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Analyses pluridisciplinaires sur la crise sanitaire COVID-19 en Turquie

Institut français d'études anatoliennes

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DOI: 10.4000/books.ifeagd.3774

Publisher: Institut français d'études anatoliennes

Place of publication: Istanbul

Year of publication: 2021

Published on OpenEdition Books: 17 February 2021

Serie: La Turquie aujourd'hui

Electronic ISBN: 9782362450846



<http://books.openedition.org>

Electronic reference

MARDIN, F. Deniz. *Turkey's Healthcare Policies and the COVID-19 Pandemic* In: *Analyses pluridisciplinaires sur la crise sanitaire COVID-19 en Turquie* [online]. Istanbul: Institut français d'études anatoliennes, 2021 (generated 19 February 2021). Available on the Internet: <<http://books.openedition.org/ifeagd/3774>>. ISBN: 9782362450846. DOI: <https://doi.org/10.4000/books.ifeagd.3774>.

This text was automatically generated on 19 February 2021.

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F. Deniz Mardin

I would like to thank Ass. Prof. Fatih Artvinli, Prof. Dr. Önder Ergönül and Dr. Figen Mutlay for their contributions and feedbacks to this article.

- 1 Healthcare policies are a part of health policies, and health policies, in the simplest definition, contain all the policies that affect the health of a society. This definition comprises all kinds of regulations that would affect both healthcare policies and the health of the society (Rudolph *et al*, 2013).
- 2 This paper, which is an introduction to health policies from the perspective of healthcare policies during the COVID-19 outbreak in Turkey, will respectively discuss Turkey's healthcare system, the outbreak management strategies and Turkey's health policies during the pandemic.
- 3 In order to evaluate Turkey's healthcare policies during the course of the outbreak, we will begin with discussing the current situation in the healthcare system within the scope of the 'Health Transformation Program' and the issue of human resources for health.

Healthcare Services, Human Resources for Health and Health Data in Turkey

- 4 Within the scope of the 'Health Transformation Program',¹ the health system began a process of structural transformation in terms of service provision and financing in 2003. The purpose of the health system reform is to provide a more effective and efficient health service which is accessible for all. This reform also aims to reduce the expenditure of healthcare services. There has been a transformation in both the provincial and central structuring of health services in terms of employment and organisation.

- 5 'Primary Health Care Centres', which were part of the primary care institutions that provided preventive services were replaced by the newly established 'Family Health Centres', and the hospitals, where secondary and tertiary health services which primarily provide curative and rehabilitative services, have been affiliated to Public Hospital Unions within the provincial and central organisation. While all provincial health institutions were coordinated under a single administrative structure prior to the reform, the administration of the primary and secondary healthcare institutions were separated from each other by district and province. In recent years, public health directorates coordinating the primary health care services have again been affiliated to the provincial health directorates as it was deemed appropriate to be managed under a single roof (Altındağ & Yıldız, 2020).
- 6 In accessing primary healthcare services, the people are required to register at family physicians in Family Health Centres and it is stated that those who are not registered, would be accepted as guest patients. In terms of the services provided, priority was given to individual-oriented services in Family Health Centres and in cases where a health service would be required for the social structure, the responsibility was given to the district health directorates (although public health directorates and district health directorates were established in each district in the first stage of the reform, in the following stage the two institutions came under the same roof of the district health directorate as a single structure). The establishment of a more financially autonomous structure, particularly in secondary and tertiary healthcare institutions, has led to an increase of control and practices in financial affairs, and a preference of some medical interventions with higher financial gain (Sert, 2019).
- 7 Another important objective of this reform is the transition of the Ministry of Health (*Sağlık Bakanlığı*), from being a service provider to a position of planning and supervising. As a basis for this, the aim is that health institutions have a more 'autonomous' structure and the decentralisation of health services management. However, perpetual changes within the scope of the reform in both central and local structuring, have complicated the distribution of tasks and the transfer of knowledge of those who have gained experience in certain positions (Hayran, 2017). This situation becomes even more important when health services need to be organised in a quick and efficient way in extraordinary situations such as an epidemic.
- 8 Increasing the number of human resources for health is also a part of the reform. In the report published by the Ministry of Health in 2012, the target for human resources for health for 2023 has been projected. In this context, it is planned to increase the number of educational quotas and educational institutions in order to increase the number of health professionals in various fields and to meet the future supply (Altındağ & Yıldız, 2020).
- 9 Within the scope of the reform implemented in health financing, all social insurance institutions were affiliated to a single institution and by the General Health Insurance law, hospitals affiliated to different social insurance institutions were also gathered under a single roof. The reform also encouraged public-private partnerships in healthcare service delivery (Sert, 2019).

