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RESEARCH ARTICLE

TRUST IN THE HEALTHCARE SYSTEM AND SOCIAL CORONAVIRUS ANXIETY; A STUDY IN THE TURKISH SOCIETY

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ABSTRACT

Purpose: The aim of this research is to determine the level of trust in the healthcare system and coronavirus anxiety of the Turkish society during the COVID-19 pandemic.

Methods: To obtain the data; "Multidimensional Trust in Health-Care Systems Scale (MTHCSS)" and "Coronavirus Anxiety Scale (CAS)" were used. The research was carried out with 1185 people living in Turkey between August and September 2020, using an online questionnaire. Two-Sample Independent T-Test, One-Way Analysis of Variance (ANOVA) and correlation analysis were used in the analysis of the data.

Results: It was determined that the mean scale scores of the participants the MTHCSS was high (59.06±13.76) and the mean score of the CAS was (1.86±3.30) low. Analyses carried out; showed that there are significant statistical differences between gender, presence of chronic disease, working status and compliance with the measures taken, trust in the healthcare system and coronavirus anxiety ($p< 0.05$). In Addition, the correlation analysis performed showed that there is a weak negative relationship between trust in the healthcare system and social coronavirus anxiety.

Conclusion: The results showed that the Turkish society trusts their healthcare system. This makes think that the struggle given under the pandemic conditions is well managed by the Turkish healthcare system.

Keywords: COVID-19, Pandemic, Healthcare system, Trust, Social Coronavirus anxiety.

INTRODUCTION

Coronavirus disease (COVID-19), which was first identified in China in December 2019, spread rapidly after this date, and has turned into a serious health problem globally, causing a crisis all over the world with its economic, sociological, and psychological effects. The World Health Organization (WHO) declared this pandemic as "an international concern public health emergency" on January 31, 2020 (1). In addition to its highly contagious nature, coronavirus has created a serious burden on healthcare systems and providers all over the world, as it develops serious lung infection in 20% of patients and requires intensive care and respiratory support in about 5-10% of patients (2) and increases demand for limited-service provision resources such as intensive care beds, respirators, and healthcare personnel. Currently, all healthcare systems around the world are facing increased demand for healthcare from COVID-19, which is challenging healthcare systems' ability to deliver. When such strain is experienced, morbidity often exacerbates, disabilities increase,

and deaths from both pandemic (direct) deaths and vaccine preventable and treatable (preventable) conditions increase (3). During a pandemic, the purpose of the healthcare system in a country is to provide an effective intervention that includes providing quality health care, ensuring the continuity of health services, taking protection and control measures against infection, raising public awareness, and ultimately reducing mortality and morbidity related to the disease, despite the increasing need for healthcare services (4).

Situation in Turkey

In Turkey, the first COVID-19 case was seen on 11 March 2020, and the number of cases and deaths has increased day by day (5). However, Turkey has performed dramatically better than most countries in the world in limiting and managing the impact of the COVID-19 pandemic (6). Acting under the guidance of the "Pandemic Influenza National Preparedness Plan (2019)" prepared earlier during the pandemic, a very fast, successful, and effective intervention and struggle is carried out with the testing, monitoring, isolation, and restriction of social mobility, which are effective in reducing the spread of the virus in the society. In addition, with the emphasis on "social solidarity and collective fight", the successful management of the pandemic is ensured by implementing a communication strategy that will have the society work together as a whole against the pandemic (4).

