



▶ Extending social health protection: Accelerating progress towards universal health coverage in Georgia

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▶ 1. Introduction

Georgia is located in the western part of Transcaucasia on the eastern coast of the Black Sea. It has a medium level of development (Human Development Index – 0.844 in 2023) (UNDP 2025) and a population of 3,728 million. GDP per capita was 24,681 international dollars at purchasing power parity in 2023 (World Bank 2023). In the early 1990s, after gaining independence, the country faced economic and political crises that excessively impacted the standard of living and social protection of the population. In 1994, Georgia's real GDP fell by 72.5 per cent compared to 1990. However, since 1994, there has been almost constant economic growth, with the exception of declines in 2009 and 2020 (the latter of which was caused by COVID-19). GDP reached US\$18.7 billion in 2021 (World Bank, n.d.).

Until 2010, economic growth was not accompanied by improvements in access to social health protection or to the health status of the population. This was due largely to underfinancing of the health system, a rejection of universal health coverage from 2006-2010 resulting from privatization of the social health protection system,¹ the war of 2008, as well as a high prevalence of smoking and alcohol consumption between 1994 and 2009, among other factors (Richardson and Gugeshashvili 2016). The period from 2010 to 2019 was marked by improvements, with measures aimed at improving safety on roads, ensuring universal access to health care, improving the quality of services, strengthening the financial protection of the population, and improving health care management, laying the foundations to improve the population's health. Notably, during this period, improvements were made to infant mortality, premature deaths (at the age of 30 – 69) from four major non-communicable diseases were reduced, and coverage of children with immunization against measles and rubella was increased (WHO 2017a). Unfortunately, progress was halted in 2020 by the COVID-19 pandemic.

¹ Following the implementation of mandatory health insurance in the 1990s, the Government introduced a private health insurance system in 2006. Under the system, private health insurers were responsible for purchasing health services, and the Government purchased private health insurance coverage for the poorest.

▶ 2. Context

Until 1991, the Georgian health care system was based on the Semashko model, characterized by a high level of centralization and a government owned and operated national health service (NHS) system, free at the point of service. The Semashko model in Georgia was renowned for a density of medical personnel and hospital beds exceeding the EU average. It was also known for the integration of primary health care (PHC) into municipal hospitals, medical technologies that lagged far behind Western European standards and the widespread practice of informal so-called “gratitude” payments to medical personnel.

In the early 1990s, due to economic challenges, political unrest and the transition to a market economy, the health sector was in decay:

- ▶ Public financing reduced because of economic decline and a growing informal economy, which made it a struggle to cover the cost of the relatively generous benefit package and maintain financial protection levels.
- ▶ The physical shortage of medical goods common to the Semashko system worsened because of the collapse of the former USSR market and difficulties in integrating into global markets.
- ▶ Widespread blackouts and destruction of central heating, in parallel with an almost complete lack of investment, eroded health care infrastructure.

In response to these challenges, health care providers made the following adjustments:

- ▶ “Gratitude payments” for medical personnel became the main form of income for providers. OOP payments by far surpassed government health expenditure.
- ▶ Costs were saved by reducing the number of medical personnel. The ratio of nurses to physicians reduced from 1.5 in 1996 to 1.2 in 2000 and 0.9 in 2010 (World Bank Group, n.d.).
- ▶ Many doctors and nurses sought a better income outside of the medical sector in Georgia or looked for jobs abroad. The movement of medical professionals from Georgia has features of the brain drain, and potentially brain waste as well, demonstrated by cases of Georgian certified nurses working as informal carers of senior citizens in Western Europe.
- ▶ Self-medication, as well as reliance on herbal treatments, was a way for many patients to cope with the deficit of medical goods and growing costs of medical treatment.
- ▶ Working and operating medical facilities during daylight hours only and heating medical facilities using makeshift stoves became widespread across the country.

Due to these challenges, the effectiveness of the national health system decreased significantly, leading to a decline in the quality and accessibility of medical care, and negative impacts on the population's health.

The first substantial health care reform in Georgia was initiated in 1995, which included transformations aimed at designing new legislation, strengthening the financing of health care and promoting healthy living for the country's population. A key trigger for the reform was the lack of access to free high-quality medical care services for the entire population (Rukhadze 2013). In the 1990s, a movement towards more equitable care was initiated, based on the implementation of mandatory health insurance scheme. A supervisory body – the Insurance State Supervision Service (ISSS) of Georgia – was established in 1997 to implement state objectives in the insurance sphere and to provide state regulation of insurance activities. Pooling of public resources, capitation-based remuneration of PHC, and capacity building of Mandatory Health Insurance (MHI) institutions at national and regional levels were the main features of the health financing reforms of the late 1990s. However, throughout the 1997- 2005 period, MHI did not tackle the main determinants of poor health care, namely critically low public financing, the prevalence of informal OOP payments and obsolete public health infrastructure. The privatization of the pharmaceutical sector and the emergence of private health care providers were the main features of this period. In 2004, MHI was abandoned.

In 2007, the Government introduced the Medical Assistance for the Poor (MAP) programme through which it financed vouchers for private health insurance for the poor and vulnerable. In 2011, the MAP accounted for nearly half of government spending on health. Initially, private health insurance companies won tenders according to region, resulting in each region relying on one company for the programme.

In the years following the programme's introduction, these companies were making profit margins averaging 30 to 40 per cent, and 18 per cent by 2012. As a result, in 2013, the programme in its initial form was discontinued (Richardson and Berdzuli 2017).