Table 1. Specific Data Regarding Institutions, Infrastructures and Human Resources for Health in 2010

2010	Ministry of Health	University	Private	Other*	Total
Number of Hospitals	843	62	489	45	1,439
Number of Hospital Beds	119,891	35,001	28,063	16,995	199,950
Total Number of Intensive Care Beds	8,674	3,726	6,583		18,983
Number of Adult Intensive Care Beds	6,130	2,900	4,142		13,172
Number of Neonatal Intensive Care Beds	2,544	826	2,441		5,811
Number of MRI Units per 100.000 Individuals	0.33	0.10	0.51		0.94
Number of CT Scanners per 100.000 Individuals	0.51	0.14	0.58		1.23
Specialist Physician	31,527	11,843	19,749	444	63,563
General Practitioner	33,229	262	4,328	999	38,818
Physician Assistant	7,679	13,340	0	47	21,066
Total Number of Physicians	72,435	25,445	24,077	1,490	123,447
Nurse	77,472	15,852	17,209	4,239	114,772
Midwife	45,515	561	4,253	14	50,343

This table was created from the data in the Health Statistics Yearbook 2010 (Sağlık Bakanlığı, 2010).
*Other: Shows the number of health personnel working in administrative jobs other than the Ministry of Health.

Table 2. Specific Data Regarding Institutions, Infrastructures and Human Resources for Health in 2018

2018	Ministry of Health	University	Private	Total
Number of Hospitals	898	68	577	1,534
Number of Hospital Beds	139,651	42,066	50,196	231,913
Total Number of Intensive Care Beds	16,086	6,039	15,973	38,098
Number of Adult Intensive Care Beds	11,171	4,049	8,851	24,071
Number of Neonatal Intensive Care Beds	3,974	1,448	6,980	12,402
Number of Paediatric Intensive Care Beds	941	542	142	1,625
Number of MRI Units per 1,000,000 Individuals	4.1	1.5	5.6	11.2
Number of CT Scanners per 1,000,000 Individuals	6.6	1.7	6.5	14.8
Specialist Physician	43,347	14,438	25,109	82,894
General Practitioner	39,442	291	4,320	44,053
Physician Assistant	8,770	17,411	-	26,181

Total Number of Physicians	91,599	32,140	29,429	153,128
Nurse	126,891	29,263	34,345	190,499
Midwife	52,495	789	3,067	56,351

This table was created from the data in the Health Statistics Yearbook 2018 (Sağlık Bakanlığı, 2018). (As only the summary of the Health Statistics Yearbook 2019 was published during the writing process of this article, 2018 data was taken as a basis).

- 10 When the data in the tables are compared, it is possible to see the large increase in the number of intensive care beds and imaging devices. The fact that the increase in the number of specialist physicians is higher when compared to the increase in the number of general practitioners, and the increase in the number of imaging devices and intensive care beds indicates that the healthcare service delivery has been strengthened within the context of curative services. In addition, the increase in the number of private hospitals is higher than hospitals affiliated to the Ministry of Health and university hospitals. This situation indicates the extent of privatisation in health services (Tables 1 and 2).

