access to essential services for infectious diseases, but access for noncommunicable diseases (NCDs) has slipped and is now a focus for policy efforts, particularly for cancer care.
- NCDs 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 from NCDs.
- Excess mortality due to COVID-19 far exceeded the WHO European Region average and COVID-19 was the leading cause of disability-adjusted life years (DALYs) in 2021.
- Male smoking prevalence was estimated to be the highest in Europe in 2023, at 54.6% of those aged 15 years and over, whereas female smoking prevalence, at 7.0%, was among the lowest. Tobacco control is a public health priority and indoor smoking and tobacco advertising bans have been robust.
- Georgia has a large number of doctors per capita, with the highest density in the capital Tbilisi and significant shortages in rural and mountainous areas. At the same time, the country is facing an acute shortage of nurses. Health workforce shortages are an increasingly important barrier to accessing health services.

1 ORGANIZING THE HEALTH SYSTEM

Publicly financed health services are purchased centrally from predominantly private providers

Georgia underwent a series of radical changes of health financing system design, abolishing a limited social health insurance scheme in 2004, introducing a means-tested targeted Medical Insurance Programme in 2007 and then contracting out administration to private insurers. A single public purchaser was then re-established in 2013 as part of the Universal Health Care Programme (UHCP) and population coverage was extended to all legal residents with various levels of coverage. Entitlements vary significantly based on income, age and other factors. The National Health Agency (with 10 regional departments) is the single purchaser of services under the UHCP and most other government-funded health care programmes. State budget transfers for health programmes are negotiated annually as part of the general budget negotiation process.

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 primary care providers. Several inpatient facilities are also united under the government-owned Georgian Medical Holding for key specialist services (for example, tuberculosis (TB), HIV and mental health), as well as general hospitals. The holding now accounts for around 20% of hospital beds in the country. In Georgia it has been difficult to engage in selective contracting or facility master-planning, enforce minimum standards and balance competing interests because private health insurance and private provider interests lobby for deregulated environments in the health sector (Hawkins, Habicht & Kasekamp, 2023).

Improving financial protection and expanding coverage have been key reform aims since 2013 under the UHCP

In 2023 the UHCP provided 93.7% of the resident population with some degree of coverage. About 16% of the population was covered by private health insurance (although some were also covered under the UHCP) and around 5% of the population were not registered for any form of coverage (UHCP or private health insurance). When the UHCP was introduced in February 2013, 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, chemotherapy, hormone therapy, radiotherapy and childbirth. The new "basic package" was available to any legal resident who had no form of health insurance coverage, although in 2017 UHCP benefits were removed from the richest households for everything but infectious disease management and childbirth; this affected 1.4% of the population in 2023. Since November 2023 access to the cancer care benefits package has become available for everyone, regardless of income or insurance status. In 2017, a limited list of medicines for the most prevalent conditions was added to the benefits package for households living in poverty. Coverage of these medicines was extended to pensioners and people with disabilities in 2019. The list of conditions covered was also expanded and medicines for especially vulnerable groups were financed 100%, without co-payments but within annual ceilings per condition. Medicines for epilepsy and Parkinson's disease management were covered for everyone, regardless of their status. In 2024, medicines for glaucoma management were added to the list of reimbursable medicines and annual reimbursement ceilings were removed. Alongside this, price regulation mechanisms for essential medicines have been introduced, capping the retail price of over 7000 medicines. The aim is for these targeted increases in coverage to reduce OOP spending on medicines because it is the main driver of catastrophic spending.

Overall, the package of benefits is broad but extremely complex and substantial co-payments are required. 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. Prior to the introduction of diagnosis-related group payments in November 2022, there were ceilings on the amount the government covered. Limits were set per episode of care for inpatient surgeries and annually for planned inpatient care. Once the coverage limit was reached, the user was responsible for covering the price of the service until the beginning of the new financial year. For example, 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). Before 2023, there was no cap on the charges paid by patients and no caps on the prices that hospitals could charge patients. Since 2023, with the introduction of new payment mechanisms for inpatient care, balance-billing is no longer allowed.

2 FINANCING AND ENSURING FINANCIAL PROTECTION

Although current health spending is comparatively low, the share from public sources grew substantially in response to the COVID-19 pandemic

Average health spending per capita in the WHO European Region in 2021 was US$ 3841 when adjusted for purchasing power and US$ 4733 in the European Union (EU). In Georgia it was US$ 1413, lower than the average for upper middle-income countries (UMICs) in the WHO European Region, which was US$ 1646 **(Fig.1)**.

Most financing for health is from public sources, primarily through general taxation. In 2021, public spending on health was US$ 754 per capita adjusted for purchasing power, or 53% of current health spending. Public spending on health was boosted by extra spending on the COVID-19 response. OOP spending is the main source of private spending on health, accounting for US$ 441 per capita adjusted for purchasing power in 2021, or 31% of current health spending. The role of voluntary health insurance and other sources (such as donor funding) in financing health is marginal, despite previous policies seeking proactively to develop a private insurance market.

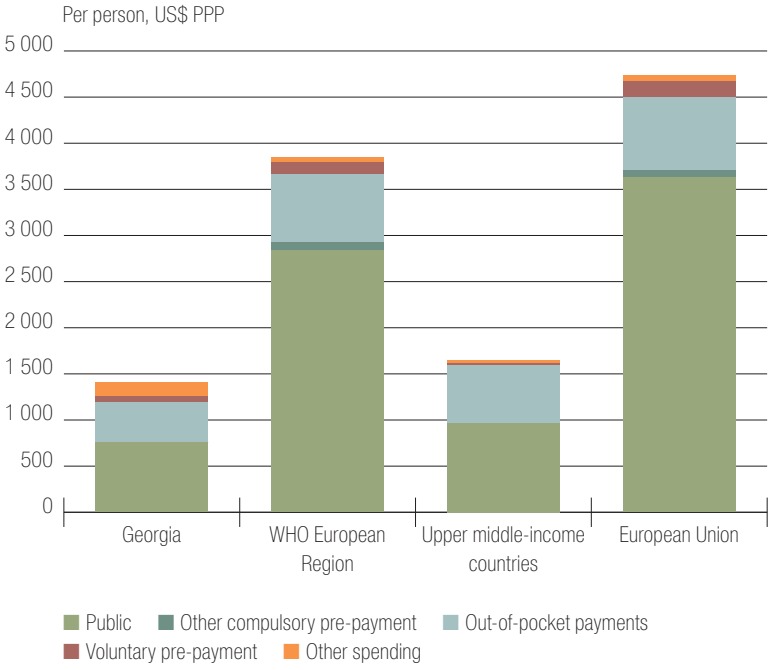
Increased government health spending since 2013 has reduced OOP spending considerably

Through most of the 2000s, public spending on health 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 spending was covered from general taxation rather than being paid for out of pocket **(Fig.2)**. Public spending on health as a share of GDP increased rapidly, to 3.7% in 2020 and 4.5% in 2021, in response to the COVID-19 pandemic, pushing public spending on health as a share of GDP above the average for UMICs (4.2%), although remaining below averages for the WHO European Region (5.9%) and the EU (7.1%). In 2021, 14.2% of general government expenditure was on health, but this fell back to 10.5% in 2022 when the COVID-19 special funding ended. The extra financing for the COVID-19 response was temporary and organized as a vertical programme, so did not increase spending on health not related to the pandemic. Consequently, the health budget was reduced to below pre-pandemic levels in 2022 and 2023 and public spending on health as a share of GDP fell back to 3.1% in 2022.

Since 2011, OOP spending on health has fallen steadily in Georgia. From 2013, the reduction is the result of concerted policy efforts to reduce the reliance on OOP spending significantly, with a correspondingly steep increase in government budget allocations to health. The fiscal priority of health spending has increased markedly (Hawkins, Habicht & Kasekamp, 2023). Between 2013 and 2022, public spending on health increased from 7% to 11% of general government expenditure (WHO, 2024a). In 2021, OOP spending on health fell to 31.2% of current health spending **(Fig.3)**. Average prices of NCD medicines in 2019–2021, weighted by consumption, increased by 26% (from +13% for epilepsy medicines to +86% for cancer) (Kadyrova et al., 2023). Medicines remain the main driver of OOP spending **(Box 1)**.