In 2013, the Government launched a Basic Benefit Package programme which shortly after became known as the Universal Health Coverage Programme (UHCP), implemented under the administration of the Social Service Agency (SSA) – an autonomous body under the Ministry of Labour, Health and Social Affairs in charge of administering all social protection benefits in the country. As a result, private insurance companies lost oversight over the administration of public social health protection funds. This change was reflected in the allocation of public health spending, with an initially significant drop in administrative costs. In addition to resulting in a change in institutional arrangements of social health protection, the UHCP also widened the scope of population coverage. Prior to 2013, a means-test was applied with relatively narrow targeting criteria for eligibility to the private health insurance vouchers.² In contrast, the UHCP scheme is near-universal, excluding only households with the highest incomes. The scheme was initially intended for those who lacked private insurance, but since there is no data sharing between private insurers and the SSA, in practice, households under the income threshold can have both UHCP and private health cover. The programme provides outpatient care, emergency inpatient and outpatient care, planned surgical interventions, cancer treatment, obstetric care and essential medicines. Like its predecessor, the UHCP scheme is financed by the general government budget from tax revenues. In addition to the UHCP, MoLHSA finances vertical programmes that are accessible to all.

In October 2024, the government announced the upcoming introduction of co-payments within the UHCP, allowing patients to top up payments to select specific providers or facilities. The reform intends to increase flexibility for patients while preserving a free base level of service. Specific co-payment conditions and service limits are to be determined by the end of 2024 (Aiypkhanova 2024).

New reform priorities outlined in the Georgia 2020 Strategy include:

- ▶ Improving public health care spending systems;
- ▶ Improving the quality of health care;
- ▶ Strengthening primary health care.

These strategic objectives were reaffirmed in the National Health Strategy 2022–2030, which introduced additional priorities such as improving financial protection, strengthening health purchasing mechanisms, and expanding outpatient medicine coverage (WHO 2023).

These transformations have increased access to health care and reduced OOP spending. Progress has also been noted on some health indicators, such as life expectancy at birth, infant mortality, tuberculosis incidence and treatment of new health regressions. For example, infant mortality decreased from 27.3 in 2000 to 9.0 in 2021 (National Statistics Office of Georgia 2021b). The incidence of tuberculosis decreased from 3,609 cases in 2015 to 1,831 in 2020, of which new cases decreased from 2,776 to 1,537 cases (National Statistics Office of Georgia 2021c).

▶ 3. Design of the social health protection system

Financing

Over the last decade, Georgia has experienced a trend of increased financing on health care in terms of government spending and GDP, with a decrease in OOP payments and an increase in government funding with the introduction of the UHCP. In 2019, the share of domestic general government health expenditure was 8.1 per cent of general government expenditure and 2.8 per cent of GDP, increasing from 5 per cent of total government spending and 1.4 per cent of GDP in 2011 (WHO, n.d.). Public expenditure

² Initially only the poor below the poverty line were included, and progressively additional groups were included, such as civil servants, children and pensioners.

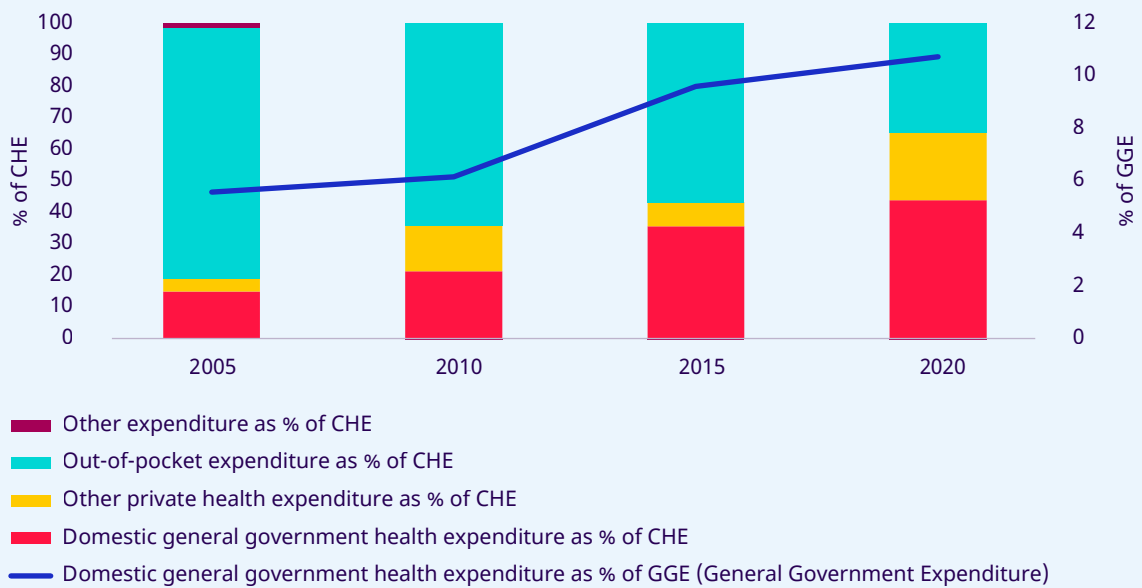
on health as a share of GDP rose to 3.1 per cent by 2021, yet still remains below the EU average and the WHO target for universal health coverage (UHC) systems (WHO 2023).

In 2020, domestic general government health expenditure comprised 47 per cent of CHE, OOP spending comprised 47 per cent and voluntary prepayments (mainly private health insurance) comprised 6 per cent. Despite improvements, Georgia continues to have high the level of OOP spending due to a low level of public funding (figure 34).