Table 3. Specific Data for Health Centres and Human Resources for Health in 2010 and in 2018*

	2010	2018
Number of Family Health Centres	6,367	7,979
Population per Family Physician	3,652	3,124
Number of physicians per 100,000 individuals	167	187
Number of nurses and midwives per 100,000 individuals	224	301
Number of intensive care beds per 10,000 individuals	1.2 (Ministry of Health) 2.6 (All sectors)	2.0 (Ministry of Health) 4.6 (All sectors)

*The data given in Table 3 varies across regions in Turkey and this indicates that the utilisation of healthcare services differs by region.

- 11 According to the OECD health data, the number of physicians per 100,000 individuals, when compared with the European Union countries, the EU average is 371. Among the EU countries, Greece has the highest average of 607 physicians per 100,000 individuals while Germany has 425 and the United Kingdom has 281. The EU average of nurses and midwives is 841. Norway has the highest average of nurses and midwives at 1,821 per 100,000 individuals while Germany has 1,322 and the United Kingdom has 831 (Sağlık Bakanlığı, 2018). The number of health personnel per 100,000 individuals in Turkey, when compared with the data from the European Union countries, indicates that the increase in the human resources for health is insufficient and that the workload of health personnel in Turkey is much more intense compared to EU countries (Tables 1, 2 and 3).
- 12 In addition to healthcare data, global health indicators also help evaluate the effectiveness of healthcare delivery in a given country. The Ministry of Health publishes data regarding health status each year in the Health Statistic Yearbook.

There are certain indicators accepted by the World Health Organisation which describe the health status of a country, among these, such as “life expectancy at birth”, “maternal mortality rate” and “infant mortality rate” are at the top.

- 13 Turkey has made great progress in terms of these indicators over the years. However, the data obtained through research questions the reliability of the data published by the Ministry of Health. A case study calculating the infant mortality rate in Bursa in 2008 compares the data obtained from various institutions with the data of the Ministry of Health. The infant mortality rate as calculated in this study is 20.8 per 1,000 while the same rate is published as 6 per 1,000 by the Ministry of Health. This study revealed the problems in the data published by public institutions both in terms of recording and notice, as well as sharing this with the public (Pala, Türkkkan & Gerçek, 2010).

Outbreak Management Strategies

- 14 Various health policies can be pursued in dealing with an infectious disease without a vaccine. These include the strategies of ‘Suppression’, ‘Mitigation’ and ‘Herd Immunity’. Suppression strategy aims to reduce the number of infected individuals through strict measures that foresee the cessation of contact among the society, thus person-to-person transmission would be minimised. Mitigation strategy aims to reduce the number of infected individuals and deaths caused by the outbreak by reducing contact between individuals, while Herd Immunity strategy aims to protect susceptible individuals and to allow the rest of the society develop immunity by catching the disease. Herd Immunity strategy aims to decrease the number of cases after a certain period of time by the elimination of the risk of getting reinfected with the disease as a certain proportion of the society would develop immunity. However, as a result of this strategy, it is expected that a large portion of the society would become infected with the disease and the number of deaths would be high (Pala, 2020a).
- 15 In order to practice suppression and mitigation strategies, restrictions such as the maintenance of physical distance, the use of masks, limitations in public areas and the interruption of education, might be imposed. In case when the mitigation strategy is implemented, there is a risk of increase in the number of cases with the lifting of restrictions. Under these conditions, it is recommended to adopt a suppression strategy in order to protect the vulnerable groups. In order for society to comply with all these restrictions, the state must provide economic and social support. In addition, a further problem that can occur in the suppression strategy is the difficulty of maintaining restrictions until a cure or vaccine is developed (Kayı & Sakarya, 2020).
- 16 Evaluating the impact of different strategies on society, Ferguson *et al.* (2020) tried to calculate how different restriction types would affect the number of cases and deaths in England, by using data from Italy. The study showed that the mitigation strategy would result in a health system failure with an insufficient healthcare capacity to provide services to patients and hundreds or thousands of deaths. The study also showed that the suppression strategy, which implements restrictions such as physical distance, isolation of infected individuals in their homes, closure of schools, etc., could reduce the death number by half and the demand for healthcare services by approximately 66% (Ferguson *et al.*, 2020). The data obtained in this study had an important role in the transition of the United Kingdom into the suppression strategy.

