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GEORGIA
Health Systems in Action

Georgia
The Health Systems in Action series

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- provide core information and data on health systems succinctly and accessibly
- outline the country health system context in which WHO’s European 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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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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<table>
<thead>
<tr>
<th>Contents</th>
<th>page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  ORGANIZING THE HEALTH SYSTEM</td>
<td>8</td>
</tr>
<tr>
<td>2  FINANCING AND ENSURING FINANCIAL PROTECTION</td>
<td>9</td>
</tr>
<tr>
<td>3  GENERATING RESOURCES, PROVIDING SERVICES AND ENSURING ACCESS</td>
<td>10</td>
</tr>
<tr>
<td>4  IMPROVING THE HEALTH OF THE POPULATION</td>
<td>14</td>
</tr>
<tr>
<td>5  SPOTLIGHT ON ANTIMICROBIAL RESISTANCE</td>
<td>18</td>
</tr>
<tr>
<td>6  EUROPEAN PROGRAMME OF WORK (EPW)</td>
<td>19</td>
</tr>
</tbody>
</table>
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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

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 2.7% of gross domestic product in 2019), it has increased as coverage has expanded and out-of-pocket spending on health has fallen considerably.

- However, the 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.

- Access to essential services has improved, especially for HIV, multidrug-resistant tuberculosis and hepatitis C (HepC). Georgia has a well-developed HepC elimination programme, with up to 75% of the adult population screened as of May 2022; active HepC infections have been reduced by 67%.

- Communicable disease control is a longstanding priority and Georgia has achieved high coverage rates for routine childhood vaccinations, although these have been disrupted by the COVID-19 pandemic.

- There is a large gap between male and female life expectancy (8.6 years in 2019).

- The male smoking rate was the highest in Europe in 2020, 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.

- Excess mortality due to COVID-19 far exceeded the WHO European Region average.

- Tackling antimicrobial resistance is a political priority, with both monitoring and regulation improving since 2017.
1 ORGANIZING THE HEALTH SYSTEM

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 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, chemotherapy, hormone therapy, 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 Social Services Agency. A new National Health Agency 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 2021 the UHCP provided 94.3% 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 had no form of coverage (UHCP or private health insurance). The highest income households (around 1% of the population; defined as households earning over Georgian Lari (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 are income-based for those who do not have private insurance. There are also 22 vertical national health programmes, which cover the whole population for specific diseases or treatments; they 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) receive 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).

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 (MoDPLHSA) 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 (see below). 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.
Health Systems in Action: Georgia

2 FINANCING AND ENSURING FINANCIAL PROTECTION

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

Through most of the 2000s public spending as a share of gross domestic product (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 of 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 (see Fig. 1).

In 2019, public expenditure on health as a share of GDP was 2.7%, still below the averages for upper middle-income countries (3.4%), the WHO European Region (5%) and the European Union (EU) (6%).

Average health expenditure per capita in the WHO European Region in 2019 was US$ 3,225 when adjusted for purchasing power. In Georgia it was US$ 970, lower than the average for upper middle-income countries in the WHO European Region (see Fig. 2).

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

Public spending on health in Georgia accounted for 41% of current health expenditure in 2019, an increase from 19% in 2012, before the UHCP was introduced. 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 46.8% in 2019 (see Fig. 3). 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 4.5% of current health spending in 2019. 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 9.4% in 2019, as has pressure to contain costs (see Box 1).

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 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. 4).

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Fig. 1
Public spending on health as a share of GDP has increased, but is still low

Fig. 2
Health spending per capita in Georgia is low
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. 5), but numbers have increased in recent years across the country. In 2020, there were 499 hospital beds per 100,000 population (NCDC, 2021a). 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, tuberculosis (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 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

### 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. There is renewed focus on referral and encouraging the utilization of primary care services instead of specialist care with the launch of primary health care 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 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 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.
state on a fixed salary. Rural ambulatories are owned by the local government or the state-owned company that is accountable to the 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 and magnetic resonance imaging 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 information technology systems in the health sector has been a priority for the MoIDPLHSA, particularly for strengthening service purchasing through the Social Services Agency.

