



Georgia

Highlights on Health and Well-being



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Abstract

Highlights on health and well-being give an overview of a country's health status, describing data on mortality, morbidity and exposure to key risk factors, along with trends over time. They are developed in collaboration with WHO European Member States. When possible, each report also compares a country to a reference group, which in this report is the whole WHO European Region and the Commonwealth of Independent States. To make the comparisons as valid as possible, data as a rule are taken from one source to ensure that they have been harmonized in a reasonably consistent way. Whenever possible, the data in the report are drawn from the European Health for All database of the WHO Regional Office for Europe. These data are collected from Member States on an annual basis and include metadata that specify the original source of data for specific indicators.

Keywords

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Contents

Acknowledgements.....	iv
Overview.....	v
Introduction.....	1
Health 2020	1
Highlights on health in Georgia	4
Demographic trends and economic indicators.....	4
Life expectancy: adding years to life and life to years.....	4
Challenges across the life-course.....	6
Leading causes of death.....	6
Maternal and infant mortality	7
Morbidity.....	8
Reorientation towards prevention: risk factors and determinants of health.....	10
Health system	11
Conclusions	13
References	15

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Overview

Key messages

- Universal health-care reform in Georgia has improved access to health services and reduced financial barriers and out-of-pocket costs for the population.
- The maternal mortality rate is high, and infant (including neonatal) mortality also remains a challenge.
- The largest burden of disease in Georgia is related to noncommunicable diseases, including circulatory diseases, cancer, diabetes and respiratory diseases.
- Georgia faces ongoing challenges in the form of high levels of communicable diseases, with an increasing incidence of HIV and a high incidence of tuberculosis, including multidrug-resistant tuberculosis.
- Georgia has used new technologies for electronic data capture and exchange to improve case registration and coverage and quality of information on the existing burden of disease in the country.
- Georgia should address:
 - the need for sustainable financing of government health programmes and further reductions in out-of-pocket costs for the population;
 - the rising rates of communicable and noncommunicable diseases in the population;
 - the high maternal mortality rate, as well as the infant (including neonatal) mortality rate;
 - the large proportion of ill-defined causes of death in the civil registration and vital statistics system; and
 - the high level of tobacco smoking among Georgian males.

Georgia has made progress in improving the health of its population, particularly over the past decade. The country adopted a number of state-based reforms in the health sector to ensure universal access to high-quality medical services, to improve the primary health care system and to decrease the financial risks to the population posed by high out-of-pocket expenditures on health.

In April 2015, Georgia adopted its long-term strategy on hepatitis C for 2016–2020. The strategy includes actions to raise awareness about the disease, and programmes on disease surveillance, prevention, screening, diagnostics and treatment. Georgia also has a national health promotion strategy that includes tobacco control measures.

In recent years, the country introduced new technologies for electronic data capture and exchange within several components of the health information system to improve case registration. It also established several new registries to provide better information about the existing burden of disease.

In spite of the progress made in a number of indicators, however, some challenges remain in the areas of communicable and noncommunicable diseases, well-being and the social determinants of health (Gini coefficient and unemployment rates).

When observing the country's health trends in recent years, several key factors must be taken into consideration: (a) the country's reform of health care service delivery; (b) the change in population size recorded in its 2014 census; and (c) improvements in the coverage of case and death registrations and quality of data in the health information system.

Introduction

This highlight summarizes the more detailed *Georgia. Profile of health and well-being (1)*. It shows how the country is progressing towards the shared health goals set out in Health 2020, the health policy of the WHO European Region, and describes some specific features of Georgian health and health policy. Whenever possible and unless stated otherwise, the data in the report are drawn from the European Health for All database (HFA-DB) of the WHO Regional Office for Europe (2).

Health 2020

We are all challenged ... with the task of making sense of and integrating the many different actors and sectoral services ... needed to keep ourselves, our families and our populations healthy and happy.

Dr Zsuzsanna Jakab,

WHO Regional Director for Europe – in her forward to
Health 2020: the European policy for health
and well-being (3)

Health 2020 aims to support action across government and society to significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality (3). Member States in the WHO European Region have agreed on a set of core indicators to monitor progress towards the Health 2020 policy targets both nationally and regionally (4).