Fig. 1

Health spending per capita in Georgia is low in international comparison

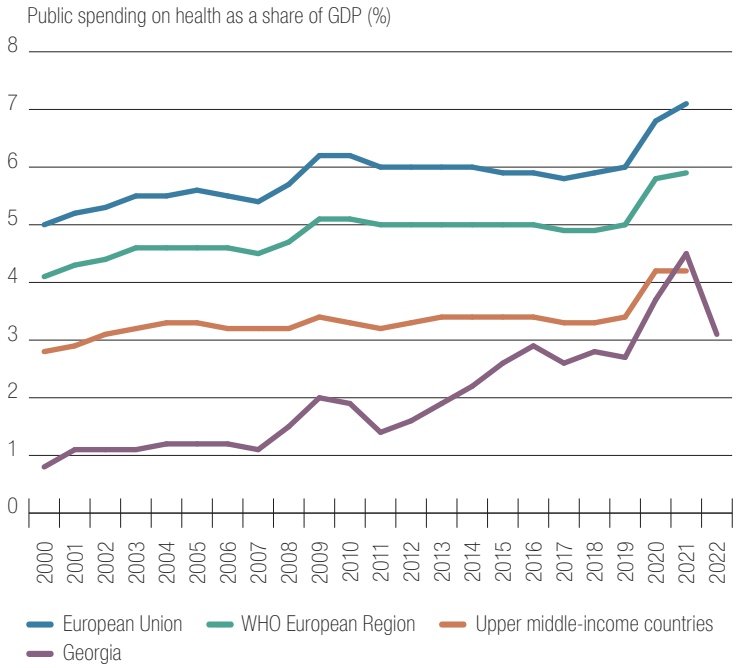


Source: WHO, 2024a.

Notes: 2021 data. Public refers to transfers from government budgets and social health insurance contributions. Other compulsory pre-payment refers to premiums for MHI schemes in Belgium, Finland, France, Germany, the Netherlands (Kingdom of the) and Switzerland. Other spending includes external funding and some other marginal spending. PPP: purchasing power parity.

Fig. 2

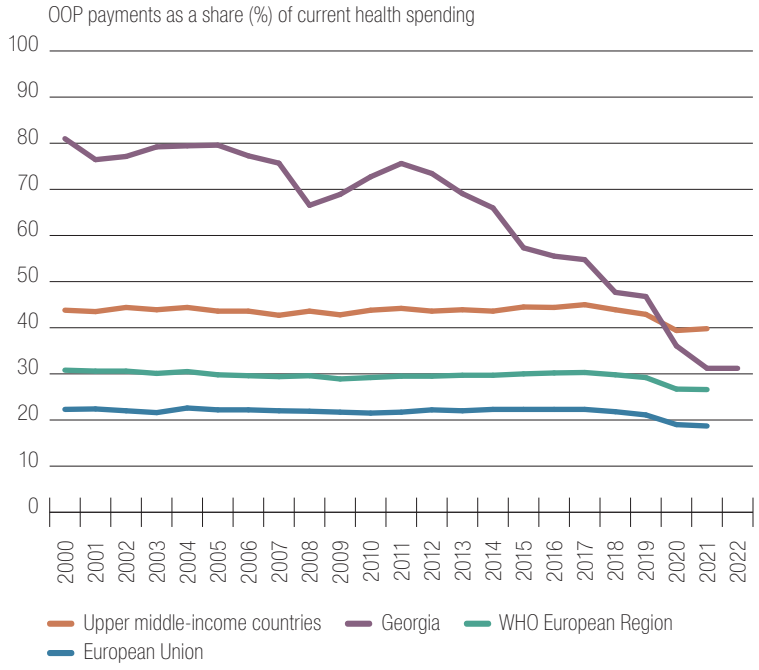
Public spending on health as a share of GDP expanded rapidly in response to the COVID-19 pandemic



Source: WHO, 2024a.

Fig. 3

In the last decade OOP spending as a share of health spending has declined overall



Source: WHO, 2024a.

Spending on inpatient care in Georgia dominates health spending

In 2019 (the most recent year for which data are available), inpatient care accounted for 33.7% of current health spending, followed by medicines and other medical goods (23.1%), outpatient care (18%) and preventive care (2.3%). These figures reflect incentives in the system that prioritize treatment at more specialized levels of care.

Since 2013, successive Georgian governments have made concerted efforts to strengthen financial protection and improve access to services

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, however, increased catastrophic health spending, driven largely by an increase in OOP 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 spending on health and 6.8% were impoverished or further impoverished **(Fig.4)**.

Price regulation is being used as a tool to reduce OOP spending and strengthen financial protection

The cost of medicines in Georgia is high and OOP spending on outpatient medicines is the main factor behind catastrophic health care costs for poorer households. In 2021, development of a new Law on Medicinal Products was initiated by the Parliamentary Committee on Health and Social Issues. The work was done with the support of international and local experts, under WHO guidance. The new legislation was supposed to create a framework for price regulation and quality assurance of essential medicines. The draft law was updated again in 2023, to reflect the latest EU directives on medicines, although parliamentary debates on a new law on medicinal products have not been initiated yet. Meanwhile, the focus was on

Box 1

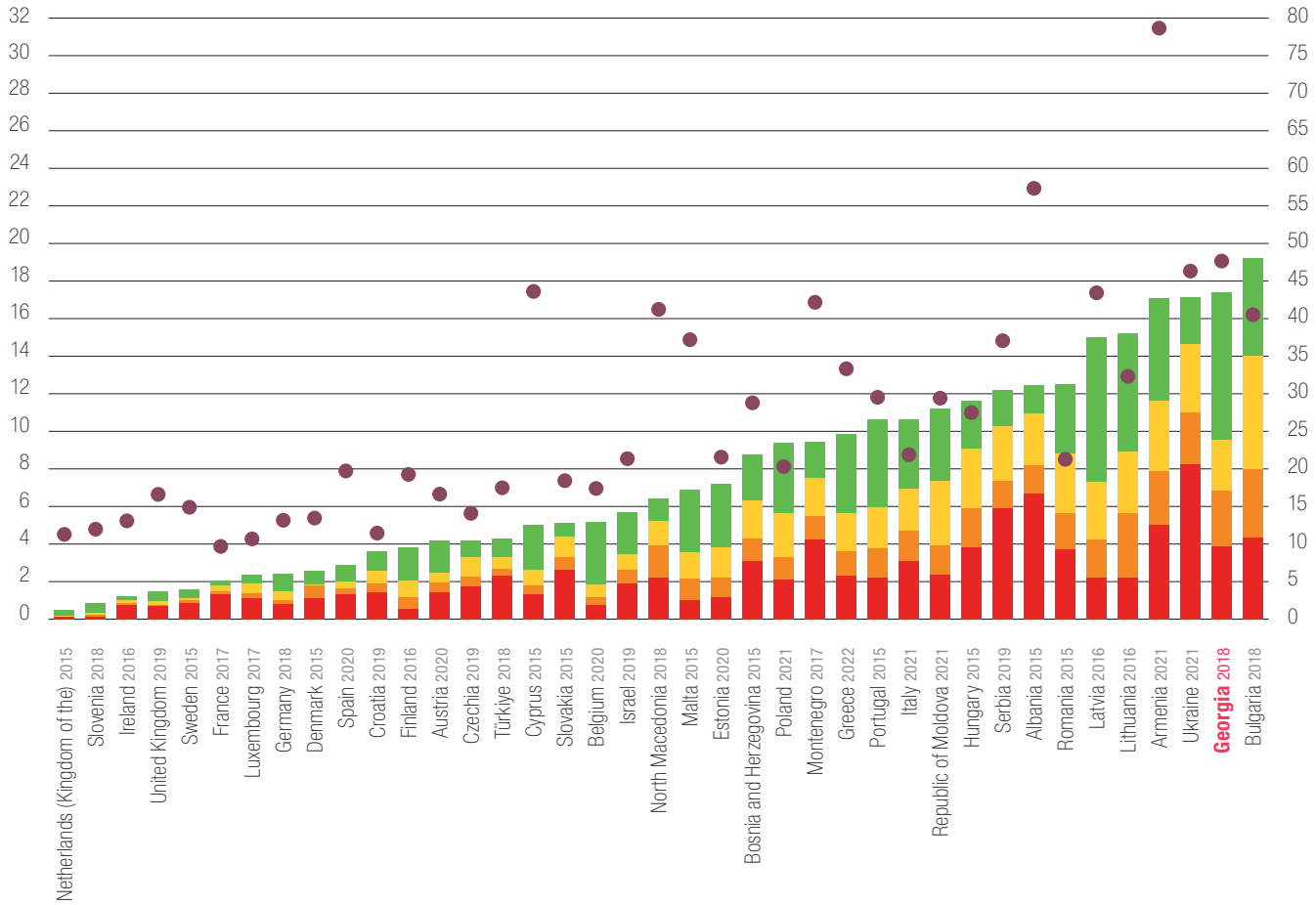
The underfunding of primary care in Georgia reduces the health system's allocative efficiency

The basic design of coverage policy in Georgia has complicated improving allocative efficiency in the system because inpatient and emergency care are prioritized over primary care. Spending on primary care as a share of public spending on health in Georgia was just 12% in 2018, or 0.3% of GDP. WHO recommends that all countries increase their public spending on primary care by an additional 1% of GDP – which would be an extra US$ 44 spent publicly per person on primary care in Georgia (WHO Regional Office for Europe, 2021).