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 reported. Since 2006 Georgia has consistently reported a large number of active doctors per capita, and reported density has increased to 511 per 100 000 population in 2020 (Fig.6).

There are three times as many reported doctors in Tbilisi as in other regions. Recruiting and retaining staff to work in remote and rural facilities is a significant challenge. The current situation regarding the health workforce stock shows a mismatch between demand and supply.

The number of nurses working in the Georgian health system has been on the rise since 2013, but it remains low in comparison to other countries in the region, at just 555 per 100 000 population in 2020. Most health staff work in inpatient facilities — in 2019 this included 52% of all physicians and 71% of all nurses and midwives.
High out-of-pocket payments are the most significant barrier to accessing care

By far the greatest barriers to accessing care in Georgia are financial and these are being addressed by efforts to improve universal health coverage. 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 almost doubled, from 2.1 visits per capita in 2012 to 4.0 in 2019.

Findings from the latest health, utilization and expenditure survey show that 82% of people consulted health care providers when ill in 2017 compared with 75% in 2010 and 79% in 2014. Reductions in unmet need were particularly strong for those income groups that were uninsured before 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 because of 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 almost GEL 24 million in 2020. The vaccination schedule was expanded to include pneumococcal vaccination from 2013, Rotavirus vaccination from 2014 and the roll-out of human papillomavirus vaccination nationally in 2019. Immunization coverage rates for routine childhood vaccinations were high in 2019, with 99.8% of infants receiving the first dose of vaccine against measles, mumps and rubella, and 97.3% receiving the second (compared with 91% in the WHO European Region). Coverage in Georgia fell to 91% in 2020 as a result of the coronavirus disease 2019 (COVID-19) pandemic. However, following a few measles outbreaks in Georgia resulting from previous weaknesses in the immunization programme that left some cohorts insufficiently immunized, strict monitoring and catch-up immunization campaigns are in place for any under-vaccinated cohorts. 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.

Communicable disease control more broadly became a political priority even before the COVID-19 pandemic. Georgia had a high prevalence of hepatitis C (HepC) infection in 2015, with an estimated 7.7% of the adult population living with HepC (Richardson & Berdzuli, 2017). An innovative HepC programme was rolled out that sought to radically reduce prevalence through mass screening and universal access to treatment. Over 70% of the adult population (2.3 million people) were screened for HepC and by December 2020, 72,811 patients had been enrolled in hepatitis C virus treatment with 98.9% treatment effectiveness. According to the second nationwide serosurvey conducted in 2021, the elimination programme has contributed to a 67% reduction in active hepatitis C virus infection. Nevertheless, in 2019, 8,671 new HepC cases were registered, of which 749 were children (NCDC, 2020). A new ambitious HepC elimination strategy covers the period 2021–2025.

**Georgia has a “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 target set by Joint United Nations Programme on HIV/AIDS (UNAIDS) for 2025, 65% of people who knew their status were estimated to be on antiretroviral medication in 2020 and of these an estimated 65% had achieved virus suppression (Fig.8). 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. However, the country did not yet meet the UNAIDS target of ensuring that 95% 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

The UHC service coverage index – a global indicator that monitors progress towards Sustainable Development Goal 3 target 3.8.1 on coverage of essential health services – increased from 45 (out of 100) in 2000 to 65 (out of 100) in 2019, although this was still below the average of the WHO European Region (Fig. 9). 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).

IMPROVING THE HEALTH OF THE POPULATION

There is a large gap between male and female life expectancy

Before 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. 10). 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, whereas the gap in the WHO European Region as a whole has 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).
Although the infant mortality rate has improved dramatically, the maternal mortality rate remains comparatively high.