Georgia has made progress in a number of the 19 core Health 2020 indicators (Table 1). It has succeeded in improving life expectancy at birth, in reducing premature mortality from the four main noncommunicable diseases (NCDs) among people aged 30–69 years, and in maintaining high levels of child immunization against measles and rubella. While Georgia has achieved considerable reductions in infant mortality, however, its rate remains higher than that for the WHO European Region as a whole.

Well-being measurements show that the country faces additional challenges. Data from the Gallup World Poll for 2014 give Georgia an overall life satisfaction index of 4.3 on a scale from zero (least satisfied) to 10 (most satisfied); this is lower than the average for the WHO European Region (5.9) (5).

Among Georgians aged 50 years and above, 43% reported in 2013 that they had relatives or friends on whom they could count when in trouble. This was much lower than the average for the WHO European Region (86%).

By 2013, Georgia had successfully reduced the proportion of children of official primary school age not enrolled to 3.3%.

The country's measure of income inequality (Gini coefficient) has remained steady since 2000, and was 40.0 in 2013. This was higher than the averages for the WHO European Region (33.4) and the Commonwealth of Independent States (CIS) (35.1, in 2012). Georgia's unemployment and Gini coefficient rates remain steady, reflecting little change in the objective well-being measures of the population.

In 2015, Georgia began the process of target-setting in the health sector. It focused on the alignment of national health services with Health 2020 targets, and the subsequent development of an implementation plan and an accountability mechanism in accordance with the recommendations of the Health 2020 policy framework. Policy-makers defined a national set of indicators to monitor progress towards the Health 2020 targets. The document has, however, not yet been formally adopted.

Table 1. Core indicators for monitoring Health 2020 policy targets, Georgia, most recent years available

Target	Indicator	Value			Year
		Male	Female	Total	
1. Reduce premature mortality^a	Premature mortality rate from cardiovascular disease, cancer, diabetes mellitus and chronic respiratory diseases among people aged 30 to under 70 years (age-standardized)	618.9	262.9	422.3	2014
	Prevalence of tobacco use among adults aged 15 years and over (age-standardized) ^b	58.5	5.8	30.0	2013
	Pure alcohol consumption per capita among adults aged 15 years and over (recorded data)	–	–	6.1	2014
	Prevalence of overweight and obese (body mass index ≥ 25) adults aged 18 years and over (age-standardized estimate)	54.0	56.0	55.0	2014
	Mortality rate from external causes of injury and poisoning, all ages (age-standardized)	76.0	21.0	46.0	2014
2. Increase life expectancy	Life expectancy at birth, in years	68.8	77.3	73.1	2014
3. Reduce inequities^c	Infant deaths per 1000 live births	10.1	8.9	9.5	2014
	Proportion of children of official primary school age not enrolled (net enrollment rate)	3.8	2.7	3.3	2013
	Unemployment rate (percentage)	–	–	12.4	2014
	National policy addressing reduction of health inequities established and documented	NA	NA	Yes, but only partially	2016
	Gini coefficient	NA	NA	40.0	2013
4. Enhance well-being^d	Overall life satisfaction among adults aged 15 years and over (5)	NA	NA	4.3	2014
	Availability of social support among adults aged 50 years and over (6)	–	–	43.0	2013
	Percentage of population with improved sanitation facilities	–	–	86.3	2015
5. Ensure universal coverage and “right to health”	Private household out-of-pocket expenditure as proportion of total health expenditure	NA	NA	58.6	2014
	Percentage of children vaccinated against measles (1 dose)	–	–	96.0	2015
	Percentage of children vaccinated against poliomyelitis (3 doses)	–	–	89.0	2015
	Percentage of children vaccinated against rubella (1 dose)	–	–	96.0	2015
	Total health expenditure as a percentage of gross domestic product	NA	NA	7.4	2014
6. Set national targets	Establishment of process for target-setting documented	NA	NA	Yes	2016
	Evidence documenting:				
	(a) national health strategy aligned with Health 2020	NA	NA	Yes	2016
	(b) implementation plan	NA	NA	No	2016
	(c) accountability mechanism	NA	NA	Yes, but only partially	2016

NA: not applicable.