- 17 The public health approach consists of five basic principles in controlling the infectious disease during an outbreak period: Rapid assessment, preventive action, surveillance,² control of the outbreak and disease management. One of the most important procedures for getting control of the outbreak is the tracing and isolation of infected individuals and those who have had contact with these individuals. In medical terminology, this is referred to as filiation.³ An active surveillance system should also be implemented to identify individuals who are at risk of being infected. In fact, this system needs to be systematically adapted to the changing conditions throughout the outbreak process. The identification of infected individuals with no symptoms is one of the key elements in preventing the spread of the disease, i.e., controlling the outbreak. In order to achieve this, it is necessary to identify those in the risk group and those who have been in contact with infected individuals and to conduct routine testing (Pala, 2020a).

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- 18 The Ministry of Health issued a circular describing the responsibilities of the institutions during flu epidemics that may occur in Turkey, in 2019.⁴ The 'Pandemic Influenza National Preparedness Plan' which was published the same year, explained about organisational, precautions to be taken, risk management and treatment methods during a possible outbreak (Sağlık Bakanlığı, 2019). In January 2020, the Ministry of Health established the Scientific Board and published the '2019-nCoV Disease Healthcare Professionals Guide', which contained the necessary information and algorithms regarding the pandemic. The first COVID-19 case was reported on 10 March and the first death due to COVID-19 on 17 March. Precautions taken against COVID-19 in Turkey included the practice of physical distance and the use of masks in public areas, the interruption of education, the establishment of pandemic hospitals, restrictions on intercity travel and curfews imposed first for certain age groups and then for everyone at certain intervals. In addition, as of February, flight restrictions were imposed and flights suspended to China and other countries (TTB, 2020, p. 16-20). The report where Mobility Reports by Google were shared, indicated that at the beginning of April, restrictions reduced human mobility in areas such as restaurants, cafes and shopping malls by 76%, in parks by 61%, in public transportation by 76% and in workplaces by 48% (HASUDER, 2020). However, the decision of whether or not the employees would go to their workplaces was left to the employers, and although most of the white-collar employees started to work from home, most of the blue-collar employees continued to work in enterprises and factories. This situation has increased the risk of a certain socio-economic group catching the disease (Güngör Delen & Peksan, 2020). The Ministry of Health and all public institutions conducted a campaign called 'Stay at Home' and 'Life Fits into Home'. However, the fact that the government had shared an IBAN number within the scope of a campaign for economic support, was met by a considerable reaction by various institutions (TTB, 2020).
- 19 The legislation published on 9 April, stated that the treatment of COVID-19 cases was taken into the scope of 'an emergency' and that foundation and private hospitals would not receive additional fees from individuals infected with COVID-19. The Presidential decree published on 13 April declared that everybody would have access to COVID-19

diagnostic tests and drug treatment free of charge, regardless of whether they had any social security (Mardin *et al*, 2020).

20 Turkey initiated a normalisation plan suddenly rather than in a gradual transition, as of beginning of June. The normalisation procedure was also supported by official statements declaring that the outbreak was under control and that Turkey had successfully managed the process. However, the fact that such statements were not based on scientific data and were made with economic concerns, has resulted in an increase of cases in Turkey and to a decrease of individual measures in society (Kızıl, 2020). Comparing the data from the Ministry of Health on 29 July and at the beginning of September, it is possible to see that the increase in the number of patients with severe symptoms is more than 100% (Pala, 2020b).