A health reform named "Health Transformation Program" was initiated in Turkey in 2003. This program has covered and strengthened almost all the building blocks of the health system in the country, with investments made from governance to health financing, from the provision of health services to health infrastructure, and redefined the roles of all relevant stakeholders (7,8). The three key aspects of the health reform program have played the role of facilitator in the fight against the pandemic for Turkey. The first of these is the strengthening of primary health care services with the transformation in health. With the family medicine system, better access, effective and timely test and contact tracking are provided during the pandemic process. Secondly, Intensive care bed capacities, negative pressure rooms, and the newly commissioned “city hospitals”, which have a large number of qualified patient bed capacities, including the factors that are important for the survival of serious patients, have placed Turkey in a higher position compared to other world states in combating the pandemic crisis. The third element is Ensuring comprehensive service delivery with a reliable information technology (IT) infrastructure that enables and supports critical response elements in the pandemic. Another important issue is that Turkey has one of the world's most comprehensive universal health insurance program. In addition, Turkey has made strategic moves in technological and technical health issues by mixing various resources and capabilities of different actors in combating the crisis (8). Turkey has initiated a coordination and cooperation for the production of mechanical ventilators to be used for respiratory support for intensive care patients (6). Thus, problems related to the supply and access of medical devices and materials were tried to be overcome.

Trust in the Healthcare System and Social Coronavirus Anxiety

Trust in the healthcare system, regardless of the conditions, is primarily related to the better access and use of the population to medical care services (9). In addition, healthcare is provided by people and interactions between many actors such as patients, doctors, pharmacists, suppliers, regulators, etc. involved in healthcare delivery play an important role in the trust in health system. As Gilson points out, "trust is important for health systems since it supports the collaboration required for healthcare production across the system" (10). It is known that people's trust in the health system is effective in access to medical care, use of health services, compliance with medicines, ensuring continuity of care and quality of care (11). Especially in times of crisis, a fundamental component that holds society together is trust. Studies have shown that individual level of trust in the health system is in fact associated with better health in individuals' self-reporting, and that trust positively affects both overall health and mental health (12).

Pandemic conditions can affect people's trust in hospitals, insurance companies and health systems, their use of services and therefore the applicability of economic and political decisions (13). For example, patients' trust in health insurers (14) and health system financing (15), affects their healthcare experience. For public-private health partnerships, trust has a critical role (16). Having a reliable health system can contribute to the development of social value and social order (10).

Another issue that needs to be addressed simultaneously with the pandemic process and the response of countries to the current crisis is the issue of how people in the country are affected by the pandemic (17). As a matter of fact, changes in daily life as a result of the measures taken due to the disease, the increase in the number of cases and deaths, the continuation of the spread of the disease despite the measures taken in all countries, economic concerns, worries about losing a relative or getting sick oneself disrupt the psychological well-being and increased waves of fear and anxiety affect the mental health of individuals negatively. For example, in a multicentred study conducted in China in the early stages of the pandemic, the prevalence rate of traumatic stress in the population was 73.4%, depression rate 50.7%, generalized anxiety rate 44.7% and insomnia rate 36.1% (18). Again, in a study conducted in China with 2237 individuals who were quarantined between February 14 and March 4, 2020, the prevalence of depressive symptoms was found to be 6.21% (19). Lee (20) revealed that coronavirus anxiety correlates positively with age, race, educational status, alcohol use, positive COVID- 19 diagnosis, religious belief, hopelessness, and suicidal ideation. In this study, Asians were the only group to show higher anxiety scores than Whites and Blacks. In addition, younger individuals and individuals with higher education levels have been shown to have higher levels of coronavirus anxiety scores. While these findings are disturbing, studies on the psychological effects of previous global disease outbreaks also show that mental adversities such as anxiety and stress associated with the pandemic situation, contamination concerns, health anxiety, post-traumatic stress disorder and suicidal tendency are increasing in the population (21,22,23,24).

This research was carried out to determine the level of Turkish people trust in the healthcare system during the COVID-19 pandemic process, to evaluate the social anxiety caused by the pandemic process and to reveal the effect of the trust in the healthcare system on the level of social anxiety experienced due to the pandemic.

METHODS

Due to pandemic conditions and restrictions, the research was conducted between August and September 2020, with the participation of 1185 people, using an online survey (google-forms) and completely based on volunteerism.

A questionnaire consisting of 3 parts (57 questions) was used to obtain the research data. The first part consists of questions prepared to determine the socio-demographic information and general health levels of the participants. In the second part, "Multidimensional Trust in Health-Care Systems Scale (MTHCSS)" developed by Egede and Ellis (25) and adapted into Turkish by Dinc et al. (26) was used to determine the trust level of the society in the health system. Finally, to determine the anxiety experienced by the society; The "Coronavirus Anxiety Scale" developed by Lee (20) was used.