All public health spending, like most social protection spending, is sourced from the general government budget. While there were several rounds of tax reforms in recent decades, most of the tax-financing originates from consumption taxes. Income tax on households and corporate taxes represent a much lower share of revenues and operate on a flat rate basis, which de facto limits their progressivity. Importantly, corporate taxes represented only 12 per cent of the fiscal revenues in 2015 and were then further reformed and reduced (Richardson and Berdzuli 2017). In a context where employers do not pay social security contributions, the fiscal basis remains skewed towards consumption and income taxes, mostly paid by households.

There is no earmarked tax for health, and the lack of social contributions to social health protection schemes limits fiscal space for expanding public coverage. Despite fiscal decentralization, local governments play a very limited role in health financing. The central government remains the dominant funder and purchaser, and there are no formal intergovernmental transfers for health. The National Health Agency (NHA) now manages 74% of all central budget revenues allocated to health, acting as the largest purchaser in the system, and is expected to implement more strategic purchasing practices to increase efficiency and impact. While the NHA oversees the main pooled budget for health, fragmentation remains due to parallel vertical programmes and weak alignment between national planning and funding flows (WHO 2023).

Figure 1. Composition of current health expenditure (CHE) in Georgia, by source of financing, 2005-2020



Source: Based on data from the WHO Global Health Expenditure Database.

Governance

The Ministry of Health, Labour and Social Affairs of Georgia³ is in charge of policy-making and accountable for the population's health and social protection, overseeing health care policy implementation, including the adequacy of medical services, and ensuring access for all. Since 2022, governance responsibilities have been clarified with the designation of the NHA as the lead implementing body for UHCP purchasing and oversight (WHO 2023).

Under the Ministry's authority are the Social Service Agency (SSA), the National Centre for Disease Control and Public Health (NCDC), the State Regulation Agency for Medical Activities (SRAMA) and the Emergency Situations Coordination and Urgent Assistance Centre (ESC & UAC).

- ▶ The Social Service Agency (SSA) is in charge of administrating and managing social protection programmes, including the UHCP, through its 68 local offices. The SSA administers insurance benefits and acts as a single purchaser of health care (ILO and UN Women 2020). Other major schemes operated by the SSA include pension, social assistance (including a child benefit programme; child disability, survivors' and disability benefits; a social package; and targeted social assistance), social services, guardianship and custody (ILO and UN Women 2020). The Agency disburses the multi-million expenses allocated to support the recipients and beneficiaries of these programmes.⁴ The SSA also maintains the Social Registry used to assess household income and determine eligibility for targeted programmes, including the UHCP and the TSA (Targeted Social Assistance) programme (WHO 2023).
- ▶ Prevention and control of infectious and non-infectious diseases, health promotion, disease surveillance, immunization, laboratory work, research and response to public health emergencies are delegated to the National Centre for Disease Control and Public Health (NCDC).
- ▶ The State Regulation Agency for Medical Activities (SRAMA) is in charge of issuing licenses and permits for medical institutions and regulating medical professionals and the work of the pharmaceutical sector.
- ▶ The Emergency Situations Coordination and Urgent Assistance Centre (ESC & UAC) coordinates emergency medical and referral assistance which aims to improve the population's health during natural disasters and martial law; its branches are located in nearly all municipalities except for the capital.

Legal coverage and eligibility

When the UHCP was first implemented in 2013, legal coverage was truly universal in nature and covered the entire population (ILO and UN Women 2020). Access to health care services were guaranteed to all residents regardless of their social class, nationality, race, gender, language, religion, age, political or other affiliations or views.

However, since 2018, legal coverage only includes households with an annual income of up to 40,000 Georgian lari, as well as stateless persons residing permanently (legally) in Georgia, according to the Law of Georgia on Health Care (1997 and subsequent amendments).⁵ The UHCP is not accessible to individuals in the highest income bracket (earning over 40,000 lari), though they are covered for emergency care and cancer treatment with co-payments.

There are currently six official UHCP beneficiary categories, grouped by age, income level, and vulnerability (e.g., poor households, pensioners, veterans, etc.). Each group is entitled to a different level of financial protection and benefit coverage (WHO 2023).

All Georgian households are entitled to be registered in the SSA database, which is used to assess their income status using a proxy means test system, and they can re-apply the following year to have their eligibility reassessed. The SSA also carries out a review every five years (Zoidze et al. 2013). While coverage is near-universal, two aspects are important to note:

³ The full name of the Ministry is the Ministry for Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Protection.

⁴ Social Service Agency's webpage, available at: <https://www.sa.gov.ge/>

⁵ Law on Health Care of 1997, available at: <https://matsne.gov.ge/en/document/view/29980>

- ▶ The process for updating the income ceiling for inclusion in the UHCP remains to be seen over the long run. Currently, only a small share of high-income households are excluded. However, if the ceiling is not periodically re-evaluated to reflect inflation and other factors, the programme may exclude an increasing share of the population, fueling OOP spending on private care and substitutive private health insurance.
- ▶ Within UHCP, the level of entitlement varies (in terms of both benefit package and financial protection) across population groups.

Benefits

The UHCP provides varying benefit packages and cost coverage depending on population groups. The SSA administers the scheme and acts as a single purchaser. The comprehensiveness of the services and the level of financial protection provided by the scheme depend primarily on a person's age and income level, with the vulnerable and the poorest receiving the most generous benefits.