21 A controlled outbreak management strategy has led to a decrease of cases and interpersonal transmission, which however has not been effective in ending the outbreak. Health Minister Fahrettin Koca stated on 2 September that the increase of cases was the result of carelessness by individuals and continued:

I can say that we are experiencing the second peak of the first wave of coronavirus. Our dynamism and carelessness during holidays and weddings, which are important part of our traditions and customs, brought us to this edge (CNN Türk, 2 September 2020).

22 With the circular issued by the Ministry of Internal Affairs, the obligation to wear masks in all open areas, public transportation and workplaces in 81 provinces was imposed as of 8 September, and it was decided to impose an administrative fine in case of failure to comply with the rules, as a consequence this penalty was announced as 900 TL (İçişleri Bakanlığı, 2020).

23 COVID-19 data are published by the Ministry of Health in daily and weekly tables. There are two classification types in the document published by the World Health Organisation regarding the clinical coding of COVID-19. The first one shows individuals who have a positive test result which describes a definite diagnosis, and the second one shows individuals who have a negative test result despite having clinical symptoms. The first one is called a confirmed case and the second one is called a suspected/probable case (Pala, 2020a). Unlike the World Health Organisation's classification, the Ministry of Health has not included suspected/probable cases of COVID-19 and has only defined individuals who had a positive test result in the PCR test as COVID-19 cases (Sayılı *et al*, 2020). In addition, as of 29 July, some of the data published in the tables by the Ministry of Health had been changed. According to these changes, the number of intensive care patients and the total number of intubated patients had been removed and instead the pneumonia rate and the number of patients with severe symptoms had been added (Kızıl, 2020; Pala, 2020b). In his statement on 3 September, Health Minister Fahrettin Koca said:

Not every case is evaluated as a patient because there are those who show no symptoms even though the test result is positive.

24 This statement means that only people who showed symptoms were published as a new number of cases (DW, 2020, September 30). According to the data published by the Ministry of Health on 15 October, the number of daily patients was 1,693, the number of deaths was 66 and the number of recovered patients was 1,311. Up until this date, the total number of recovered patients had been 342,143, the total number of deaths, 9,080 and the number of patients with severe conditions, 1,408.⁵

Organisation of Healthcare Services in Turkey during the Outbreak

- 25 Health institutions have various responsibilities and duties for outbreak management. Family Physicians follow cases and their contacts by phone for fourteen days, while the case investigation and contact tracing i.e., the filiation is carried out by healthcare professionals from the District Health Directorates. In the management process of the outbreak that affects the entire society, Family Health Centres, which have larger human resources for health had a passive role, while the District Health Directorates, which have limited human resources played an active role (Pala, 2020a). In addition, District Health Directorates carry out the tracing of those who are not registered to a Family Medicine Practitioner or those who do not live in the city where they are registered to a Family Physician. After the health reform, being unregistered to a Family Medicine Practitioner, has become one of the difficulties for benefiting from primary healthcare services. In cases such as pandemics, where society must be handled as a whole, individual service provision makes outbreak management and cooperation between units difficult.
- 26 On the other hand, Family Health Center employees were not provided with the necessary support in terms of protective materials or algorithms to cope with the pandemic and this has caused primary healthcare service workers to become infected with the disease and in some cases, to lose their lives (TTB 2020, p.105-106). In addition, considering the number of human resources for health, the fact that the increase in the number of general practitioners is smaller than that of specialist physicians indicates that primary healthcare services had not been adequately strengthened and as a result, they already had a heavy workload (TTB Pratisyen Hekimler Kolu, 2020).
- 27 During the pandemic, there have been a large number of patients in the secondary and tertiary hospitals. Although the fact that the number of intensive care beds has increased over time was seen as an advantage, half of the beds were in private hospitals, which caused accelerated patient admissions in state and university hospitals until the declaration of private hospitals as pandemic hospitals. In addition, the fact that the increase of intensive care unit beds was not supported by an increase in the number of healthcare workers, indicates the heavy workload of healthcare workers before the pandemic (Topeli, 2013). Health Minister Fahrettin Koca stated on 29 April that 7,428 healthcare workers were infected with the virus and this number reached 29,865 as of 2 September together with the deaths of 52 of these healthcare workers (Euronews, 2020, April 29; Medimagazin, 2020, September 2). In the presentation of the seventh month report by the Turkish Medical Association, it was stated that the number of healthcare workers who lost their lives up until the date of 11 October, was 112, among which 48 were physicians.⁶ This data shows that despite the fact that healthcare workers are in the group most at risk due to their work in the outbreak management, the necessary measures could not have been taken in order to protect them.
- 28 In addition to the organisation of health services and human resources for health, cooperation and transfer of experience between institutions has an important role in fighting pandemics. The Central Institute of Hygiene was established in Turkey in 1928