MTHCSS consists of 3 dimensions, namely Trust in Health Care Providers (10 item), Trust in Health Care Payers dimension (4 item) and Trust in Health Care Institutions dimension (3 item) and a total of 17 questions. The expressions in the scale are evaluated according to the 5-point Likert scale (5 = Strongly agree, 4 = Agree, 3 = Indecisive, 2 = Disagree, 1 = Strongly disagree) and scoring of the 4th and 15th statements (1= Strongly agree, 2 = I agree, 3 = Indecisive, 4 = Disagree, 5 = Strongly disagree) is done in reverse. Scale total score and subscale total scores reveal the level of trust in health services. Adapted into Turkish by Dinc et al. (26), the Cronbach's Alpha coefficient of the scale was 0.87, and the Cronbach's Alpha coefficients of its sub-dimensions were calculated as 0.91, 0.82 and 0.61, respectively.

The Coronavirus Anxiety Scale is a 5-point scale to determine the frequency of symptoms during the previous two weeks (0 = I have never experienced it, 1 = Rare, less than 1 or 2 days, 2 = A few days, 3 = more than 7 days, 4 = During the last two weeks almost every day). Lee (20), calculated the Cronbach's Alpha coefficient of the scale as 0.93. For the Turkish validity of the scale, language validity was provided first, and factor analysis was used for construct validity. Cronbach's Alpha coefficient was used for the reliability of the scale, and it was determined that it shows high internal consistency with a value of 0.891. No item was removed from the scale since it was observed that no item decreased the reliability value in the analysis performed. According to the results of the factor analysis performed for the 5-item scale, it was determined that the factor loads of the items were between 0.782 and 0.903 ($p< 0.001$).

Table 1. Descriptive Statistics of the Participants

Descriptive Characteristics	n	%	Descriptive Characteristics	n	%
Age (year)			***Smoking status***		
15-30	384	32.4	Yes	359	30.3
31-45	536	45.2	No, I left before	221	18.6
≥ 45	265	22.4	No, I never used	571	48.2
Gender			I stopped using it during the pandemic process	34	2,9
Female	777	65.6	***Alcohol use status***		
Male	Yes	34.4	Yes	290	24.5
Education			No, I left before	137	11,6
Primary school	18	1.5	No, I never used	709	59.8
Secondary school	121	10.2	I stopped using it during the pandemic process	49	4.1
Associate Degree	106	8.9	***Presence of other chronic disease***		
License	685	57.8	Yes	233	19.7
Master-Doctorate	255	21.5	No	952	80.3
Working status			***Total***	**1185**	**100**
Working	855	72.2	***Other chronic diseases***		
Not working	271	22.9	Asthma-Bronchitis-COPD	56	24.0
Retired	59	5.0	Cardiovascular Syst. Diseases	35	15.0
Income			Hypertension	41	17,6
≤ 4.000 TL	427	36.1	Diabetes mellitus	38	16.4
4.001-8.000 TL	565	47.6	Thyroid Diseases	28	12.0
≥ 8.001 TL	193	16.3	Other	35	15.0
Total	**1185**	**100**	***Total***	**233**	**100**
Did you or any of your family members need healthcare during the pandemic process?					
No, I didn't need				725	61.2
Yes, just 1 time				256	21.6
Yes, 1-3 times				175	14.8
Yes, more than 3 times				29	2.4
Total				**1185**	**100**
What kind of healthcare service did you use for your healthcare needs?					
I needed to use healthcare services, but I didn't apply to the hospital because of the pandemic measures, I used the facilities at home.				223	48.4
Emergency health services				40	8.7
Public hospital (outpatient)				90	19.6
Private hospital (outpatient)				91	19.8
Public + Private hospital (inpatient treatment)				16	3.5
Total				**460**	**100**
During the pandemic process, did you have any problem in accessing medicine-medical supplies?					
No, I didn't have any problems.				951	80.3
As part of the measures taken, I could not go out to get my medicine.				30	2.5
I could not take my medicine because there is no pharmacy near me				3	0.3
I could not find my medicine in the pharmacy.				18	1.5
Missing				183	15.4
Do you think you fully comply with the measures taken during the coronavirus process (curfew, use of masks, social distance, hand washing, etc.)?					
Yes				998	84.2
Partially				173	14.6
No				14	1.2
Total				**1185**	**100**