^a Health 2020 target 1 includes percentage of children vaccinated against measles (1 dose), poliomyelitis (3 doses) and rubella (1 dose).^b Prevalence includes both daily and occasional (less than daily) use among adults ages 15 years and over.^c Target 3 includes life expectancy at birth.^d Target 4 includes Gini coefficient, the unemployment rate and the proportion of children not enrolled in primary school.

Source: HFA-DB (2) unless otherwise specified.

Highlights on health in Georgia

Demographic trends and economic indicators

The WHO European Region as a whole is facing a number of demographic and health challenges, including an ageing population and a declining birth rate. The population structure of Georgia reflects for the most part those of the WHO European Region and the CIS. People are living longer and fewer infants are dying in the first year of life. The 2014 census recorded that there was a slightly higher proportion of people living in Georgia's urban areas (57.4% in 2014) compared to a decade ago (7).

According to data from the HFA-DB, Georgia maintained stable economic growth over the last decade. The gross domestic product (GDP), expressed in US\$ per capita, grew to US\$ 3796 in 2015.

Life expectancy: adding years to life and life to years

Life expectancy at birth is defined as the average number of years that a newborn infant would live if prevailing patterns of mortality at the time of birth were to continue throughout his or her life.

Georgia has had one of the highest rates of life expectancy compared to the countries of the CIS. While life expectancy at birth has been increasing, a sharp drop was observed in 2014 due to the decrease in population size as measured by the 2014 census (7). This means that the life expectancy estimate for prior years, calculated with the higher population figures recorded in the 2002 census, had produced higher life expectancy estimates.

The marked difference between 2014 and preceding years appears in all life expectancy-related indicators. In 2014, life expectancy at birth in Georgia was 68.8 years for males and 77.3 years for females (Figs. 1, 2). This was higher than the average for the CIS (66.4 years for males and 76.0 years for females) but lower than that for the WHO European Region (74.2 years for males and 80.8 years for females, in 2013). The difference in life expectancy between females and males was 8.5 years in favour of females, which was larger than the difference in the WHO European Region (6.7 years), but smaller than that in the CIS (9.7 years).

The lower population size registered by the 2014 census influenced the calculations of the main health and demographic indicators for that year. After the National Statistics Office of Georgia recalculates the population for the intercensus period (between 2002 and 2014), the sharp changes in the values for these indicators between 2013 and 2014 will be corrected (8).

Fig. 1. Life expectancy at birth for males, Georgia, WHO European Region and CIS, 1985–2014

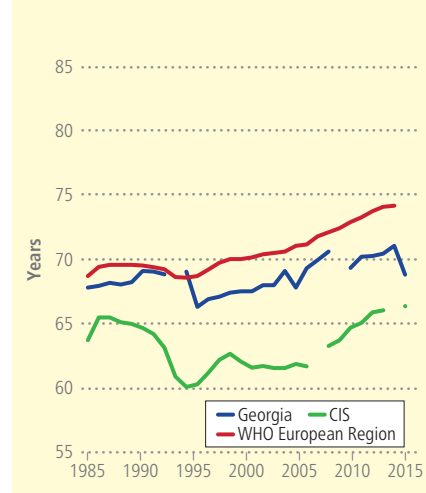
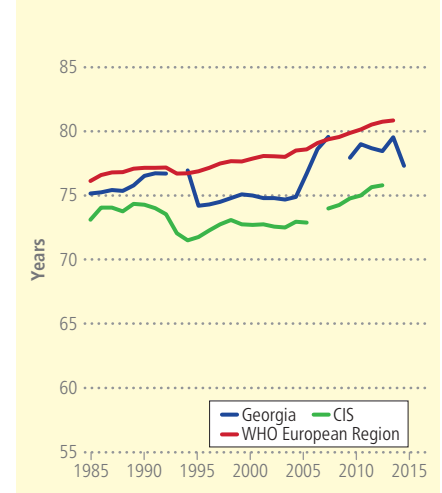


Fig. 2. Life expectancy at birth for females, Georgia, WHO European Region and CIS, 1985–2014



Challenges across the life-course

Leading causes of death

The main causes of death in Georgia are the same as those in most European countries (malignant neoplasms (cancers), diseases of the circulatory, respiratory and digestive systems, and external causes of injury and poisoning) and include NCDs.