The different packages are defined as follows:

- 1. Universal Health care package for specific age and vulnerable groups:** Children aged 0–6, pensioners and other specified categories of the population (such as IDPs) can access a comprehensive package covering primary care, hospitalization and other services plus additional insurance.
- 2. Standard State Universal Health care package:** Children above 6 years of age and people of working age subject to income tests can access a standard package which offers less financial protection than the package for specific vulnerable groups.
- 3. Minimal State Universal Health care package:** This minimum package is offered to those who were previously privately insured and whose policy was discontinued. Those eligible for the minimum package include those who were insured before 2017. The package includes the services of a general practitioner, free nursing, blood and urine tests, and emergency outpatient and inpatient services for more than 450 specific listed medical conditions defined by the programme.

Georgia has a uniform positive list of health services that are included in the packages for the vulnerable and the standard package, but they are subject to different co-payment levels depending on the population group (see box 18). The poor, children, pensioners and war veterans are either exempt from co-payments or pay minimal co-payments. Other groups of the population receive basic PHC services (not drugs) with no co-payment but have to cover about 30 per cent of the costs of secondary outpatient and inpatient services.

The UHCP covers 70-100 per cent of the cost of outpatient services, including a range of primary and secondary health care services, namely diagnostic services (20-30 per cent of the cost is co-paid by a patient), elective surgery, oncology services, obstetric care, some essential medicines and emergency care. Scheduled surgical operations are covered by the State at 70 per cent of the cost, with an annual ceiling of 15,000 lari (or US\$5,300), while non-surgical treatment of cancer patients is covered at 80 per cent, with an annual ceiling of 12,000 lari (US\$4,200). Moreover, 70 per cent of the costs for the services of specialized doctors are covered.

► Box 1. Co-payments and exemptions under UHCP in Georgia

The SSA applies various co-payments and exemption rules for different population groups, which make the social health protection system difficult to comprehend and navigate. The following rules apply:

- Medical and sanitary services are provided for vulnerable groups, such as children under five, retirees, students, disabled children under 18, and persons with pronounced disabilities, who are fully subsidized by the Government. Such target groups benefit from 100 per cent coverage of programme services (including primary health care) with certain limitations indicated in the standard package (described above). In addition, they are eligible for 100 per cent coverage of ultrasound and x-ray examinations (fluoroscopy, radiography and mammography). Visits to specialists are free of charge for these groups upon family/village/district doctor's referral.
- Outpatient family doctor visits are provided with no official user charges for eligible beneficiaries, except for those whose income exceeds 40,000 lari.
- Emergency outpatient care is provided with no official user charges for households below the poverty line (poor), children, pensioners, veterans and those with low incomes. Those with incomes above the medium threshold are required to contribute 50 per cent of the service price.
- Outpatient specialist visits for primary care and basic laboratory tests are provided with no official user charges for the poor, children, pensioners and veterans. Other insured persons have to pay 30 per cent of the service price.
- Outpatient medicines are partially covered for the poor, children, pensioners and veterans up to the annual ceilings according to conditions.
- Dental care is not covered under the UHCP.
- Diagnostic tests, including ultrasound, ECG and X-ray, do not incur official charges for the poor and veterans. However, for children and pensioners, there is a fee ranging from 10-20 per cent of the service price for CT scans. For other individuals, a fee of 30 per cent of the service price is charged.
- Maternity care is covered without co-payments, but there are limits on the amount of public funding. For normal delivery and caesarean section procedures, there are no official charges up to 500 lari per normal delivery and 800 lari per caesarean section.
- Long-term care (nursing), with the exception of acute psychiatric treatment, is not covered by public financing.
- Regarding elective surgery, the poor and veterans are not subject to official charges. However, 10-30 per cent of the service price will be charged for other individuals, with a ceiling up to 15,000 lari per case.
- Chemotherapy, hormone therapy and radiotherapy are available without official charges for individuals classified as poor and veterans. For others, a fee ranging from 10 – 20 per cent of the service price applies, with a ceiling up to lari 15,000 per case.
- Regular patients, with the exception of vulnerable groups, purchase medicines at their own expense. The Government provides partial reimbursement (varying from 50-100 per cent) of costs for vulnerable groups, persons in particular age groups and disabled persons

Until 2020, the list of covered outpatient medicines under the UHCP was limited to around 50 essential medicines for heart disease, respiratory diseases, gastrointestinal diseases and allergies as well as antibiotics and non-steroidal anti-inflammatory medicines. As of 2023, expansion efforts brought this number closer to 100, but the benefit remains limited in scope and focused on high-burden chronic diseases like hypertension, diabetes and asthma (WHO 2023).

The State also finances health services for all legal residents under 23 years of age through priority public health protection programmes. These aim to provide broad geographic coverage and access to disease prevention, immunization, early detection and screening, disease management, and risk reduction counselling for designated health conditions or services, including: mental health conditions, diabetes management, paediatric leukaemia, dialysis and kidney transplantation, palliative care, certain rare diseases, ambulance services, village doctor services and referral services, tuberculosis control, malaria

surveillance, viral hepatitis screening and HIV/AIDS management. A programme for the management of COVID-19 was launched in May 2020.

A highly unusual feature of the Georgian social health protection system is that specific health services are subject to a monetary ceiling, usually a typical feature of private health insurance. The ceiling is set either per episode of care or on an annual basis. For example, the State will not cover services worth more than 15,000 lari for each episode of emergency inpatient care, 15,000 lari a year for elective surgery, or 12,000 lari a year for cancer treatment.

Another problematic feature of the system is that health care providers are allowed to charge patients over the price fixed by the scheme (balance billing) – that is, they are allowed to charge patients the difference between UHCP agreed tariffs and what they wish to charge for both outpatient and inpatient care (Goginashvili et al. 2021).