for the dissemination of modern health practices, the production of drugs and vaccines and the management of laboratories. After the death of Dr. Refik Saydam, the institute was renamed as the Refik Saydam Central Institute of Hygiene but was closed in 2011. One of the important tasks of this institute was its role in infectious diseases and outbreak management. The institute was involved in the treatment of many infectious diseases such as tuberculosis, malaria and syphilis as well as in the outbreak of cholera, smallpox and diphtheria both in the management of the outbreak and the training of human resources for health. Artvinli (2020) stated in his article titled 'Salgınların Tarihi (History of Epidemics)' that "*Institutional memory is as important and functional as social memory in outbreak management*".

- 29 One of the main problems in epidemic management is that institutions and individuals cannot transfer their accumulation of knowledge and experience in a rapidly changing health system. This situation also complicates the timely implementation of necessary and effective interventions during the outbreak process.
- 30 There have also been problems in utilisation of healthcare by those with health problems other than COVID-19. In various studies, it has been determined that individuals with health problems other than COVID-19 had longer waiting periods to access healthcare services and their treatment was also delayed, which in turn has caused an increase in deaths from conditions other than COVID-19 (Sayılı et al, 2020; Örün, 2020).
- 31 The growth of the outbreak, the increase of cases and deaths can lead to an increase of anxiety among society and long-lasting anxiety can lead to depression. (Grupe & Nitschke, 2013). The addition of job losses and the lack of social support increases the risk of illnesses and death among these people (Şimşek, 2020).

Transparency and Communication in Data Sharing during the Outbreak Management Process

- 32 Another key element in outbreak management is data sharing, evidence-based knowledge production and community-based policy production.
- 33 One of the issues that betrays the trust in the data published during the pandemic, is seeing that the data obtained in research are different to the data published by the public institutions. An example of this, is a study that compares the death registration data of Istanbul in the years 2019 and 2020. The study revealed that the excess in the number of deaths in Istanbul during the two-month period from the beginning of the outbreak, compared to the previous year, was close to the number of reported deaths by COVID-19 in the entire region of Turkey for the same period. In the study, it was determined that, "*the mortality rate by week increased by between 15% and 55% and a total number of 3654 (2714-4664) excess deaths had been reported*" (Sayılı et al, 2020).
- 34 Similar data has been found when the total number of deaths in the first eight months of the COVID-19 outbreak is compared with the average number of deaths in the last five and ten years in Turkey. Comparing the number of deaths reported in previous years with the 2020 data in various countries, it is possible to see an increase by 70% due to COVID-19. Considering a similar situation is applicable also for Turkey, the total number of deaths reported until the beginning of September should be four times more (Kisa & Kisa, 2020).