Mortality from leading causes in Georgia (625.1 per 100 000) is comparable with the average for the WHO European Region (632.9 per 100 000), yet lower than that for the CIS (969.4 per 100 000) (Fig. 3).

Premature mortality from all causes (for the population younger than 65 years) has considerably increased since 2000, and reached 380.2 per 100 000 in 2014. Diseases of the circulatory system and malignant neoplasms are the leading causes of death in the population as a whole, as well as among those under 65 years of age. The rate of premature mortality from diseases of the circulatory system decreased to 92.3 per 100 000 in 2014. However, the rate of premature mortality from cancers slightly increased to 64.7 per 100 000 in the same year (Fig. 4).

Fig. 3. Mortality from leading causes of death, Georgia, WHO European Region and CIS, 1990–2014 or latest available year

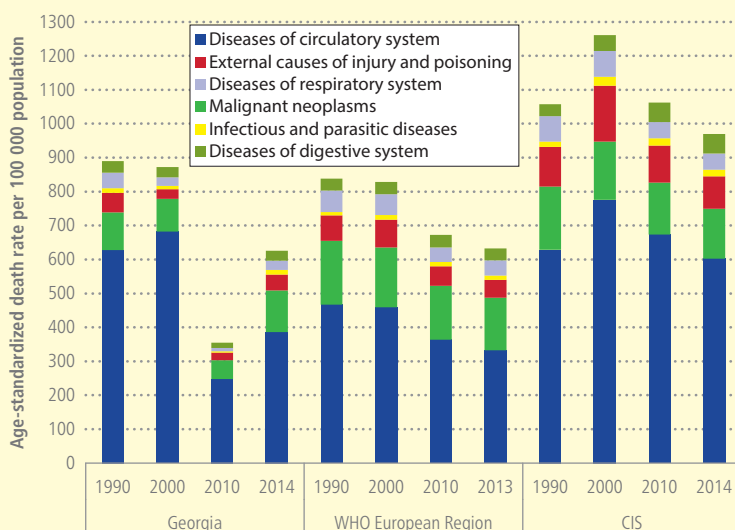
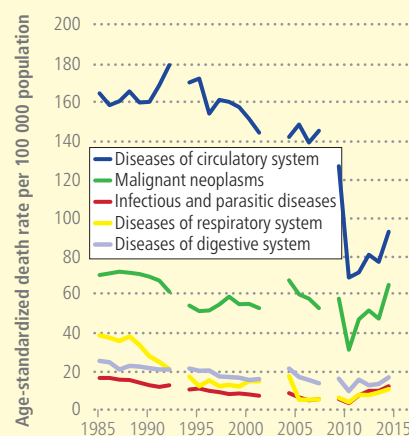


Fig. 4. Premature mortality from selected key causes of death, 0–64 years, Georgia, 1985–2014



Interpretation of these mortality rates should be carried out with caution, considering Georgia's high proportion of ill-defined causes of death (9) and its incomplete coverage of death registrations in the past (10). Ill-defined causes of death complicate analysis, as data may be assigning incorrect causes of death either due to errors in coding or to the systematic misclassification of underlying causes of death. Furthermore, when deaths are not registered universally, accurately describing trends and distributions of main causes of death in the country is difficult. More effort is needed to improve the quality of essential population health data in the country.

By introducing new electronic data collection and exchange systems, Georgia will improve the completeness and quality of information and improve the coverage of data sources.