As a complement to the UHCP, MoLHSA finances a range of vertical disease programmes accessible to all (including those excluded from UHCP). Some of these programmes —such as dialysis, HIV/AIDS treatment, and hepatitis C elimination—are fully state-funded and operate independently of UHCP eligibility (WHO 2023).

In addition to health care benefits, according to the Organic Law of Georgia,⁶ other cash benefits related to public health include (ILO and UN Women 2020):

- Sickness benefits for all formally employed persons, amounting to 100 per cent of their previous salary and allowances for up to 30 days (which may be extended in certain circumstances).⁷ However this is based on employers' liability, de facto limiting coverage, since around 30 per cent of the employed work in the informal economy.
- Maternity benefits for all formally employed women (state benefit for the private sector and employer liability for the public sector). This is a lump sum equal to the full salary for six months (183 days) or 1,000 lari (whichever is lower). However, there are no benefits for economically inactive or informally working women.

Network of service providers

As a legacy of the neoclassical policies of 2004-2012, most health care providers at the primary and secondary levels are private with low regulation, and private health insurance plays a relatively significant role in the sector since many health care providers are owned by private health insurance or pharmaceutical companies. As of 2022, approximately 86% of health care providers contracted under the UHCP were private, including almost all primary care providers and many secondary and tertiary providers. Public hospitals operate only a small share of tertiary care services (WHO 2023).

Since 2013, the SSA has taken on the role of purchasing the government-funded benefits package, which was previously purchased and provided by private insurance companies. Currently, the SSA procures health care services from various service providers, ensuring the involvement of both public and private health care institutions (Richardson and Berdzuli 2017).

The SSA has limited mechanisms for active provider selection, with most eligible providers contracted based on self-application and adherence to administrative and technical criteria. Selective contracting is only applied in specific areas, such as maternal and neonatal care, based on minimum volume and staffing requirements (WHO 2023).

Primary health care involves the provision of services from paramedics, family doctors or general practitioners. Primary health care services in urban areas are provided by family medicine centres, or by family doctors in rural areas, who are predominantly private. The Rural Doctor Programme remains one of the few publicly managed PHC schemes. Rural doctors are salaried, while urban providers are paid via capitation (WHO 2023).

⁶ Labour Code of Georgia, No. 1393 of 27 September 2013, available at: <https://matsne.gov.ge/en/document/view/1155567?publication=21>

⁷ According to the Labour Code of Georgia, the State provides employer liability programmes, including paid sick leave (cash sickness benefits) and mandatory employment injury insurance (not yet implemented as of 2020).

Secondary health care services are provided in polyclinics and multidisciplinary medical institutions that offer outpatient and inpatient services and conduct laboratory diagnostic tests. They may also be served based on a referral from a family doctor. Patients are free to choose the health care providers, without being tied to a clinic near their place of residence.

Tertiary health care services are provided by specialized health care providers, such as cardiological centres, neurosurgery centres, transplantation centres and burn centres, where high-precision diagnostics and complex surgical operations are performed.

All health care facilities operate as independent entities. Private health insurance companies play a pivotal role in this landscape. The prevailing payment mechanism predominantly follows a fee-for-service structure (Richardson and Berdzuli 2017). However, in 2023, a Diagnosis-Related Group (DRG) payment model was implemented nationwide for inpatient surgical care. DRGs now serve as the primary method for reimbursing hospital admissions covered under UHCP, with tariffs determined by diagnosis and case severity. Fee-for-service remains in use for outpatient and diagnostic services (WHO 2023).

This marked a shift away from fee-for-service models and aimed to increase transparency, cost control, and efficiency. However, the DRG rollout faced resistance from providers due to low tariffs and the state's refusal to reimburse certain services in case of coding errors, prompting tariff adjustments for intensive care and other high-cost services (Aiypkhanova 2024).

Health care providers can participate in the UHCP by applying to offer their services and receive reimbursement from the SSA at fixed price rates. To be eligible for reimbursement from the SSA, these facilities must agree to adhere to the agency's established reimbursement procedures. The SSA establishes a standardized list of prices for hospital services based on a list of diseases, as well as per capita rates for primary care services covered under the UHCP. However these pricing structures are generally aligned with those used by private insurance companies (Richardson and Berdzuli 2017). Tariffs are published by the National Health Agency and are adjusted periodically (WHO 2023).

Furthermore, the procedure for inpatient admission often requires the patient to request pre-authorization to SSA, after which a voucher for the procedure is delivered, upon which the patient can obtain the procedure. This process can create delays and places a heavy administrative burden on the patient (ILO and UN Women 2020; Richardson and Berdzuli 2017). The shift to DRG payments has reduced the pre-authorization burden for some surgical procedures, but administrative requirements remain high, especially for high-cost services such as oncology and diagnostics. SSA is in the process of developing digital tools to streamline this process (WHO 2023).

The SSA purchases services from both public and private health care providers on an equal footing. All facilities have financial autonomy and hire their own health workers. The UHCP uses capitation for primary care, and a mix of case-based payments and fee-for-service for other services. Prices tend to align with those of private insurers. The contracting model differs from the model that was implemented prior to the introduction of the UHCP; since 2017, SSA has progressively introduced more strategic purchasing methods for selected services (Richardson and Berdzuli 2017).

► 4. Results

Coverage

Georgia's near-universal UHCP programme covers around 94 per cent of the total population as of 2022 (WHO 2023). Private insurance, provided either through employer-based plans or other private schemes, account for around 8 per cent of the total population. High levels of co-payments and relatively low ceilings of UHCP benefits lead to more demand for private health insurance.