***TL: Turkish Lira**

For the analysis, the parametric hypothesis tests were used assuming a normal distribution due to the high sample size. To determine the relationship between scale scores and independent variables, our Independent Two-Sample T Test was used to compare the means between pairs, and One-Way Analysis of Variance (ANOVA) was used to compare the means between more than two groups.

This research was carried out with the approvals and permissions of the TR. Ministry of Health General Directorate of Health Services Scientific Research Platform and Kırıkkale University Non-Invasive

Table 2. The Evaluations of Participants Regarding the Health Services They Received/Will Receive if They Were Diagnosed with Coronavirus or Assumed They Were Diagnosed with Coronavirus.

Expressions		Disagree %	Undecided %	Agree %
1.	I had full confidence that the diagnostic test applied to me in the health facility gave accurate results and that the diagnosis was correct.	20.4	18.9	60.7
2.	I was confident that the necessary quarantine processes and processes would be initiated immediately after the diagnosis was made.	18.7	11.8	69.5
3.	I have full confidence that the highest quality treatment and health care will be provided by timely intervention in the health institution.	18.9	16.6	64.5
4.	I have full confidence that the healthcare professionals will make the right decisions about my treatment, do whatever it takes to provide the medical care I need, and provide the most appropriate treatment.	17.0	12.5	70.5
5.	In this process, I have full confidence that our healthcare system will keep my health and the necessary treatment superior to everything, including treatment costs.	19.6	16.1	64.3
6.	I have full confidence that all the precautions have been taken regarding the processes of keeping the medicines or medical supplies related to my treatment by hospitals or personally procuring them from pharmacies.	20.8	17.2	62.0
7.	I had full confidence that the follow-up, diagnosis and treatment of my family or people around me who might have infected this disease would be done properly.	20.3	15.6	64.1
8.	After I was diagnosed with coronavirus, I was completely confident that the treatments given by health institutions and specialists would have positive results and I would be completely cured.	19.6	19.6	60.8

Research Ethics Committee (Approval date: 30.09.2020, Decision number: 2020.08.05). Online survey method was used for the research due to pandemic conditions and social restrictions. After the sample size was calculated, participants aged 15 and over were sent a questionnaire via e-mail to ensure their participation. The population aged 15 and over in Turkey at the time of the survey is 63,942,652 in total (27). The sample size that should be reached at 0.05 margin of error and 95% confidence level was calculated as 385, and a total of 1,185 people were reached between 01.8.2020-30.9.2020.

RESULTS

In this study, which was conducted in Turkey between August and September 2020 with the participation of 1185 people in total, the average age of the participants is 36.92 years (SD: 11.53) and 45.2% are between 31-45 years old. 65.6% of the participants are women, 57.8% have undergraduate degrees. 72.2% stated that they are still working and 34.3% stated that they earn between 4000-6000 TL per month. 19.7% of the participants stated that they had a diagnosed disease, whereas 30.3% stated to be smoking and 24.5% using alcohol. 17.5% of smokers stated that the frequency of their smoking activities during coronavirus outbreak have increased, while 42.9% stated the opposite, and 39.7% stated no changes in their habits. On the other hand, 11.1% of alcohol users stated that the amount of their alcohol consumption increased, whereas 50.9% stated a decrease and 37.9% stated to consume the same amount during the coronavirus process (Table 1).