Maternal and infant mortality

The Government of Georgia has demonstrated a strong commitment to improving the quality and efficiency of perinatal services. In 2017, the Georgian government developed a comprehensive long-term Maternal and Newborn Health Strategy (2017–2030) and a closely related short-term Action Plan (2017–2019) with the aim to give direction and provide guidance for the improvement of maternal and newborn health in the country. In 2014, the infant mortality rate was 9.5 deaths per 1000 live births, which was higher than the WHO European Region's average (6.6 deaths per 1000 live births) and similar to that of the CIS (9.3 deaths per 1000 live births). The same year, the maternal mortality rate was 31 deaths per 100 000 live births, which was higher than the average rates for both the WHO European Region (12 deaths per 100 000 live births) and the CIS (17 deaths per 100 000 live births).

Mortality studies of women of reproductive age revealed significant improvements in the completeness of death registration for women of reproductive age over the past decade. This was determined to be 98% in 2012 (11).

In 2016, the country implemented an electronic registration system for monitoring maternal and child health, and antenatal and obstetric services. This Electronic Module of Pregnant Women and Newborn Health Care (the “birth registry”) registers antenatal visits for each pregnant woman as well as pregnancy outcomes, including the health status of newborns (12).

Morbidity

Communicable diseases

Unlike many countries across the WHO European Region, Georgia faces ongoing challenges in the form of high levels of communicable diseases. In recent years, the Government introduced a number of programmes for the prevention and control of these diseases.

In 2015, Georgia started a national programme aimed at the elimination of hepatitis C in the country (13). Within the framework of the programme, the National Center for Disease Control and Public Health in Georgia, in collaboration with the Centers for Disease Control and Prevention of the United States of America, conducted the first nationwide hepatitis C virus (HCV) serosurvey in the country (8). The major risk factors for hepatitis C were shown to be injecting drug use and blood transfusions: around 38.2% of antibody-positive study participants had mentioned injecting drug use, and 19.7% had mentioned blood transfusions (8).

Currently, each person infected with hepatitis C in Georgia has free access to the newest antiviral therapy (13). The country's long-term strategy on hepatitis C for 2016–2020 aimed at raising awareness of the disease and improving surveillance, prevention, screening, diagnostics and treatment (13).

Tuberculosis (TB) remains a matter of public health concern in Georgia. According to the *Roadmap to implement the tuberculosis action plan for the WHO European Region 2016–2020* (14), Georgia is among the countries with the highest incidence of TB in the WHO European Region. This is in spite of the marked decreasing trend in notified TB cases over the past 10 years, from 104 registered cases per 100 000 in 2006 to 86 per 100 000 in 2014.

The high burden of anti-TB drug resistance is a key challenge for the national TB programme and the main challenge for effective TB control in the country. In 2015, the prevalence of multidrug-resistant TB was 12% and 33% in new and previously treated TB cases, respectively (15).

Fig. 5. Incidence of cancer, Georgia, WHO European Region and CIS, 1985–2014

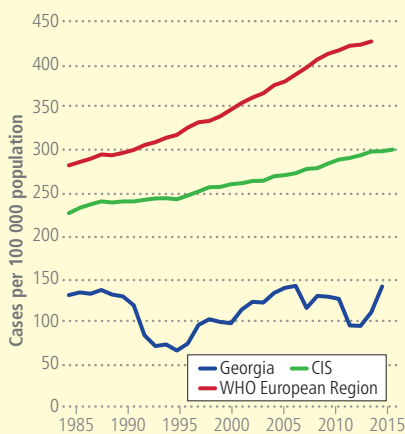
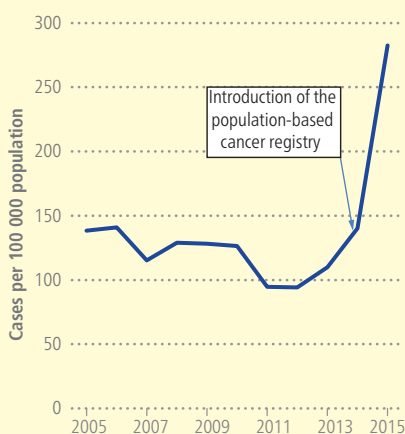


Fig. 6. Incidence of malignant neoplasms, Georgia, 2005–2015



Source: NATIONAL CENTRE FOR DISEASE CONTROL (8).