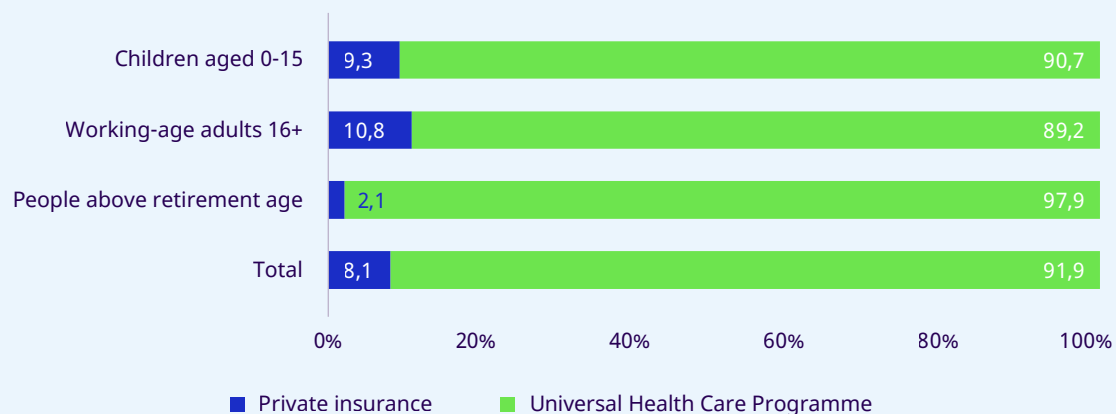
According to data from 2018, among the covered population, old-age pensioners are the most likely age group to benefit from government vouchers (98 per cent), while working-age persons are the least likely (89 per cent), and a significant share (9.3 per cent) of insured children are covered under private

plans (ILO and UN Women 2020). Since April 2017, the Government has implemented a policy whereby the most affluent households are no longer eligible for government-funded benefits and are instead encouraged to maintain private health insurance coverage (Richardson and Berdzuli 2017). These high-income groups (defined as earning over 40,000 lari annually) retain access to a limited set of publicly funded services, such as maternity care and infectious disease treatment, as well as selected vertical programmes (WHO 2023).

After a series of social health protection reforms, the proportion of the Georgian population eligible for UHCP increased from 20 per cent in 2011 to 90 per cent in 2014. This was mainly achieved through increased public health spending, which substantially improved access to health care (Thomson et al. 2019).

By 2020, only 0.3 per cent of the population had no form of health coverage (neither UHCP nor private insurance). In 2022, beneficiaries included not only citizens but also permanent residents, persons under humanitarian status, and residents of occupied territories (WHO 2023).

Figure 2. Third party payers for health care coverage in Georgia: Percentage of the population covered by health insurance, by type of insurance (broad) and age group, 2018



Source: ILO and UN Women 2020.

Adequacy of benefits

The introduction of the UHCP programme correlates with a decrease in OOP, yet OOP on health care remains high and disproportionately affects the population in the lowest income quintiles. In 2021, the incidence of catastrophic health care spending (calculated at the 10 per cent yearly income threshold) was 31.21 per cent, and 9.74 per cent at the 25 per cent of yearly income threshold (WHO 2023a). These figures are the highest in Europe and indicate that the most vulnerable groups might not be able to access health care services due to financial difficulties.

Gaps in financial protection are largely driven by design features of the UHCP that limit financial protection, such as a limited range of services, co-payments higher than 20 per cent for many items and many population groups, the application of ceilings, as well as the authorization of balance billing by providers. Indeed, health care providers are permitted to balance bill patients – that is, they are allowed to charge them more than the UHCP tariff for both outpatient and inpatient care (Goginashvili et al. 2021).

OOP spending, particularly for the lower wealth quintiles, is driven by pharmaceuticals. Indeed, most outpatient pharmaceuticals are not included in UHCP benefit packages. Moreover, Georgia has set a maximum spending amount per person that can be covered by the scheme of 50 lari (approximately US\$20), which is easily exceeded in cases of severe illnesses (Thomson et al. 2019).

Around 50 medicines for outpatient treatment are covered by the UHCP. Since 2017, essential drugs for chronic diseases (such as cardiovascular diseases, including hypertension, chronic lung disease, diabetes, thyroid disease, epilepsy and Parkinson's disease) have been partly subsidized for the poor. Household budget survey data shows that the proportion of households that pay for outpatient medicines out of pocket increased from 72 per cent in 2011 to 79 per cent in 2015 (Thomson et al. 2019). Since 2018, 50 per cent of the cost of these drugs has been subsidized for pensioners and persons with disabilities. In addition, pensioners and persons with disabilities are eligible for an outpatient drug subsidy of up to 50–80 per cent of the retail price, depending on income group and drug type (WHO 2023).