The participants were asked if they needed health services as of March 2020, which is the date accepted as the beginning of the pandemic throughout the country and when all hospitals were declared as Pandemic Hospitals, and 38.8% of the participants stated that they needed to use health services at least once. While most of the participants (48.4%) in need of healthcare services preferred not to go to the hospital and to be treated at home due to the pandemic measurements, 39.4% used outpatient services in public and private health institutions and 8.7% used emergency health services. On the other hand, 3.5% of the participants had to receive inpatient treatment. 80.3% of the participants stated that they did not have any problems related to accessing the medicines and medical supplies needed during the pandemic process (Table 2).

Table 2 presents the responses of the participants to the statements to measure their confidence in the health services they will receive / received when they were diagnosed with coronavirus or assumed, they were diagnosed with coronavirus. According to the results obtained; 70.5% of the participants agreed to the statement that *"I was confident that healthcare professionals will make the right decisions about my*

Table 3. Comparison of Multidimensional Trust to Health Care System Scale and Coronavirus Anxiety Scale to Sociodemographic Characteristics

	Trust in Health Care Providers		**Trust in Health Care Payers**		**Trust in Health Care Institutions**		**MTHCSS**		**CAS**	
Socio-demographic characteristics	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
Gender										
Female	35.87	8.40	13.68	3.97	9.99	2.13	59.53	12.85	2.26	3.59
Male	35.27	10.18	13.02	4.57	9.86	2.21	58.15	15.34	1.08	2.51
	t=1.076 p=0.282		**t=2.562 p=0.011***		**t=1.010 p=0.313**		**t=1.646 p=0.100**		**t=5.907 p=0.000***	
Presence of other chronic disease										
Yes	34.10	9.92	12.96	4.78	9.76	2.24	56.82	15.32	2.59	4.13
No	36.04	8.79	13.57	4.04	9.99	2.13	59.60	13.31	1.68	3.04
	t=-2.944 p=0.003*		**t=-1.994 p=0.046***		**t=-1.446 p=0.148**		**t=-2.770 p=0.006***		**t=3.800 p=0.000***	
Working status										
Working	35.41	9.36	13.39	4.23	9.89	2.13	58.68	14.04	**1.67**	3.09
Not working	36.33	8.17	13.62	4.11	10.08	2.22	60.03	13.00	**2.33**	3.78
	t=-1.572 p=0.116		**t=-0.860 p=0.390**		**t=-1.352 p=0.177**		**t=-1.507 p=0.132**		**t=-3.068 p=0.002***	
Education										
High school and below	35.26	9.70	13.32	4.91	10.14	2.30	58.73	15.49	2.24	3.62
Associate degree	35.27	10.54	13.85	4.58	10.00	2.23	59.12	15.85	1.90	3.23
Undergraduate	35.72	8.85	13.53	4.06	9.92	2.14	59.16	13.46	1.81	3.39
Postgraduate	35.90	8.59	13.15	3.98	9.88	2.08	58.93	12.71	1.74	2.91
	F=0.224 p=0.880		**F=0.866 p=0.458**		**F=0.537 p=0.657**		**F=0.047 p=0.986**		**F=0.794 p=0.497**	
Income										
≤ 4.000 TL	35.64	9.10	13.36	4.39	10.01	2.09	59.01	14.08	2.08	3.56
4.001-8.000 TL	35.53	9.24	13.56	4.13	9.96	2.25	59.05	13.96	1.71	3.09
≥ 8.001 TL	36.09	8.39	13.33	3.97	9.74	2.03	59.17	12.54	1.79	3.31
	F=.280 p=0.756		**F=0.388 p=0.678**		**F=1.018 p=0.339**		**F=0.008 p=0.992**		**F=1.622 p=0.198**	
Adapting to pandemic measures										
Yes	**35.86**	9.24	13.54	4.22	**10.02**	2.20	**59.42**	13.98	**1.86**	3.24
No	**30.14**	12.28	12.14	4.72	**9.00**	1.84	**51.29**	16.92	**4.14**	5.78
Partially	**34.98**	7.37	13.07	4.01	**9.55**	1.87	**57.6**	11.96	**1.66**	3.34
	F=3.336 p=0.036*		**F=1.605 p=0.201**		**F=4.697 p=0.007***		**F=3.557 p=0.029***		**F=3.659 p=0.026***	

*p<0,05 **Mean ± SD in parametric tests were calculated.