As the health system is so deregulated and so few service providers are under direct government control, it is difficult to ensure hospital planning is rational. Nevertheless, in 2022 the Georgian government launched the Health Strategy 2030, a comprehensive multi-pillar reform strategy seeking to improve efficiency in the system and continue the journey towards UHC.

Fig. 4

Catastrophic health spending and OOP spending as % of current spending on health



Source: WHO Regional Office for Europe, 2024a.

Notes: The data on OOP payments are for the same year as the data on catastrophic health spending (except for Greece, where data on OOP spending are from 2021). 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).

implementing price regulation mechanisms for essential medicines. Reference pricing now caps the retail and wholesale prices of over 7000 medicines and for some categories (such as antibiotics) prices have been reduced by more than 40%. In November 2023, a managed entry agreement mechanism was introduced to ensure access to innovative cancer medicines and from 2024 the government removed the GEL 25 000 annual limit for the reimbursement of cancer medicines.

In November 2022, the government introduced a system of diagnosis-related groups to pay contracted hospitals for covered services and increased public spending on inpatient care. Provider prices are now unified and providers are no longer allowed to ask people to pay anything in addition to the standard co-payment. The government also introduced a cap on co-payments for inpatient care. The cap is lower for pensioners and other priority age groups. Government reports indicate that, because of these changes, co-payments fell from 27% of the total cost of inpatient care in 2022 to 10% in 2023 (WHO, 2023a). Although data on unmet needs for health care due to cost are unavailable, these changes are likely to have helped to reduce unmet needs further.

3 GENERATING RESOURCES, PROVIDING SERVICES AND ENSURING ACCESS

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

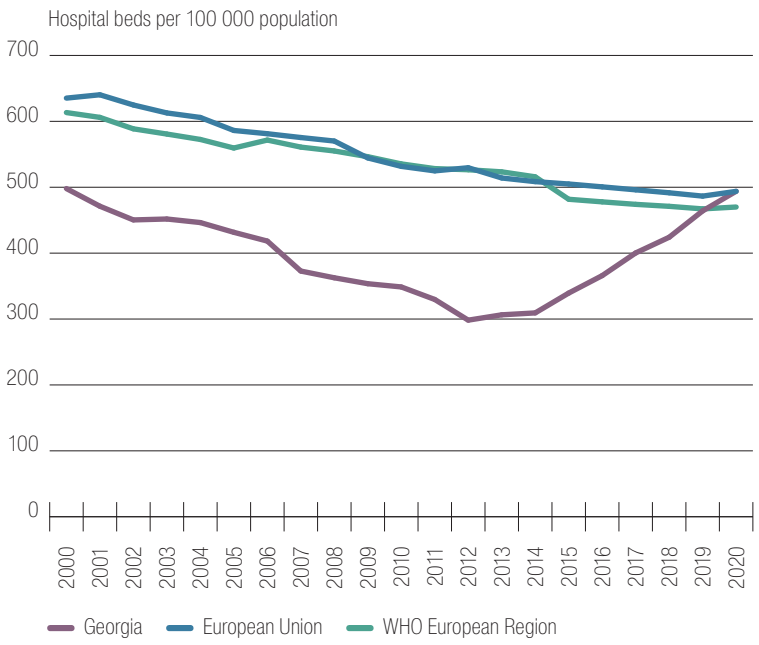
Hospital bed numbers in Georgia have increased in recent years across the country **(Fig.5)**. In 2020, there were 494 hospital beds per 100 000 population. In 2022, bed occupancy was at 45.8% – indicating that the system has either excess capacity or high unmet needs for health services. The Georgian health system has been extensively privatized and about 80% of all hospital beds are private, as are almost all urban primary care providers and outpatient specialists. Only a handful of single-profile hospitals (such as for emergency care, psychiatry, TB, HIV and other infectious diseases, and the national immunology centre) remain in the public sector. In total, there are 58 medical facilities under state ownership providing both inpatient and outpatient services. There are also 1287 primary care providers, operating mainly in mountainous and remote rural areas, to maintain access where there are insufficient financial incentives for private providers to operate. These rural doctors are mainly in solo practices, and employed by the state on a fixed salary. Rural ambulatories are owned by the local government or the state-owned company (Georgian Medical Holding) that is accountable to the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs (MoIDPLHSA), 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 for units per population for high-technology equipment. As a result, there is a significant proliferation, particularly of computed tomography (CT) and magnetic resonance imaging (MRI) scanners, in urban areas (Richardson & Berdzuli, 2017).

Georgia has successfully developed an overabundance of high-level digital solutions for health care. However, having multiple incompatible digital databases managed by different institutions might result in duplicated efforts, increased workload and dissatisfaction among health care workers. The situation has been further complicated by the development of various health information solutions by private providers, spurred by deregulation and privatization.

Fig. 5

Hospital beds per 100 000 population have increased substantially since 2014



Source: WHO, 2024b.

Georgia has many doctors per capita, but an acute shortage of nurses

Extensive capacity in the Georgian health system extends to the number of doctors reported. Although rates have fluctuated, Georgia has consistently reported a large number of active doctors per capita and density has increased to 561 per 100 000 population in 2022 **(Fig.6)**. The number of nurses working in the Georgian health system has been on the rise since 2012, but it remains low in comparison to other countries in the region, at just 588 per 100 000 population in 2022. The ratio of doctors to nurses working in the system is almost 1:1. Georgia has one of the highest rates of doctors per capita in the WHO European Region but below average rates of nurses per capita.

Most health professionals work in inpatient facilities – in 2019, this included 52% of all physicians and 71% of all nurses and midwives. There are three times as many doctors in the capital Tbilisi as in other regions. Recruiting and retaining staff to work in remote and rural facilities remains a significant challenge and is a key barrier to access for local populations.

The provision of services is hampered by OOP spending and health workforce shortages

By far the greatest barriers to accessing care in Georgia are financial and these are being addressed by efforts to improve UHC **(see Section 1)**. Waiting time is not a major barrier to access, and geographical access has improved, although health workforce shortages are a persistent barrier in remote areas (WHO Regional Office for Europe, 2023). 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 almost doubled, from 2.1 visits per capita in 2012 to 4.0 in 2019. In 2022, it was 4.1 visits per capita according to national data (GEOSTAT, 2024a).

Previously high coverage rates for routine childhood vaccinations have fallen

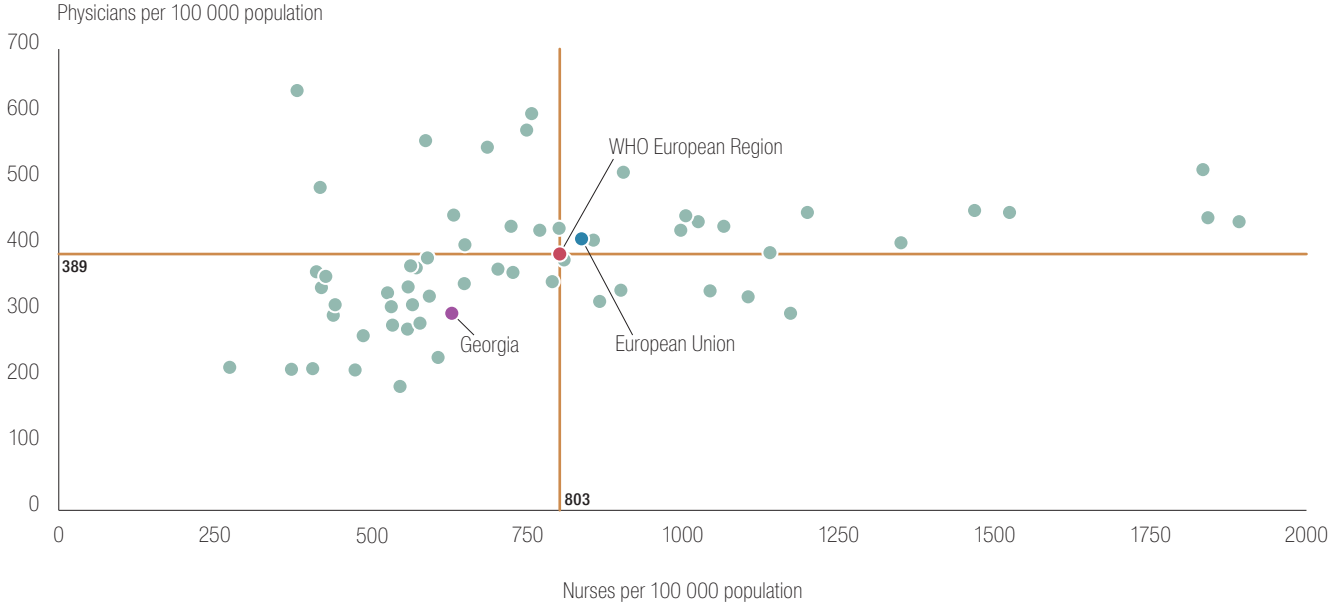
Immunization is a public health priority and the vaccination schedule was expanded to include pneumococcal vaccination from 2013, Rotavirus vaccination from 2014 and the rollout of human papillomavirus vaccination nationally in 2019. Immunization coverage rates for routine childhood vaccinations were high in 2019 but fell during the pandemic. For the full course of three vaccinations against diphtheria, tetanus and pertussis (DTP3), 85% of children were covered in 2022 and 88% in 2023, down from 94% in 2019, but recovering. In 2019, 99% of infants received the first dose of vaccine against measles, mumps and rubella, and 97% received the second (compared with 91% in the WHO European Region). Coverage in Georgia fell to 77% in 2020 as a result of the COVID-19 pandemic and remained low at 78% in 2022, before increasing to 86% in 2023. 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 years to overcome persistent gaps in coverage.