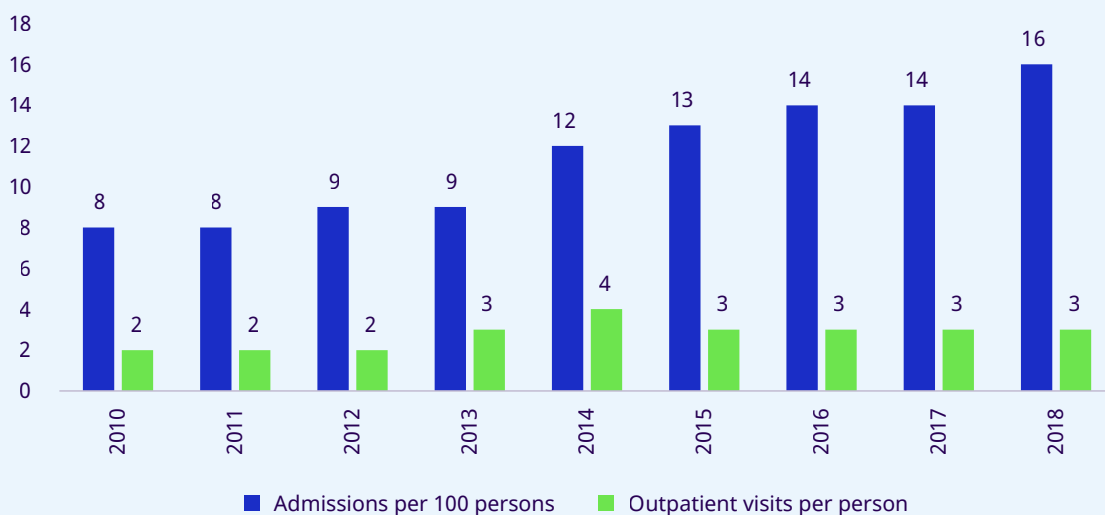
Responsiveness to population needs

Accessibility and availability

In 2019, the universal health coverage index for Georgia was 69 points which is slightly lower than it had been four years earlier (WHO 2019). This level is below the European Region average of 77 points.

Figure 36 illustrates the utilization of health services, which indicates that while the number of admissions to hospitals in Georgia is growing and currently corresponds to the EU average (around 18 per 100 persons), the number of outpatient visits is far below the EU average (about seven visits per person per year) and is stagnant. The low uptake of outpatient services in Georgia is attributed to high user charges and limited public coverage of outpatient medicines.

Figure 3. Utilization of health services in Georgia: Annual rate of outpatient visits and hospitalizations, 2010-2018



Source: Goginashvili et al. 2021.

In 2021, the number of doctors amounted to 23,000 (National Statistics Office of Georgia 2021a). The same year there were 54 medical doctors and 59 nurses and midwives per 10,000 people (WHO 2023c). However, for some time in Georgia, there was an insufficient number of nurses. This gap has been addressed by increasing the workforce by 37 per cent, from 16,400 in 2015 to 22,000 in 2021. Similarly, the lack of hospital beds recently improved, with the number of hospital beds increasing from 12,800 in 2015 to 21,000 in 2021 (National Statistics Office of Georgia 2021a).

Many private medical facilities in Georgia are well organized, equipped with high-tech facilities and staffed with qualified personnel. However, most of the private clinics are located in urban areas. In contrast, medical clinics (public and private) in rural areas lack high-quality infrastructure and, in some

cases, lack essential medical equipment, which is a significant barrier to health care services in rural areas.

Local public hospitals face shortages of medical equipment and a limited number of doctors. Most of them are in critical need of logistical support and modernization, as well as the renewal of medical equipment (JICA and Nomura Research Institute, LTD 2019).

Therefore, while progress has been made on child immunization and prenatal care, access to services for HIV, tuberculosis treatment and family planning still needs to be extended. Child immunization and access to prenatal care stand out with comparatively high coverage rates at 94 per cent and 87 per cent respectively, in contrast to HIV treatment (28 per cent), tuberculosis treatment (66 per cent), and family planning services (53 per cent) (WHO and World Bank 2017).

Due to limited availability of rural primary health care practices, patients turn towards ambulance calls or emergency care (WHO 2023b). Due to an increase in ambulance calls in recent years, improvements to emergency medical care are needed, especially during peak season times of high demand.

Since Georgia relies predominantly on OOP spending to finance primary health care, there were concerns regarding access to essential health services during the COVID-19 pandemic (WHO 2021a). Moreover, the health workforce in Georgia faced overload and burnout. As of the end of June 2021, a total of 24,345 health workers in Georgia had been diagnosed with COVID-19. Approximately 30 per cent of them were physicians and 40 per cent were nurses (about a third of all practicing physicians and over 50 per cent of employed nurses). This had significantly negative impacts on the accessibility of health services during this time (Nadareishvili et al. 2022).

Quality and acceptability

The Georgian health care system is skewed towards providing costly inpatient care rather than cost-effective primary health care. Despite reforms, the funds allocated to PHC make up only 12 per cent of total government health spending, and the share of these expenditures in GDP amounts just to 0.3 per cent (WHO 2021b). A health technology assessment has not yet been integrated into Georgia's social health protection system, but there have been discussions regarding the potential utilization of assessments developed in other countries (Richardson and Berdzuli 2017).

Public awareness of preventive medicine and health issues remains low, as indicated by the low number of outpatient visits per person, which was 3.5 in 2014. In comparison, in the European Region, this figure was 7.6 (WHO 2017b). From 2014 to 2020, the utilization rate of medical institutions providing outpatient care to the population in Georgia has not changed significantly (National Statistics Office of Georgia 2021a).

As previously noted, medical facilities at the local level face difficulties due to a lack of equipment and limited diagnostic capacities of medical centres. The public medical programme includes screening examinations and other components to improve PHC. However, some medical institutions still do not possess screening equipment (JICA and Nomura Research Institute, LTD 2019; Gokieli et al. 2021). Georgia also has an issue with regard to skills and knowledge development and the renewal of medical personnel, with many older doctors and health care workers working in difficult conditions in regional hospitals (JICA and Nomura Research Institute, LTD 2019).