- 35 Another disclosure that betrays the trust in the data published is the statement regarding the contradiction of the number of cases published by governorships in various cities in August, with the total number of deaths reported by the Ministry of Health (Koç, 2020, August 5). In fact, the argument claiming that there was not sufficient capacity for testing and diagnosis during the initial phase of the outbreak in Turkey and that there were cases even before the identification of the first case, is being discussed by scientists (Kızıl, 2020; Pala, 2020b).
- 36 History has seen states that exhibited different attitudes in sharing information and data during outbreaks. Snowden (2019) has stated in his book that the reason behind the naming of the H1N1 pandemic as the 'Spanish flu, which killed millions of people during the First World War, is due to the fact that news about the outbreak could have been published in newspapers in Spain, which had remained neutral in the war (as cited in Artvinli, 2020). Another example is the Chinese government, which prevented news channels, rights defenders and activists from reporting on the SARS outbreak in 2003. Trying to announce the outbreak to the public, Dr. Jiang was seen as a bad, harmful example to society and the country, and his behaviour was considered punishable. Unfortunately, a similar attitude was repeated in early December when the COVID-19 outbreak started, and eight people who had posted about the epidemic on social media had been detained (Yuan, 2020, January 22).
- 37 A similar attitude was also displayed in March in Turkey when a secretly shot video showing a specialist doctor of infectious diseases informing the hospital staff about the COVID-19 outbreak, was shared on social media. After the circulation of the video, the hospital administration launched an investigation about the doctor making the statement (Bianet, 2020, March 19).
- 38 As of June, contacts with confirmed cases, which were followed up by the Family Physicians were removed from the list of those to be tested for COVID-19 (TTB Pratisyen Hekimler Kolu, 2020). This means that those groups at risk in the society cannot be followed up. In addition, an article published by the Turkish Thoracic Society stated that the Ministry of Health did not share data and that research could only be conducted with permission from the ministry. This makes it difficult to produce scientific data, which is a worrying situation (Bayram *et al*, 2020).
- 39 Following the Turkish Medical Association's (TTB) call on 14 September to wear a black ribbon and the campaign launched with the slogan "You can't manage, we are burning out" to draw attention to healthcare workers who have lost their lives due to COVID-19, the Nationalist Movement Party (MHP) Chairman Devlet Bahçeli posted the following on social media:
- My call is this: The Turkish Medical Association is fuelling groundless blemishes and suspicions about human and public health in such a sensitive period as this. For this reason, the Medical Association that has the word Turkish in its name must be closed immediately and without delay. Legal action must be taken against its executives (DW, 2020, September 17).
- 40 The proper sharing of information and data by public institutions will ensure the realisation of risk assessments during the pandemic process, the development of health policies and the increase of public trust in public institutions and compliance with the regulations (İnandı *et al*, 2020).
- 41 The lack of trust not only impairs the belief in the data published but also negatively affects many people in terms of compliance with health policies. A case study

demonstrating this has been conducted by Blair, Morse and Tsai (2017) in Liberia during the Ebola outbreak. The study revealed that people who had taken fewer measures were not those who had less information about the Ebola virus, as it was thought, rather they were those who did not believe that the restrictions were useful because they did not trust the government or public institutions. This study shows the importance of public trust in the state and public institutions in terms of compliance with the health policies.