TL: Turkish Lira

Tablo 4. Correlation between Subdimension of Multidimensional Trust to Health Care System Scale and Coronavirus Anxiety Scale

Variables	Mean	SD	1	2	3	MTHCSS	CAS
Trust in Health Care Providers	35.66	9.05	1				
Trust in Health Care Payers	13.45	4.19	0.661*	1			
Trust in Health Care Institutions	9.4	2.15	0.609*	0.628*	1		
MTHCSS	59.06	13.77	0.954*	0.838*	0.749*	1	
CAS	1.86	3.30	-0.050	-0.054	-0.032	-0.054	1

SD: standard deviation.*Correlation is significant 0.05 (two-tailed).

treatment and will do whatever is necessary to provide the medical care I need and provide the most appropriate treatment" and 69.5% agreed to *"I had / would have full confidence that the necessary quarantine processes and procedures would be initiated immediately after the diagnosis was made." 20.8%* did not agree with the statement *"I have full confidence that all the precautions have been taken regarding the processes of having medicines or medical supplies related to my treatment by hospitals or personally procuring from pharmacies", 20.4%* did not agree with the statement *"The diagnostic test applied to me in the health institution gave correct results and was correct"* and *20.3%* of them did not agree with the statement "*I have full confidence that my family or people around me who may be infected with this disease will be subject to follow-up, diagnose and treatment procedures properly."*

The mean score of the participants on the MTHCSS was calculated as 59.06±13.76. “Trust in Health Care Providers” subscale mean score was 35.66±9.05; The mean score of the "Trust in Health Care Payers" sub-dimension was 13.45±4.19, and the mean score for the "Trust in Health Care Institutions" sub-dimension was 9.94±2.15. The mean scores of the participants on the "Coronavirus Anxiety Scale" are calculated as 1.86±3.30. In Table 3; It was evaluated whether there was a statistically significant difference between the determined variables and the mean scores of the MTHCSS sub-dimensions and the Coronavirus Anxiety Scale. According to the results, participants whose sex is female, "health care payers", have a higher level of trust (13.68±3.97; p< 0.05). However, female participants had higher levels of coronavirus anxiety than male participants (mean 2.26±3.59; p<0,05). Participants without chronic disease, Health Care Providers (mean 36.04±8.79), obtained higher means than Health Care Payers (mean13.57±4.04) sub-dimensions and MTHCSS (mean 59.60±13.31) (p <0.05). Again, it was determined that participants without chronic diseases had lower coronavirus anxiety levels (mean1.68 ± 3.40). In addition, the participants who think that they have adapted to the measures taken by the government due to the pandemic had higher averages than the "Health Care Providers" (mean 35.86±9.24) and "Health Care Institutions" (mean 10.2±2.20) sub-dimensions and MTHCSS (mean 59.42±13.98) and their coronavirus anxiety levels were lower. Another result obtained is that the work status of the participants made a statistically significant difference in their coronavirus anxiety levels (p< 0.05). The analysis performed showed that the coronavirus anxiety level of the non-working participants (mean 2.33±3.78) was higher than the working participants (mean 1.67±3.09) (Table 3).

One of the aims of this study is to determine whether there is a relationship between participants' trust in the healthcare system and their coronavirus anxiety levels. The correlation analysis results carried out; ıt showed that there is a weak negative correlation between Trust in Healthcare System and Coronavirus Anxiety. (Table 4).

DISCUSSION

Firstly, this research was carried out to determine the level of trust in the Turkish healthcare system during the COVID-19 pandemic process, to evaluate the social anxiety caused by the pandemic process.

The results obtained indicate that 38.8% of the participants needed to use healthcare services at least once in the period from March 2020 when the first case was seen in Turkey until the period when the study was carried out while 39.4% of them received outpatient services in public and private health institutions, 8.7% of them used emergency health services and 3.5% of them received inpatient treatment. In this process, most of the participants stated that they did not have any problems with accessing the medicine-medical supplies they needed.