Georgia also has an issue with regard to skills and knowledge development and the renewal of medical personnel, with many older doctors and health care workers working in difficult conditions in regional hospitals (JICA and Nomura Research Institute, LTD 2019). The average age of practicing doctors in Georgia is increasing, and new medical graduates often seek employment abroad. A national workforce plan has been announced to improve retention and incentivize deployment in underserved areas (WHO 2023).

According to the Law on the Issuing of Licences and Permits for Business Activities (2005), the State Regulation Agency for Medical Activities (SRAMA) handles the licensing of health providers, grants permission to health care facilities and pharmacies, and regulates medical professionals, pharmaceuticals and medical devices. However, its role is made difficult by the lack of a clear legal framework to regulate the health system and by limited resources (Richardson and Berdzuli 2017). The accreditation of hospitals

was originally envisioned to be carried out by the Georgian Hospital Association, established in 2009 but it was ultimately not involved in this capacity. The scope of provider regulation extends from primary care to long-term care, including secondary care, dental care and outpatient pharmaceuticals. Notably, public health services do not fall under the purview of licensing or accreditation by SRAMA. Private health care providers operate under relatively limited regulatory oversight (Richardson and Berdzuli 2017).

This situation is reflected in the population's perceptions. According to a study conducted in 2019, despite an expansion in population coverage through the UHCP, satisfaction levels with health care services have remained low, in terms of qualifications and communication abilities of medical personnel, timely service provision, and affordability of services (Gokieli et al. 2021). Notably, the study observed that individuals with private insurance reported higher satisfaction levels (67.8 per cent) compared to UHCP beneficiaries without access to private insurance benefits (50.4 per cent). The primary factor for this low satisfaction is the cost of health care (Gokieli et al. 2021). Conversely, a study focusing on women's satisfaction with maternal care services reveals a high level of satisfaction, particularly among urban residents who are not subject to user fees for antenatal, natal and immediate postnatal care services (Sehngelia et al. 2021).

There are examples of integration and coordination between social protection cash benefits and health care benefits under the UHCP. In particular, the SSA manages a central database to identify the population and vulnerable groups for the provision of both cash benefits and the most generous UHCP package. Almost all programmes are tax-financed and means-tested, aside from a universal old age pension, which though universal is set at a very low level (ILO and UN Women 2020).

► 5. Way forward

Although Georgia has implemented complex health care and social protection reforms, existing barriers still hinder sustainable development and adequate protection of the entire population. The Government of Georgia is committed to tackling these challenges and taking further steps to advance the development of social health protection. The country has adopted crucial strategic documents indicating prospects for the system's development.

The National Health Strategy 2022–2030, endorsed by the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs, lays out the vision for developing the health care system based on international and national standards. The main objectives of the public policy are to increase the population's life expectancy, reduce maternal and child mortality, and enhance health and quality of life. Ensuring universal access to health care and adequate financing of the health care sector should contribute to these national objectives (WHO 2021b).⁸ The strategy emphasizes strengthening PHC, promoting equitable access, reducing financial barriers, and integrating digital health tools and evidence-based planning into service delivery (WHO 2023). Shifting national targets from objectives with little relevance for public health (for example, privatization and the development of voluntary health insurance) towards UHC is a promising development.

In 2017, a long-term Maternal and Newborn Health Strategy (2017–2030) was adopted to improve the effectiveness of maternal and child health care. The goals set by the strategy are to provide adequate protection for mothers and children and significantly enhance their health. Further strengthening of PHC is likely required in order for the strategy to be successful. The upcoming institutionalization of the National Health Agency as the central purchaser and the expansion of strategic purchasing (e.g., DRG payments) could provide a structural basis for efficiency and equity improvements, if properly implemented. Furthermore, Georgia's plan to revise co-payment policies and expand outpatient drug coverage offers an opportunity to close persistent financial protection gaps (WHO 2023).

⁸ Government of Georgia, 2014 on Approval of the 2014–2020 State Concept of Health care System of Georgia for Universal Health Care and Quality Control for the Protection of Patients' Rights, available at: <https://matsne.gov.ge/en/document/view/2657250>

▶ 6. Main lessons learned

- ▶ The historical shift from narrowly targeted and means-tested health cover administered by private health insurers to a near-universal UHCP managed by the SSA has been successful in many respects. It illustrates the difficulties faced by the former architecture in effectively providing quality and cost-effective coverage to all, and the limitations of both narrow targeting and private health insurance administration of benefits. However, challenges remain to improve financial protection against health care costs and the efficiency of spending in a context where the private for-profit health sector dominates.
- ▶ While the wide-reaching population coverage in Georgia is an achievement, critical gaps remain in terms of adequacy of benefits. Households shoulder a significant share of health spending, and two-thirds of OOP payments are attributed to pharmaceuticals. More generous benefit packages under UHCP, starting with coverage of outpatient medicines with proven high levels of efficiency, and changes in design features that impact financial protection, such as limiting co-payments and ceilings and regulating balance billing, are needed reforms.
- ▶ Looking forward, more public funds are needed to improve the adequacy of UHCP benefits and more broadly of social protection benefits, the level of many of which remain relatively low. An extended tax base with progressive sources of revenues is required to mobilize more public funds for health and social protection in an equitable fashion.

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Contact details

International Labour Organization
 Universal Social Protection Department
 Route des Morillons 4
 CH-1211 Geneva 22
 Switzerland

T: +41 22 799 7239
E: socpro@ilo.org
W: www.ilo.org
www.social-protection.org