In recent years, there has been an increase in the incidence of HIV/AIDS in Georgia. Increased HIV case detection is also attributed to HIV and HCV tandem testing offered to the population within the hepatitis C elimination programme (16). HIV/AIDS patients in Georgia have universal access to antiretroviral treatment (16).

NCDs

Due to changes in the country's registration system that interrupted the surveillance of some chronic diseases,¹ limited consistent data are available on malignant neoplasms and cancer morbidity in Georgia (10). Reported cancer incidence and mortality rates from malignant neoplasms are therefore significantly lower than the average rates for both the CIS and the WHO European Region (Fig. 5).

In January 2015, Georgia established a national population-based cancer registry in order to improve the epidemiological surveillance of cancer. Following this, more than 9500 new cases of malignant neoplasms were registered in 2015, excluding non-melanoma skin cancers and in situ neoplasms (8). In 2015, the incidence rate for all cancers was 287.2 per 100 000 (8) (Fig. 6).

As in the rest of the WHO European Region and the countries of the CIS, rates of diabetes mellitus have increased in Georgia in recent years. The 2014 rate (2.2%) was similar to the average for the CIS (2.3%) but lower than that for the WHO European Region (3.8%, in 2013).

¹ Until 2007, a special dispensary surveillance system for patients with some chronic diseases, such as cancer, mental disorders (including alcohol and drug dependence), endocrine diseases and TB, was in place in Georgia. In 2003–2007, the country began replacing these dispensaries with integrated health care centres; introduced incentives for building private health care centres; and established a programme to provide private-practice medical services in rural settings. These reforms redistributed patients across primary health care facilities and, as a result, the monitoring of patients with some chronic diseases ceased. Georgia therefore introduced electronic systems for data capture and exchange, and established several registries.

Reorientation towards prevention: risk factors and determinants of health

Georgia has a mixed profile of key risk indicators for NCDs, such as tobacco smoking, alcohol use, overweight and obesity (Fig. 7). It is estimated that the highest burden of disease in Georgia is associated with dietary risks, high systolic blood pressure, high body mass index and tobacco smoking (17).

In 2013, the estimated age-standardized prevalence of regular tobacco smoking among males (58.5%) was one of the highest in the WHO European Region. The rate for females, however, was low (5.8%).

In 2014, the recorded alcohol consumption per capita for the adult population in Georgia was around 6.1 litres per year. This was lower than the averages for both the WHO European Region (8.6 litres) and the CIS (8.0 litres). The estimated unrecorded consumption of alcohol in Georgia is moderate: 2.3 litres per capita in 2010 (18).

Georgia's prevalence of overweight and obesity are similar to the WHO European Region's averages for females (55% are overweight and 25% are obese), but lower than its average for males (63% are overweight and 21% are obese).

Georgia's comprehensive National Health Promotion Strategy for 2014–2019 (19) envisages a shared approach to improving and protecting health through participation across the whole of government and society. The Strategy includes a health promotion programme with a tobacco control component.

Fig. 7. **Selected lifestyle data**, Georgia, 2013 and 2014



Health system

Since 2013, Georgia has laid the foundation for health policy that is oriented towards public health and welfare (8). In February 2013, it implemented a universal health care insurance programme to provide state-funded medical care (20). More than 90% of the population participates in the programme; the remaining 10% is covered by private medical insurance (8).

The programme covers planned outpatient, emergency in- and outpatient services, elective surgeries, cancer treatments, obstetrical care and funding for essential drugs. Georgia's universal health care reform has improved access to health services and reduced financial barriers and out-of-pocket costs for the population (8).

The proportion of private household out-of-pocket expenditure has decreased since 2000, and was 58.6% in 2014. However, the 2014 expenditure was almost twice the average for the WHO European Region. This likely results in inequitable access to health care and financial hardship for many households—especially poorer households—which may in turn exacerbate poverty and have a negative impact on health.