- 42 Similar data was obtained in Turkey in the research conducted by Konda research and consultancy company in March. The results revealed that 86.5% of the society knew how the virus spread, 85% know what to do for protection, however only 55% followed the necessary precautions. In addition, 45% indicated that they did not believe that, “*the Ministry of Health and state institutions took adequate measures against the virus*” or that, “*the relevant institutions gave correct information to the society*” (Konda, 2020).
- 43 Trust in public institutions and government is different from interpersonal trust, but whether individuals working in these institutions fulfil their responsibilities is the main factor affecting the trust in these institutions. Individual trust in institutions also varies depending on their own experiences and whether their expectations are met or not (Örselli & Sipahi, 2016).
- 44 Data obtained in a public survey on social engagement and trust in public institutions conducted in twenty-five European countries were compared in COVID-19 mortality. The study has revealed that trust in public institutions is a factor reducing mortality during the COVID-19 outbreak and has a protective effect. Trust in public institutions increases compliance with the recommendations and regulations made by the government and this eliminates some of the factors that increase the spread of the virus. In countries, where there is little trust in the government, penalties are imposed for those who do not comply with the rules, as in Italy (Oksanen *et al*, 2020). A similar situation is observed in Turkey. The failure to share information causes a decrease of trust, which in turn leads to less compliance with health policies and this will cause the virus to spread. Moreover, the repressive attitude of the government to those who argue for the transparency of the data and the perception created by the government that being infected with the virus is the individual’s responsibility, causes the trust in public institutions to decrease over time. Under the circumstances where new information regarding the COVID-19 infection and the immunity predicted to develop is obtained daily, and where there is still uncertainty on some issues, transparency of data and trust in public institutions are essential elements in outbreak management.
- 45 In a country that is constantly changing both structurally and in terms of human resources, where data production is not transparent and not accomplished with the participation of different groups as it should be, and where scientists are excluded from the stages of policymaking, it is rather impossible to develop effective and rapid health policies and adjust these into society during the pandemic period. As a
- 46 result, unfortunately, while the cases are starting
- 47 to increase again, Turkey has come to the phase of “denial” from “management”⁷ in its pandemic governance.

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NOTES

1. For more detailed information, look at Yılmaz V. (2017), *The Politics of Healthcare Reform in Turkey*, London: Palgrave Macmillan.
2. Surveillance: Regular, routine, and continuous collection of data for disease prevention, control sharing and distribution of the information with the relevant units, the scientific environment and the public. HASUDER (2020), Kavramlar ve Tanımlar Rehberi, *Halk Sağlığı Uzmanları Derneği (HASUDER)*, Ankara.
3. Filiation: Determining the source and the agent and/or taking protection and control measures including contacts. HASUDER (2020), Kavramlar ve Tanımlar Rehberi, *Halk Sağlığı Uzmanları Derneği (HASUDER)*, Ankara.
4. Presidential Circular on the Pandemic 2019/5, 13 April 2019, Issue 30744.
5. Ministry of Health, COVID-19 Information, <https://covid19.saglik.gov.tr/TR-66935/genel-koronavirus-tablosu.html>.
6. Turkish Medical Association – 7th Month Report Presentation, https://www.ttb.org.tr/kollar/COVID19/haber_goster.php?Guid=87946e5c-0c7f-11eb-8c8a-efeed974bb4d.
7. The use of this terminology was inspired by the article published in *Birikim Magazine*. <https://www.birikimdergisi.com/dergiler/birikim/1/sayi-213-ocak-2007/2396/inkar-siyasetinden-idare-politikasina-kurtlerin-zorunlu-gocu/5003>.

ABSTRACTS

During the pandemic, health policies have been affected by many factors. The primary concerns are the current health system, human resources for health and an epidemic management strategy. Due to the 'Health Transformation Program', health services in Turkey have changed in terms of structure, service delivery and financing. Increasing investments in therapeutic services and private-public cooperation within the scope of the program has made preventive healthcare services weak in terms of structure and health personnel. Although interventions for the management of the outbreak were initiated quickly, the failure to fully implement a suppression strategy and the early removal of the interventions, have led to an increase in the number of cases. Also, a lack of transparency in data sharing has led to the failure to properly organise health services for epidemic control and has shaken the public's trust in public institutions. In addition, due to the changing health system, people and institutions with knowledge in epidemic management were not able to transfer their experience, which prevented necessary and effective interventions from being carried out on time. As a result, it became impossible to develop effective and rapid health policies during the epidemic in a country that is constantly changing in terms of both structural and human resources for health, there is no transparency for data

sharing and scientists are forced into the role of consultants and are not able to participate in the stages of policymaking.

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