To achieve the purpose of the research, participants' stance to the various statements that would test their trust in health system under the condition that "they are diagnosed with coronavirus or assumed to be diagnosed" are examined. Most of the participants (60-70%) stated they are confident that the "the diagnostic test provided by the health institutions

during this process gives correct results", "the necessary quarantine procedures and processes will be started immediately after the diagnosis", "they would be provided with timely intervention and the highest quality of treatment and health care.", "the costs for their treatment will be ignored", "they will not have any problems in accessing the medicines and medical treatment necessary for their treatment", "the follow-up, diagnosis and treatment of the infected people in their family or environment will be done properly and "the treatments given after being diagnosed with coronavirus will result in positive results and heal completely". However, approximately 20% of the participants partially agreed with these statements, while approximately 20% stated that they disagreed and did not trust the health system. In another study conducted in Turkey, they found that approximately 25% of the participants had an unmet healthcare need (28). This result obtained in our research is thought to be related to the unmet health care needs of individuals. The mean score of the participants on the MTHCSS was calculated as 59.06±13.76. "Trust in Health Care Providers" subscale mean score was 35.66±9.05; The mean score of the "Trust in Health Care Payers" sub-dimension was 13.45±4.19, and the mean score for the "Trust in Health Care Institutions" sub-dimension was 9.94±2.15. Dinc et al. (26) in their study conducted in Turkey, calculated the mean score of the MTHCSS as 64.7± 0.7 and the mean scores for the sub-dimensions as 40.6 ± 7.4, 13.2±3.8 and 10.9±2.7, respectively. When the results are compared to 2013, it can be said that trust in the health system decreased relatively in Turkish society during the pandemic period, and this decrease occurred in the "Trust in Health Care Providers" sub-dimension. In the literature review, no other research on the subject was found in Turkey. Egede and Ellis (25) calculated the mean score of the scale as 63.0±8.8 and the scores of the sub-dimensions as 40.0±6.2, 12.8±3.0 and 10.3±2.1, respectively, in their study conducted in the USA. Although there are systemic and social differences with the USA, in both studies conducted in Turkish society, higher scores were obtained for the "Trust in Health Care Payers" sub-dimension. In addition to the difference in healthcare financing, it can be said that the trust of the Turkish community in the healthcare system is higher than in the USA. Moreover, the findings obtained in this study showed that there are significant differences between gender, presence of a chronic disease, adaptation to the measures taken and trust in the health care system ($p< 0.05$). According to the results, female participants have higher level of Trust in Health Care Payers, but higher anxiety level than male participants ($p< 0.05$). It was determined that participants without chronic diseases have a higher level of trust in the health system. However, coronavirus anxiety levels were found to be higher in participants with chronic diseases ($p= 0.000$) and participants who are not currently working ($p= 0.002$). No statistically significant difference was found between the mean scores of the MTHCSS and the Coronavirus Anxiety Scale in terms of education and income levels of the participants ($p> 0.05$).

The social and economic impacts of the COVID-19 pandemic, which started from China and spread all over the world in about 2 months, and whose effects continued still are at an unprecedented level. As a result, the media has been locked into the pandemic process all over the world, the course of the disease and the statistical information about the disease were brought to the agenda almost every day through all media organs, and with this, serious increases in the stress level and anxiety occurred in the society (29,30). In this study, the average score obtained by the participants from the "Coronavirus Anxiety Scale" was calculated as 1.86±3.30. Such scale was developed to assess the mental health levels and concerns of people affected by the coronavirus pandemic and to identify possible cases of dysfunctional anxiety associated with the COVID-19 crisis (20). When the obtained scores are evaluated, it can be said that the level of social anxiety during the pandemic process in Turkish society is close to the medium level (Min:1-Max:4). Regarding the increase in the level of anxiety, 17.5% of the smokers stated that they their smoking habits worsened and 11.1% of the participants who used alcohol during the pandemic period increased their alcohol use. These behaviours are thought to reflect psychological effects such as fear, and anxiety related to coronavirus. Increasing anxiety in society brings along many problems. Measures taken during the pandemic process such as isolation, social distance, quarantine practices, travel restrictions adversely affect the mental health of individuals and may lead to the emergence of avoidance behaviours due to unwanted lifestyles, eating styles, and limited socialization. Therefore, it is very important to determine the factors that cause anxiety in the society and the conditions that decrease and / or increase the anxiety level during pandemic periods (31,32,33).