WHO estimated that Georgia's total expenditure on health (as a percentage of GDP) slightly increased between 2000 and 2014 to 7.4%. This level of expenditure was close to the average for the CIS (6.6%) and a little below the average for the WHO European Region (8.2%).

The number of physicians in Georgia has been increasing since 2006, and is notably higher than the averages for the WHO European Region and the CIS. In contrast, the number of nurses has been decreasing since 1998 and is much lower than the averages for the WHO European Region and the CIS (Table 2).

Table 2. Key indicators for health resources, use of health services and health expenditure, Georgia, WHO European Region and CIS, 2014

Indicator	Georgia	Percentage change since 2000	WHO European Region	CIS
Hospital beds per 100 000	313.3	–34.8%	553.9	715.7
Physicians per 100 000	517.0	+36.5%	322.3	309.98
Dentists per 100 000	57.7	+69.6%	53.4	33.2
Nurses per 100 000	413.6	–10.9%	740.4	622.3
Midwives per 100 000	16.3	–61.3%	39.9	45.2
Inpatient care discharges per 100	10.5	+125.8%	17.9	19.9
Average length of stay, all hospitals (days)	5.2	–48.6%	8.7	11.0
Outpatient contacts per person per year	3.5	+150.0%	7.6	8.9
Total health expenditure as percentage of GDP ^a	7.4	+6.9%	8.2	6.6
Total health expenditure expressed in purchasing power parity (US\$) per capita ^a	627.7	+274.9%	2574.7	1233.1
Public-sector health expenditure as percentage of total health expenditure ^a	20.9	+23.1%	67.9	51.1
Private household out-of-pocket payments on health as percentage of total health expenditure	58.6	–29.0%	26.6	46.2

^a WHO estimates.

Source: HFA-DB (2).

Conclusions

I envision a world in which everyone can live healthy, productive lives, regardless of who they are or where they live.

Dr Tedros Adhanom Ghebreyesus,

WHO Director-General – in his vision statement
Together for a healthier world (21)

Over recent decades, the Government of Georgia has shown a commitment to health policy that embraces the Health 2020 value of equity. As a result, Georgia has made notable progress in improving the health status of the entire population while addressing major risk factors and threats to health.

The Government has implemented a series of health reforms that have included establishing a state-based health insurance programme to provide equitable and universal access to health care and to protect citizens from catastrophic health expenditure; introducing and improving data collection systems; committing to the elimination of hepatitis C; and adopting a health promotion strategy that includes tobacco control measures. Going forward, it will be essential to closely monitor progress towards the goals of these programmes, and to ensure their positive impact on the health of the population.

Despite these actions, Georgia faces significant challenges related to the sustainability of its programmes and the health of its population. Maternal and infant mortality, cancer, cardiovascular diseases and the high rate of tobacco smoking among males all pose threats to health and well-being in the country. Premature mortality has been reduced in the past 20 years, but is still higher than the average for the WHO European Region.

To overcome these challenges, the country must establish a sustainable health financing system and continue to address key health issues, including both communicable diseases and NCDs.

It should also take steps to ensure that information from data reporting systems is used effectively, and to improve the quality and coverage of statistics and information essential to the analysis of population health, including causes of death. Georgia has begun to invest in new technologies in the health information system; when fully operational, these will support health monitoring and planning, and provide the public with access to key health statistics and information.

Georgia's progress towards the Health 2020 targets has been significant but inconsistent. It has improved life expectancy at birth and maintained high levels of child vaccination. Measures of inequality, however, show a mixed picture. While the proportion of children of official primary school age not enrolled decreased between 2004 and 2013, progress is needed in the areas of unemployment and income inequality (Gini coefficient). Georgia's life satisfaction index is also below the WHO European Region's average.

Of particular importance are Georgia's ongoing efforts to continue aligning national health policies with Health 2020 goals and targets. Sustained implementation of existing and planned health programmes, along with ongoing monitoring of changes in health trends, will allow Georgia to improve its health profile in the coming years. The continued adoption of this approach, supported by evidence-informed system reforms, will assist Georgia in becoming a healthier nation.

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