According to WHO estimates, the infant mortality rate per 1,000 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 per 1,000 live births in 2018), compared with 2000 when it was nearly double the average (17.1 deaths per 1,000 live births).

According to United Nations estimates, 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 per 100,000 live births in 2017). In 2000 there were an estimated 31 maternal deaths per 100,000 live births, but the maternal mortality rate peaked at 43 per 100,000 live births in 2009. Although 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.

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**Fig. 9**

Access to essential services has improved but shows signs of stagnation in recent years.

*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, 2022c.

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**Fig. 10**

Life expectancy at birth in Georgia remains comparatively low.

*Note:* Data are for 2019 or latest available year (shown in brackets). No data for 2000 for Türkiye and Bosnia and Herzegovina; data for Georgia for 2000 not shown, as only marginally lower than in 2019. CIS: Commonwealth of Independent States; SEE: South-Eastern European countries.

*Source:* WHO, 2022b.
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 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. 11).

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. 12). 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. It is the biggest risk factor affecting health status as a proportion of all deaths. Similarly, the number of people living with type 2 diabetes is also increasing, and dietary risks, high fasting plasma glucose and overweight are also important risk factors in Georgia (Fig. 13).

The leading behavioural risk factors are tobacco and alcohol consumption as well as unhealthy diets. Smoking prevalence in 2020 was estimated at 31.7% 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 56.3% of all males aged over 15 years, whereas the female smoking rate, at 7.1%, was among the lowest (WHO, 2022b). The country has recognized the importance of strengthening tobacco control measures (see 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 summary). 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 9.7% of all deaths in 2019. Tuberculosis is another persistent challenge (Box 3).

The COVID-19 pandemic has increased mortality

Many countries in Europe had very high mortality rates in 2020 because of the COVID-19 pandemic. The pattern is somewhat different in Georgia where excess mortality peaked in 2021, far exceeding the average of the WHO European Region (Fig. 14).

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 new 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 from December 2022. Compliance with the smoke-free policy is over 97% in cafes 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, by 2020, smoking prevalence had decreased by 10%, consumption of tobacco among smokers dropped by 15% and tobacco-related air pollution decreased by 90% in public places.

Sources: WHO, 2018; NCDC, 2021b; FCTC Monitoring and Implementation Centre in Georgia, 2021.

Fig. 13
High blood pressure is the leading risk factor for mortality

<table>
<thead>
<tr>
<th>Top 10 risk factors as a share of all deaths</th>
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<tbody>
<tr>
<td>High systolic blood pressure</td>
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<tr>
<td>Dietary risks</td>
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<tr>
<td>High fasting plasma glucose</td>
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<tr>
<td>High body mass index</td>
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<tr>
<td>Tobacco</td>
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<tr>
<td>High LDL cholesterol</td>
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<tr>
<td>Air pollution</td>
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<tr>
<td>Kidney dysfunction</td>
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<tr>
<td>Non-optimal temperature</td>
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<tr>
<td>Alcohol use</td>
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Note: Shares overlap and therefore add up to more than 100%.

5 SPOTLIGHT ON ANTIMICROBIAL RESISTANCE

Georgia has one of the higher antibiotic consumption rates in Europe

Georgia has implemented national surveillance of antimicrobial medicine consumption and monitors it using import records provided by the drug agency. However, data on local products sold in pharmacies are not included in the surveillance, and total antibiotic consumption is likely to be underestimated. In 2018, there was a higher share of antibiotics that should only be used for a specific, limited number of indications, classified as Watch group under the WHO AWaRe classification for antibiotics. Georgia did not meet the WHO national monitoring target of at least 60% of total antibacterial consumption being from the “Access” category in 2018 (Fig. 15), indicating that stronger antimicrobial stewardship efforts are still needed.