The pandemic control measures taken throughout the country are one of the leading social anxiety sources. Results obtained from the analysis have shown that the participants who think that they have adapted to the measures taken by the government due to the pandemic have a higher level of trust in "Health Care Providers", "Health Care Institutions" and the Health Services System, and have lower level of coronavirus anxiety levels ($p< 0.05$). In another saying, Participants with low level of trust in the health services system stated that they could not adapt to the measures taken with a statistically significant difference ($p <0.05$). Studies show that trust in the health system during the Covid-19 process increases compliance with the measures taken (34,35). Therefore, it is possible to say that the issue of trust in the health care system is effective in many issues such as adapting to the restrictions and treatment determined by the decision-makers of the society, controlling the rate of spread of infection and related deaths, and decreasing the level of anxiety caused by stress (36,37).

Finally, it was examined whether there is a relationship between participants' trust in the healthcare system and the coronavirus anxiety levels experienced, and the analysis showed that there is a weak, negative relationship between Trust in the Healthcare System and Coronavirus Anxiety. It should be considered that the trust in the health system is affected by different variables in achieving this result. Nevertheless, it can be stated that trusting the healthcare system has an effect that reduces social anxiety. In a study conducted by Harris and Sandal (38) in Norway, the factors affecting psychological anxiety in the society were determined. According to this study, it has been determined that being women, younger age, lower education level, being infected with COVID-19, being medically vulnerable, being a health worker, being in voluntary quarantine, and having an immigrant background are factors that affect psychological anxiety in the community. The same study found that people the medically vulnerable group, those under 61 years of age, and those in quarantine in the community had lower levels of trust in the health system and reported higher levels of psychological distress (38).

CONCLUSION

The world goes through a period in which health systems are tested for their responsiveness and durability. Scientific evidence suggests that trust in community members or government agencies serves as a determinant of health behaviour and outcomes (39,40,41). Especially in the context of outbreaks, trust in health authorities and state institutions is an important element in ensuring citizens' compliance with public health policies, restrictions, and guidelines (42,43). It is emphasized that in the management of the epidemic by health systems; transparency, decisive leadership, global cooperation, use of modern technology, making improvements in insurance institutions and policies, investing especially in health systems, health workforce and health technologies come to the fore as important elements (44). It is believed that countries with reliable healthcare systems and reliable healthcare institutions will be more successful in overcoming the potentially devastating effects of the pandemic.

The findings obtained from this study point to the risky groups (non-working, women, and individuals with chronic diseases) that should be considered in social mental health and policies during an epidemic. The fact that the coronavirus anxiety is below the middle level in the Turkish population suggests that most of the society coped relatively well with the current situation in the early stages of the pandemic period.

One year after the beginning of the pandemic, vaccination studies, which are the greatest hope to prevent COVID-19 infection, have ended and vaccination process have been initiated all over the world. In Turkey, vaccination process was started as of January 13, 2021, and as of September 2021, a success of 82% was achieved in the 1st dose vaccination rates in the population aged 18 and over (45). In this regard, it is obvious that trust in the healthcare system, especially in healthcare professionals and employees, will come to the fore. Indeed, a study reported that the participants saw healthcare professionals and healthcare workers as the most reliable sources of information on vaccine acceptance (46). Health system administrators and politicians need to strive for the safety of the vaccine, its acceptance by the society, and the delivery of the vaccine to the whole community, especially vulnerable groups, and take measures to reduce social anxiety by developing good communication with the public and providing accurate information. Because vaccination programs are only successful when there are high acceptance and coverage rates.

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