Georgia implements a successful "treatment for all" strategy for HIV/AIDS

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 per 100 000 population 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 and commercial sex workers). In terms of the 95 : 95 : 95 targets set by the Joint United Nations Programme on HIV/AIDS (UNAIDS) for 2025, the situation has improved greatly over the past two years. In 2020, 65% of people who knew their HIV positive status were estimated to be on antiretroviral medication and of these an estimated 65% had achieved viral suppression. However, by 2022 this had increased to an estimated 86% of people knowing their status being on antiretrovirals and 92% achieving viral suppression **(Fig.7)**. 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 with antiretroviral therapy has been available to men who have sex with men since 2017 through a pilot programme. Although the country has not yet met the UNAIDS target of ensuring that 95% of people living with HIV know their status, this figure too has increased significantly, from 76% in 2020 to 84% in 2022.

Fig. 6

Georgia has one of the highest numbers of physicians per 100 000 population in the WHO European Region



Source: WHO, 2024c.

Notes: Densities were multiplied by 10 to calculate the density per 100 000 population. Averages are based on latest available years.

Fig. 7

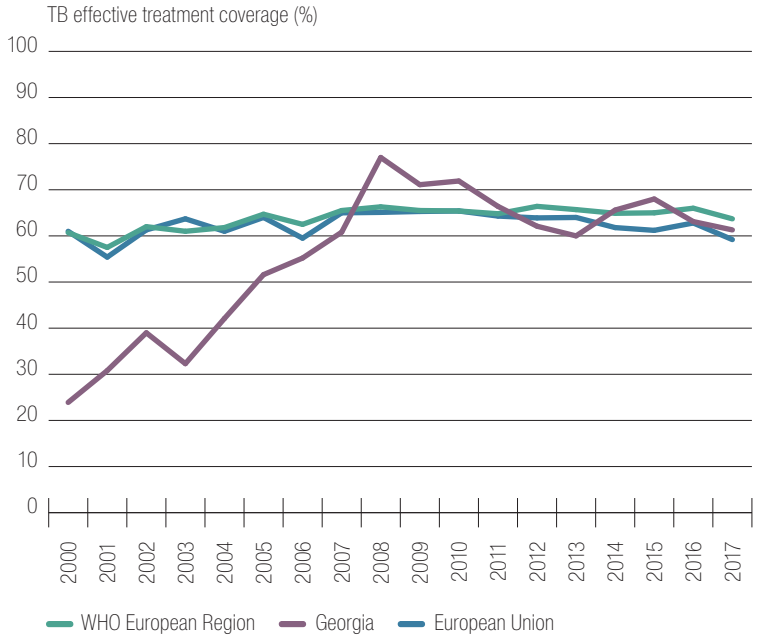
Service coverage for people living with HIV is moving closer to the targets for 2025

Source: UNAIDS, 2023.

Note: The size of the boxes illustrates the number of people living with HIV who benefit from diagnosis and treatment.

Fig. 8

TB effective treatment coverage has increased dramatically since 2000



Source: WHO, 2024b.

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

Georgia has improved access to essential services for infectious diseases, but access for NCDs has slipped

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 OOP spending despite the implementation of policies to expand access to specific medicines for the prevention and treatment of certain chronic conditions **(see Section 1)**.

The UHC service coverage index measures access to essential services. It increased swiftly between 2000 and 2015, from 47 to 71 (out of 100), but progress then slowed, falling back to 68 in 2021, while the WHO European Region average increased **(Fig.9)**. The dimensions of service capacity and access were historically high in Georgia (98 out of 100 in 2000–2010) but have subsequently fallen below this level (to 86 in 2021). The strong overall improvements in the UHC service coverage index between 2000 and 2015 were driven by gains in service coverage for infectious diseases. The sub-index on infectious diseases increased from 15 in 2000 to 75 by 2015, reaching 78 by 2019. However, the UHC service coverage sub-index on NCDs fell from 53 in 2000 to 49 in 2015 and has remained at this level.

4 IMPROVING THE HEALTH OF THE POPULATION

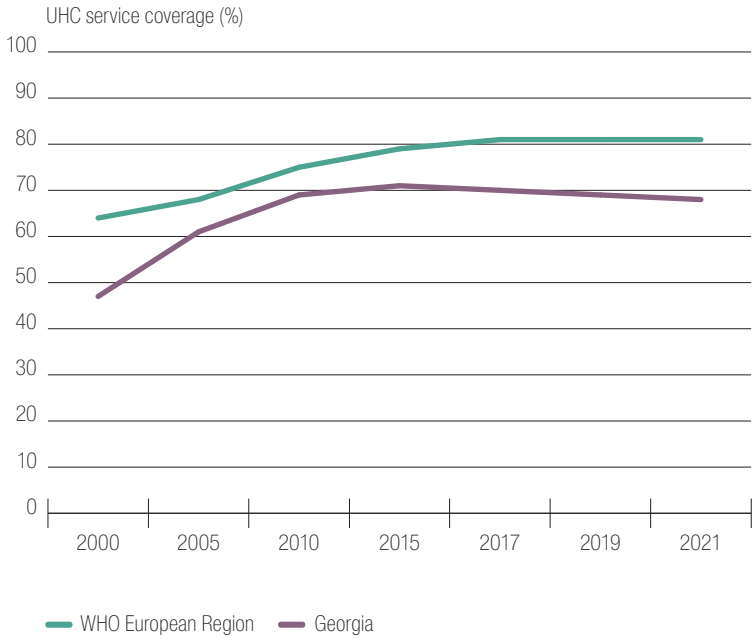
Life expectancy at birth is comparatively low and there is a wide gap between males and females

Life expectancy at birth stood at 73.7 years in 2022, a decline from 74.2 years in 2006 and relatively low compared with the average for the WHO European Region **(Fig. 10)**. The apparent lack of change could, however, be due to changes in the methodology used to estimate population numbers. According to national data sources, life expectancy at birth reached 75 years in 2023 (GEOSTAT, 2024b).

However, the overall figure masks a wide gap in life expectancy at birth between males and females, which stood at 8.7 years in 2022, whereas the gap in the WHO European Region as a whole narrowed from 7.7 years in 2000 to 6.3 years in 2017. This runs counter to the trends seen in many post-communist countries, which have seen rapid improvements in male life expectancy. Although mortality data are not sufficiently reliable to unpick changes in cause of death between males and females in Georgia 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)**.

Fig. 9

Progress in the UHC service coverage index has stalled



Source: WHO, 2024b.