Rates of antimicrobial resistance in Georgia are above the EU/EEA average

Georgia joined the Central Asian and European Surveillance of AMR (CAESAR) Network in 2015 and was the first country to participate in the Proof-of-Principle project. The Proof-of-Principle project was developed for countries with limited routine collection of clinical samples in order to strengthen coordination, laboratory capacity, data management and analysis. Previously, routine monitoring for AMR was not conducted, but by 2021, a network of 25 laboratories were able to provide services to around 200 general hospitals covering 70% of the Georgian population (Malania et al., 2021). In 2020, the proportion of bloodstream infections due to methicillin-resistant Staphylococcus aureus in Georgia was 16.2%, while the EU/EEA average was 15.7% (Fig. 16). However, patient and isolate representativeness is poor, and blood culture diagnostics (which forms the basis of routine AMR surveillance) is underused, limiting the quality of Georgian AMR surveillance data.

Box 3
Tuberculosis is a serious public health issue, but the situation is improving

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 58 per 100 000 population 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 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 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 national data put the effective treatment rate at 83% in 2019 (NCDC, 2020).
High-level commitment to combatting AMR has strengthened monitoring, but gaps in regulating the prescription and sale of antibiotics remain

Based on the most recent TrACSS survey (2020–2021), human and animal health authorities work together on activities to counteract AMR, in line with a One Health multi-sectoral approach. The National Action Plan on AMR was passed in 2017, and it is being implemented. However, there are weaknesses in the regulatory environment. There are no laws or regulations on the prescription and sale of antimicrobials for animal use, although their use for growth promotion in agriculture is banned. However, although there are laws and regulations in place for the prescription and sale of antimicrobials for human use, most antibiotics can still be purchased over the counter without a prescription (see also Box 1).

Guidelines for optimizing antimicrobial use in human health are available, but not always implemented.

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 MoIDPLHSA, 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.

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. 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). The area of environment and health has also become a priority for 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), revision of the regulatory framework on Water, Sanitation and Health (WASH) in health care facilities, and adapting survey instruments to the local context. In 2021 a national network of healthy cities was 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.

Notes: EEA, European Economic Area. Percentage of bloodstream infections due to methicillin-resistant *Staphylococcus aureus* among patients with symptoms of bloodstream infections who have growth of *S. aureus* in tested blood samples. Data refer to 2020.

Sources: European Centre for Disease Prevention and Control, WHO Regional Office for Europe.
COUNTRY DATA SUMMARY

<table>
<thead>
<tr>
<th></th>
<th>Georgia</th>
<th>WHO European Region</th>
<th>EU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth,</td>
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<tr>
<td>Estimated maternal</td>
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<tr>
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<tr>
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<tr>
<td>Estimated infant mortality</td>
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<td>per 1 000 live births (2019)</td>
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<td>36 729</td>
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<tr>
<td>Poverty rate at national</td>
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<td>17.0</td>
</tr>
</tbody>
</table>

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

Source: WHO, 2022b.

References


FCTC Monitoring and Implementation Center in Georgia (2021). Evaluating health and economic impact of tobacco control law in Georgia. Tbilisi: FCTC Monitoring and Implementation Center in Georgia.


Notes:
- **Georgia**
  - Estimated maternal mortality: 25.0 (2017)
  - Estimated infant mortality: 8.5 (2019)

**WHO European Region**
- Life expectancy at birth: 78.3 (2017), 80.9 (2018)
- Estimated maternal mortality: 12.7 (2017)
- Estimated infant mortality: 7.0 (2019)
- Poverty rate: 14.9 (2019), 17.0 (2018)

**EU**
- Life expectancy at birth: 80.9 (2018)
- Estimated infant mortality: 3.4 (2018)
- GDP per capita: 44 421 (2018)
- Poverty rate: 17.0 (2018)

Latest year for which data are available shown in brackets.

Source: WHO, 2022b.


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.

European Programme of Work ‘United Action for Better Health in Europe’

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 policymakers, 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.