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

Although both infant and maternal mortality rates have improved dramatically, they remain comparatively high

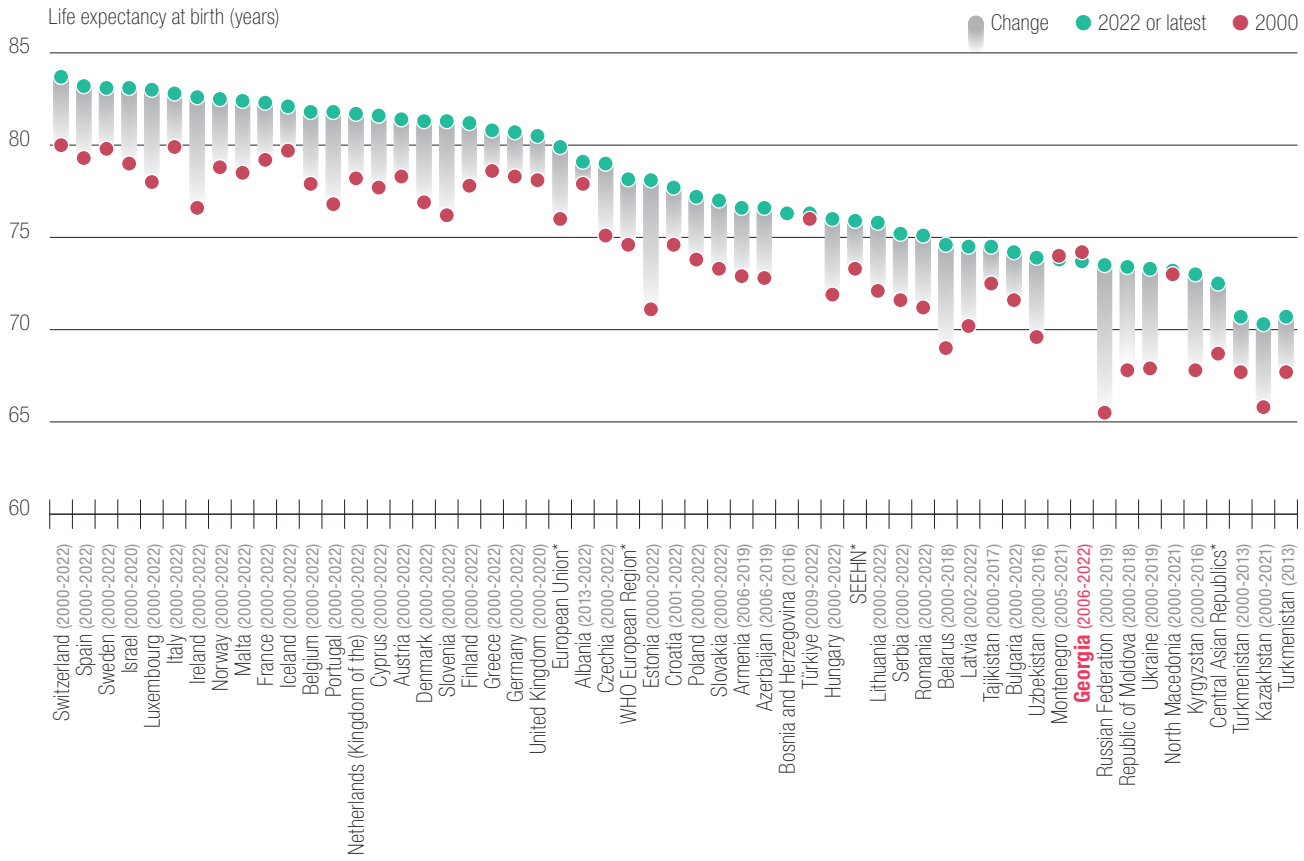
According to WHO estimates, the infant mortality rate per 1000 live births in Georgia has fallen by almost 75% between 2000 and 2021, from 32.1 to 8.4. This indicates a dramatic improvement in infant survival and the rate is now closer to the average for the WHO European Region (6.3 per 1000 live births in 2021), compared with 2000 when it was double the average of 17.1 deaths per 1000 live births.

According to United Nations estimates, the maternal mortality rate in Georgia was 27.6 per 100 000 live births in 2020, which was more than double the average for the WHO European Region (12.6 per 100 000 live births in 2020). However, the rate in Georgia constitutes substantial improvement compared to 2000, when it stood at an estimated 52.8 maternal deaths per 100 000 live births. The maternal mortality rate was lowest before the COVID-19 pandemic (26.5 in 2019).

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 Georgian Birth Registry has been in place since 2016 to track pregnancy and birth outcomes in detail and inform health policy.

Fig. 10

Between 2006 and 2022, life expectancy saw no real improvement in Georgia



Source: Eurostat, 2024, for EU/EEA countries, Albania, Montenegro, North Macedonia, Serbia, Armenia, Azerbaijan, Georgia and Türkiye; WHO Regional Office for Europe, 2024b, for all others.

Notes: * averages are based on years with data available. The South-Eastern Europe Health Network (SEEHN) includes Albania, Bosnia and Herzegovina, Bulgaria, Israel, Montenegro, North Macedonia, the Republic of Moldova, Romania and Serbia.

The overall mortality rate in Georgia is high and cardiovascular diseases are the leading cause of death

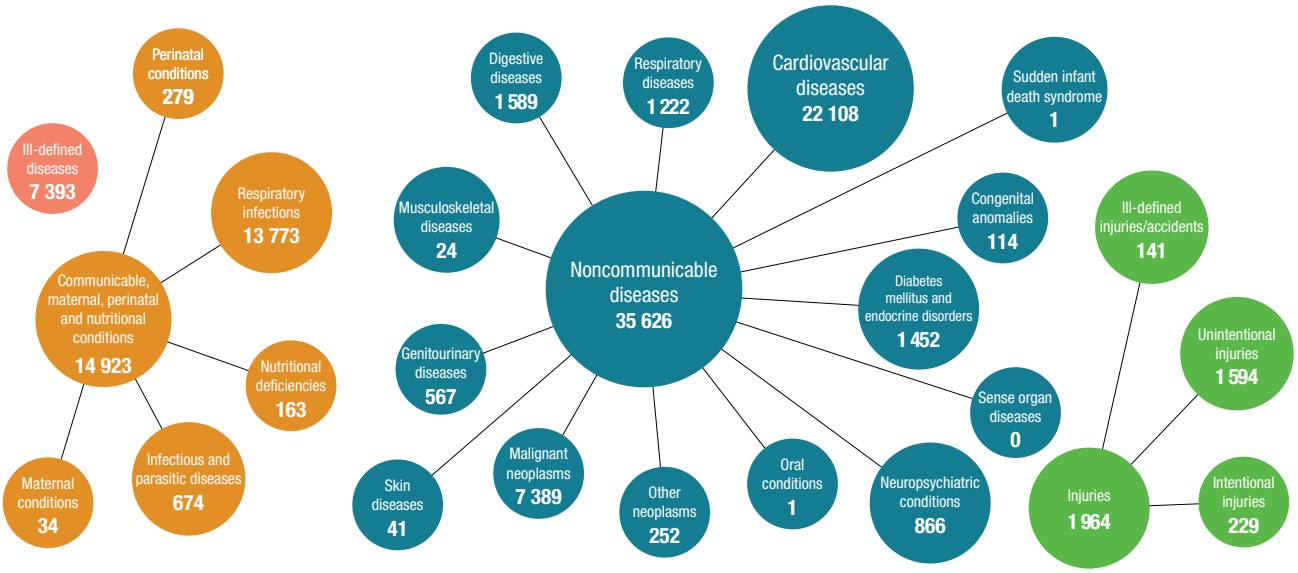
Problems with the collection of mortality data in Georgia mean that, until recently, while most deaths were registered, for more than a quarter of deaths the cause of death was unknown. There were also concerns about the accuracy of the cause of death data being recorded, as many individuals tasked with 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. In 2021, cardiovascular diseases (ischaemic heart disease and particularly stroke) were the main causes of death, followed by respiratory infections and mortality from all cancers **(Fig.11)**.

The COVID-19 pandemic caused substantial excess mortality

In 2019, the age-standardized total mortality rate in Georgia was already very high in international comparison – 964 per 100 000 population compared with 531 in the EU and 668 in the WHO European Region. However, life expectancy at birth declined by 2.3 years for males and 2.9 years for females between 2019 and 2021, most likely due to the direct and indirect effects of the COVID-19 pandemic. Excess mortality – that is, those deaths over and above what would normally be expected in a country over a specific time period – increased in 2020, as it did across the WHO European Region, but in 2021 excess mortality was even more pronounced **(Fig.12)**.

Fig. 11

During the COVID-19 pandemic, respiratory infections overtook cancer as the second most common cause of death

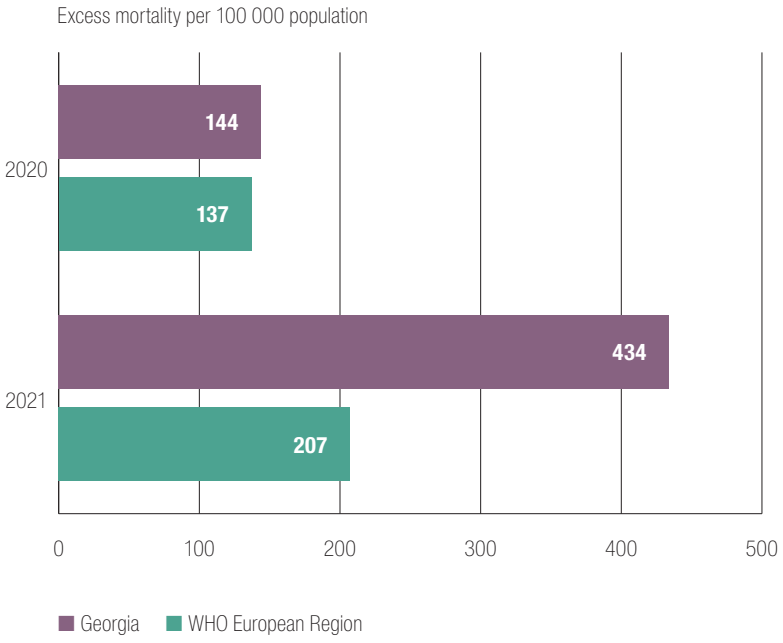


Source: WHO, 2024d.

Note: Overview of the distribution of causes of total deaths grouped by category. Data refer to 2021.

Fig. 12

Excess mortality associated with the COVID-19 pandemic was much higher than in the WHO European Region overall

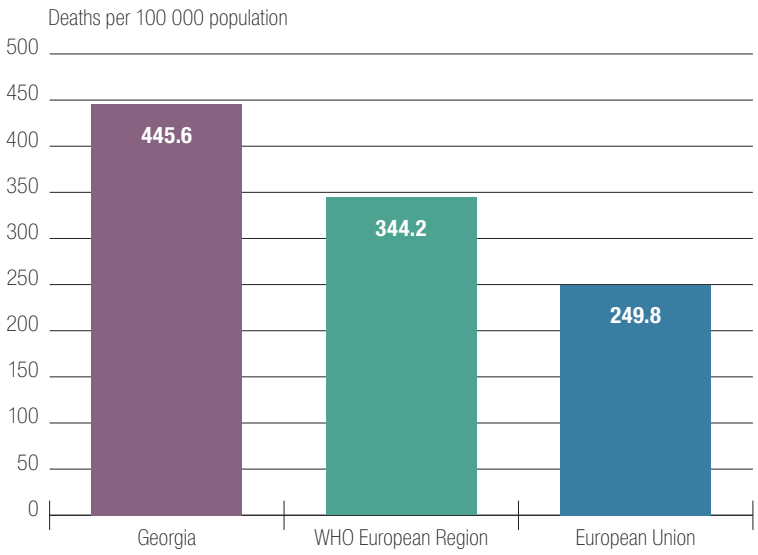


Source: WHO, 2023b.

Note: Excess mortality from all causes of death, defined as the difference between the total number of deaths and the number that would have been expected in the absence of a crisis (for example, the COVID-19 pandemic). This difference is assumed to include deaths attributable directly to COVID-19 as well as deaths indirectly associated with COVID-19 through impacts on health systems and society.

Fig. 13

Premature mortality from NCDs is high



Source: WHO Regional Office for Europe, 2024b.

Notes: Data for 2021 or nearest year (European Union = 2020; WHO European Region = 2019); premature mortality among those aged 30–69 years from four major NCDS (cardiovascular diseases, cancers, diabetes mellitus and chronic respiratory diseases).

Premature mortality from NCDs is a focus for current health policy

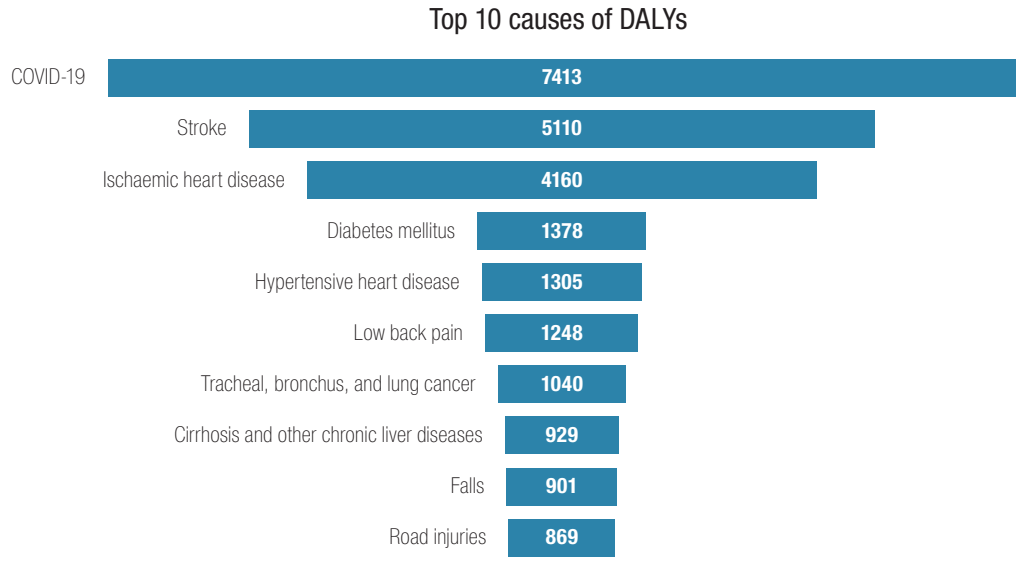
Four major NCDs (cardiovascular diseases, cancers, diabetes mellitus and chronic respiratory diseases) are responsible for most premature deaths (at ages 30–69 years). Overall, the burden of premature mortality from NCDs is so high as to constitute a threat to the country's sustainable development **(Fig.13)**. In response, a new Noncommunicable Disease Strategy is being implemented which aims to reduce premature mortality from these four NCDs by 5% by 2026 and 8% by 2030.

COVID-19 and cardiovascular diseases dominated the disease burden in Georgia in 2021

A disability-adjusted life year (DALY) provides an indicator of the burden of disease in a population, as one DALY corresponds to the loss of one year in full health due to premature mortality and years lived with a disability. The number of years lost due to ill-health, disability or early death in Georgia echoes mortality patterns, with the top causes of DALYs during the pandemic being COVID-19, stroke and ischaemic heart disease, with diabetes following at some distance behind **(Fig.14)**.

Fig. 14

Stroke and ischaemic heart disease constitute by far the greatest noncommunicable disease burden



Source: IHME, 2024.

Note: Top 10 causes of DALYs per 100 000 population for both sexes and all ages. Data refer to 2021.

The leading risk factor affecting health in Georgia is uncontrolled hypertension

A survey conducted in 2016 found that 37.7% of the population had high blood pressure (up from 33.4% in 2010), a factor which considerably increases the risk of stroke if left unmanaged. High systolic blood pressure is the biggest risk factor affecting health status as a proportion of all deaths, accounting for an estimated 25% of all deaths in 2021. Similarly, the number of people living with Type 2 diabetes is also increasing, and dietary risks, high fasting plasma glucose and overweight are important risk factors in Georgia **(Fig.15)**.

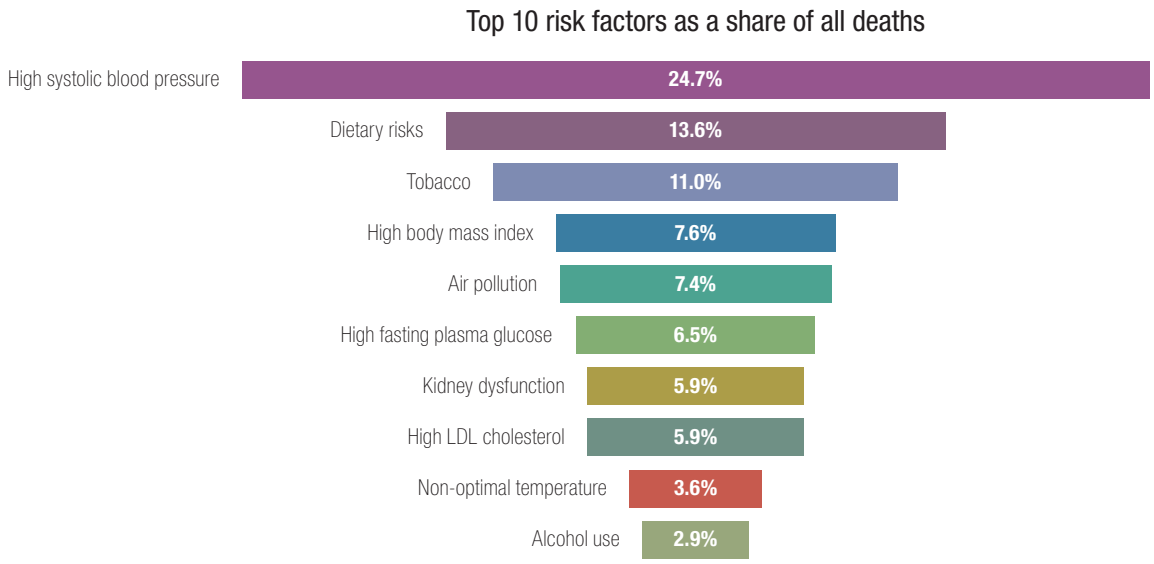
Tobacco use is another important risk factor. Smoking prevalence in 2023 was estimated at 29.2% of all people aged 15 years and above, but there were substantial gender differences. The male smoking rate was the highest in the WHO European Region, at 54.6% of all males aged 15 years and over, whereas the female smoking rate, although increasing to 7% in 2023 (from 5.2% in 2000), was among the lowest **(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 absolute poverty line, and 2023, when this share stood at 11.8% (GEOSTAT, 2024c). However, in rural areas 15.6% of the population were living below the absolute poverty line, while in urban areas it was 9.4% in 2023 (GEOSTAT, 2024c). Poverty is associated with the immediate risk factors (such as unhealthy diet, smoking and reduced access to health services) discussed above, but there is also an association between poverty and exposure to non-optimal temperatures and indoor air pollution. Air pollution, including both outdoor and household air pollution, was estimated to account for 7.4% of all deaths in 2021 **(Box 3)**.

Fig. 15

A quarter of all deaths can be attributed to high systolic blood pressure



Source: IHME, 2024.

Note: Percentage of all deaths attributable to risk factors for both sexes and all ages. Shares overlap and therefore add up to more than 100%. Data refer to 2021.

Box 2

Tobacco control and dietary interventions are key public health actions to address risk factors for NCDs

In 2017 Georgia adopted, and in 2018 began the successful implementation of, new tobacco control legislation, which largely complies with the WHO Framework Convention on Tobacco Control. By 2019, the country had levied and increased taxes on the main tobacco products. As a result of these important steps, pollution with tobacco smoke in public buildings has been reduced by 95% and by 2020 the number of smokers had decreased by approximately 100 000 people. There are early signs of reductions in some tobacco-related diseases, such as respiratory exacerbations, cardiovascular diseases and some forms of stroke. This progress has slowed since 2021 due to the aggressive marketing of new tobacco products by the tobacco industry, the suspension of further tax increases (and even tax decreases for certain tobacco products in 2024) and the weakening of certain areas of legislation. There is a need for stakeholders to intensify their efforts to address emerging challenges and close gaps.

In 2022, with the support of WHO, an investment case for noncommunicable diseases was conducted in Georgia, which determined that the economic impact of the four main noncommunicable diseases costs 6.2% of Georgia's GDP each year. This study found that investing in tobacco control as well as interventions against other risk factors are economically beneficial with a high return on investment, with the salt reduction plan having the highest return.

The MoIDPLHSA and the National Centre for Disease Control and Public Health, in collaboration with WHO, have started intensive work developing policies to reduce salt consumption and promote physical activity. The FEEDCities Study in Tbilisi was conducted to characterize street food content and environment, as well as a 24-hour urine sodium study and measurement of physical activity. A national policy for promoting physical activity has been drafted and submitted to the government for approval. The process of preparing the national strategy for reducing salt consumption is under way.

Box 3

TB remains a challenge, but the situation is improving

The COVID-19 pandemic had a very negative impact on TB services across Europe, but in Georgia the TB case detection rate had already fallen below the 85% coverage rate target in 2019, so the impact was even greater and the TB case detection rate was 68% in 2022. Nevertheless, incidence continued its downward trend (ECDC & WHO Regional Office for Europe, 2024).

Incidence of TB has more than halved since 2009 as a result of concerted policy efforts, from 129 per 100 000 population in 2009 to 59 per 100 000 population in 2022. Georgia is 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 multidrug-resistant TB (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 patients with multidrug-resistant disease. New anti-TB drugs are available under a national programme, accompanied by a new drug-safety monitoring system. A remote version of directly observed treatment (DOTS) was successfully piloted in Tbilisi using video links (VOT) to improve geographical access and adherence to treatment. Effective treatment coverage is not as high as it has been previously **(Fig.9)**, and the effective treatment rate was 87% in 2022, below the target rate of 90% (ECDC & WHO Regional Office for Europe, 2024).

5 SPOTLIGHT ON HEALTH WORKFORCE TRENDS

The health workforce in Georgia is growing and the ratio of doctors to nurses is stable

Overall, the health workforce expanded significantly between 2013 and 2022 **(Fig.16)**. Some of the growth in the numbers of doctors and nurses per capita may be due to changes in the denominator: that is, a declining population size rather than an expansion of health workforce numbers. Georgia has consistently had a large number of doctors per capita in international comparison (561 per 100 000 population in 2022 compared with 387 on average for the WHO European Region), although the rate has fluctuated widely, peaking at 756 per 100 000 population in 2018. The growth in the number of nurses has fluctuated less and the growth has been much steadier, but the overall numbers remain consistently small in international comparison (588 per 100 000 population in 2022 compared with 784 on average for the WHO European Region).

The share of generalist medical practitioners is growing but remains low

The large number of doctors per capita in Georgia masks challenging imbalances in the distribution of doctors by speciality. There are very few doctors who are generalist medical practitioners and although the proportion is increasing, from 19.4% in 2012 to 20.7% in 2021 **(Fig.17)**, it has not kept pace with demand. This can be seen as concerning for the sustainability of primary care in Georgia.

More than a third of the health workforce in Georgia will reach their retirement age in the next decade

The health workforce is following the same demographic trends as the wider Georgian population, in that it is both ageing and impacted by outmigration. In 2021, 38.9% of doctors in Georgia were aged 55 years or over and 37.9% of nurses were aged 55 years or over **(Fig.18)**. While trend data are not available for Georgia, these proportions for 2021 are very high in international comparison – most other countries in the WHO European Region have a younger health workforce – and highlight a potential problem over the next decade, as over a third of the workforce is due to retire. Demographic change means there is a shortage of graduating young medical and nursing students to replace them. Three quarters of doctors in Georgia are women (74% in 2021), as are all nurses, midwives and pharmacists, according to WHO data sources.

Wider emigration trends particularly affect the health workforce

Of the whole Georgian population, 18% expressed the intention to emigrate permanently between 2010 and 2019 and about 50% of the Georgian population intended to emigrate temporarily for work (OECD, 2022). Such migration pressures also apply to the health workforce. The health sector and other highly skilled occupations are most affected by emigration (OECD & CRRC – Georgia, 2017). In 2015/16, the number of emigrants who left the health sector equated to 16% of the number of health workers remaining (OECD & CRRC – Georgia, 2017).

Fig. 16

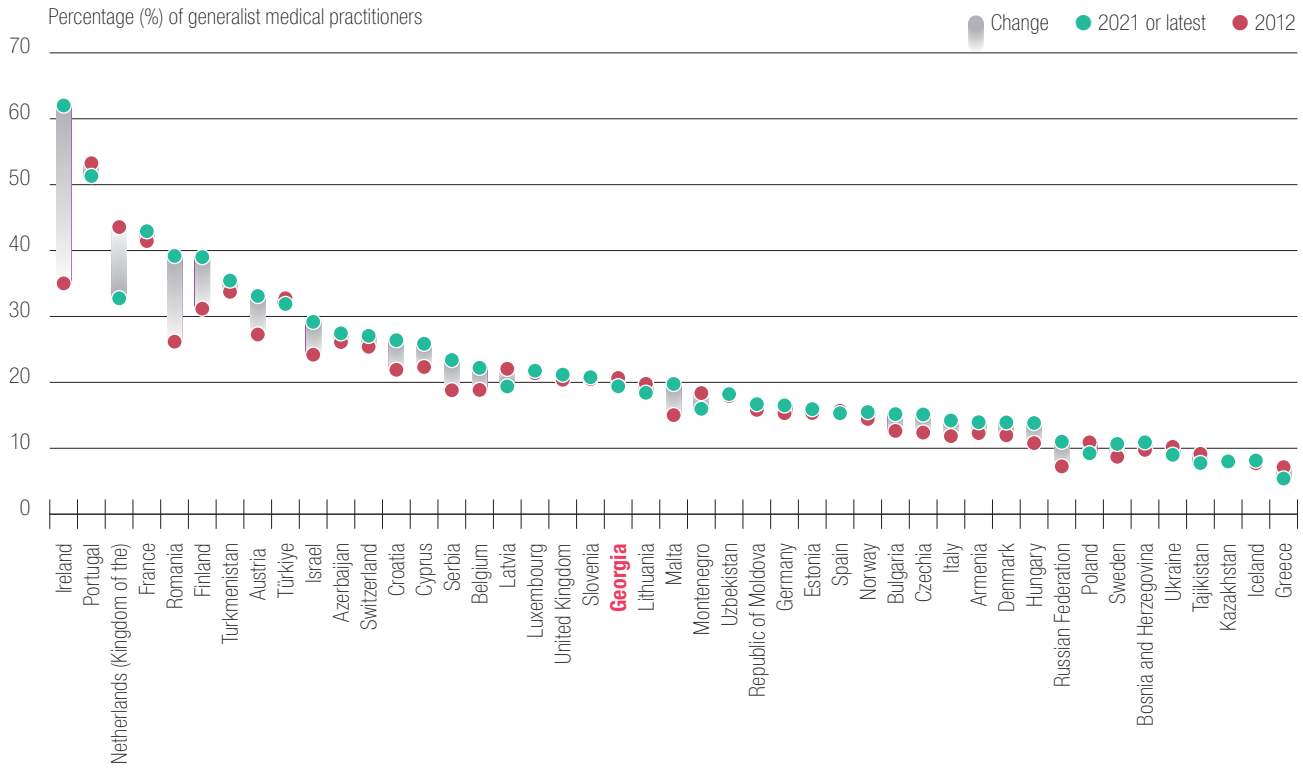
The number of doctors and nurses per 100 000 population has grown in the last decade

Source: WHO, 2024c.

Note: The number of nurses plotted for Austria has to be treated with caution, due to breaks in the time series and switching between "licensed to practise" and "practising" workforce numbers.

Fig. 17

The percentage of doctors who are generalist medical practitioners in Georgia is low

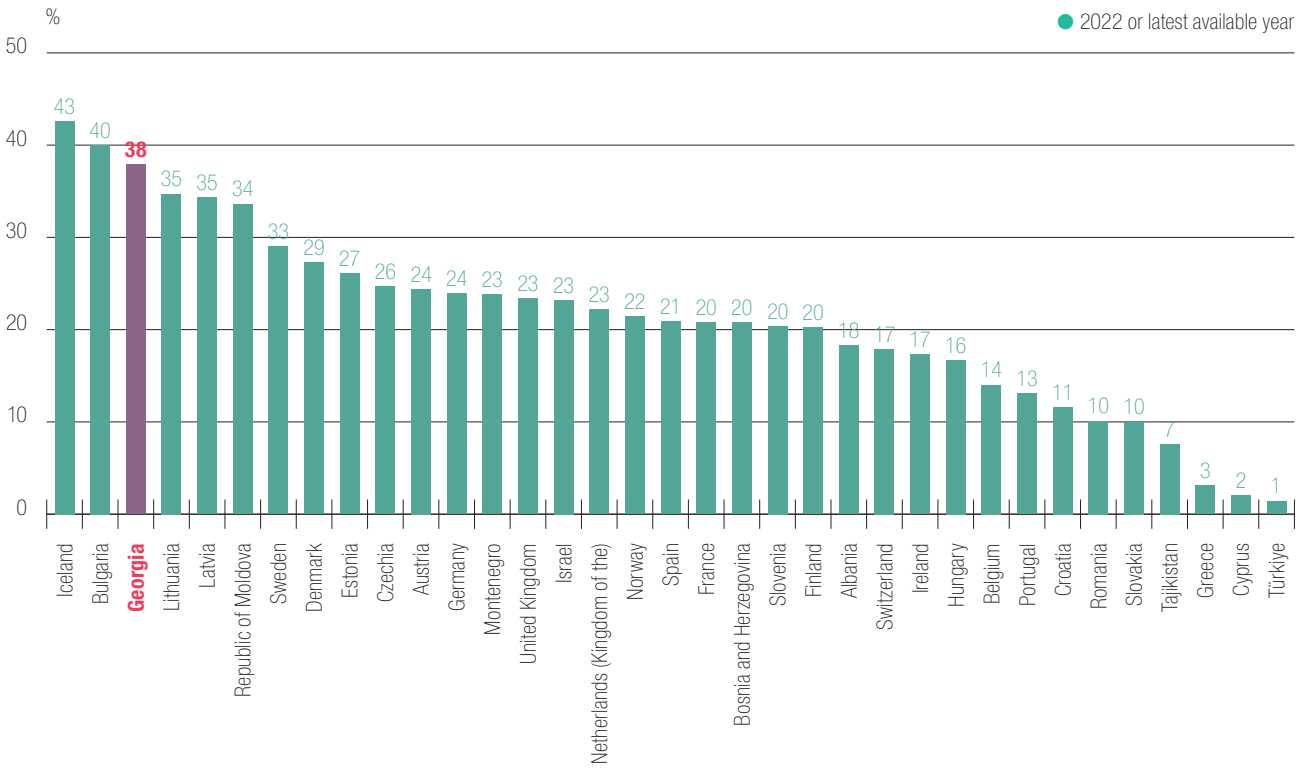


Source: WHO Regional Office for Europe, 2024c.

Note: Generalist medical practitioners (ISCO-08 code: 2211) are physicians who do not limit their practice to certain disease categories or methods of treatment and may assume responsibility for the provision of continuing and comprehensive medical care to individuals, families and communities. They include general practitioners, district medical doctors, therapists, family medical practitioners, primary health care physicians, medical doctors (general), medical officers (general) and medical interns or residents specializing in general practice or without any area of specialization yet. Although in some countries "general practice" and "family medicine" may be considered as medical specializations, these occupations are also classified here. The data for Ireland should be treated with caution due to a break in series.

Fig. 18

Georgia has a very high proportion of nurses aged 55 years and over



Source: WHO, 2024c.

6 EUROPEAN PROGRAMME OF WORK (EPW)

Moving towards universal health coverage (UHC)

Georgia has made major progress in recent years in moving towards UHC. WHO supports these efforts by providing technical assistance to advance primary care reform as a vehicle towards UHC. WHO will support revising the central procurement system for essential medicines and medical devices to improve access to high-quality essential medicines, and helping to ensure sustainable health financing. Other priorities include improving the quality of care and patient safety at all levels of health service provision.

Protecting against health emergencies

The COVID-19 pandemic highlighted areas of Georgia's health emergency architecture that require support. WHO technical support is therefore planned to strengthen health emergency preparedness and response capacities based on the all-hazard approach and in accordance with the International Health Regulations (2005). The national epidemiological surveillance system and emergency response capacities will be strengthened in parallel. WHO has already provided technical support to train epidemiologists involved in surveillance and to train laboratory staff to improve detection capacities, and support risk communication and community engagement efforts.

Promoting health and wellbeing

WHO is assisting Georgia in its efforts to reduce the burden of NCDs through strengthened prevention and control and improved access to mental health services. WHO has conducted a policy audit of the national health promotion programme and supported development of a national action plan for physical activity and is committed to strengthening effective and comprehensive cancer control policies and services. The area of environment and health has also become a priority for collaboration between WHO and the Georgian authorities. Air pollution is a major problem in Georgia, as legislation and implementation of existing regulations is weak, and air monitoring centres are underdeveloped.

COUNTRY DATA SUMMARY

	Georgia	WHO European Region	European Union
Life expectancy at birth, both sexes combined (years)	73.7 [a] (2022)	78.2 [a]	79.9 [a]
Estimated maternal mortality per 100 000 live births (2020)	27.6	12.6	6.4
Estimated infant mortality per 1 000 live births (2021)	8.4	6.3	3.2
Population size, in millions (2022)	3.7	929.1	512.7
GDP per capita, PPP$ (2021)	16 997	38 936	48 615
Poverty rate at national poverty lines, % of population	15.6 [b] (2022)	14.9 (2018)	17.0 (2018)

Sources: WHO Regional Office for Europe, 2024b;

[a] Eurostat, 2024, for EU/EEA countries, Albania, Montenegro, North Macedonia, Serbia, Armenia, Azerbaijan, Georgia and Türkiye; [b] World Bank, 2024.

Note: Life expectancy averages refer to latest available years.

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WHO Regional Office for Europe

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.

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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

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.

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