International Labour Organization

Social Protection in Action: Building social protection floors for all

Country Brief: Timor-Leste

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Extending Social Health Protection in Timor-Leste: Accelerating progress towards Universal Health Coverage

1. Introduction

A lower middle-income country, in 2018, Timor-Leste had a population of 1,267,975, and in 2014, 40.2 per cent of the population lived below the national poverty line (World Bank 2018).The social protection system in Timor-Leste is comprised of a range of 26 programmes, including broad-based cash transfer schemes, social services to vulnerable groups and free or affordable national health and education services. Presently, the health system in Timor-Leste is predominantly public, with a national health service system implemented by the Ministry of Health (MOH), which covers all Timorese citizens, residents and stateless persons. This is supplemented by a range of additional social health protection schemes and programmes designed to expand health coverage to hard-to-reach populations or target vulnerable population groups.

Health services in Timor-Leste are mainly financed and provided by the Government, and generally, health care in public facilities is free at the point of service, with out-of-pocket payments (OOPs) lower than most countries in the region. However, the low OOP rate is linked to lower utilization of health services compared to other countries in the region. Moreover, the absolute amount of public health spending is low compared to other countries in East Asia. The country faces a growing need to allocate resources towards health coverage and increase the accessibility and availability of health services, particularly for the country's rural inhabitants, who account for 74 per cent of the population. To address these challenges, in 2011, the Government launched the National Strategic Development Plan (2011–2030) to set ambitious targets towards becoming an upper-middle-income country. A key part of the national strategy is to provide access to health care and financial protection to all citizens (UN et al. 2018).

2. Context

After Timor-Leste's independence in May 2002, most of the country's infrastructure was destroyed, including the health system. Specifically, 77 per cent of health facilities were damaged and a significant number of doctors and other health professionals were displaced (Cousins 2019). The United Nations Transitional

Administration in East Timor (UNTAET) was established on 25 October 1999 as a United Nations protectorate which aimed to solve the decades-long East Timorese crisis in the area occupied by the Indonesian military. Since its establishment, UNTAET provided an interim civil administration, directly administering the territory of East Timor, and a peacekeeping mission in the territory of East Timor. This continued until the country's independence following the outcome of the East Timor Special Autonomy Referendum. One year after independence from Indonesia, the Council of Ministers approved the "Health Policy Framework for East Timor" which demonstrated a firm commitment to providing free essential services on the principles of equity, population-wide coverage and financial protection. Since independence, Timor-Leste has invested in training physicians for primary health care by sending students to study in Cuba under a Timor-Leste and Cuba government partnership.

To supplement the national health service which provides health services for free to all Timorese citizens in public health care facilities, the Integrated Community Health Service Programme, Serviço Integrado de Saúde Comunitária (SISCA) commenced in 2008, which provides community-based primary care at the village level (Martins and Trevena 2014). Following this, in 2011, MOH released the National Health Sector Strategic Plan 2011–2030 to provide guidance for the country's health sector to move towards UHC through better access to health services and financial protection (Timor-Leste Ministry of Health 2011). The plan aims to rebuild health facilities, expand community-based health services, increase the number of medical graduates, and launch the health financing strategy and family health service delivery model (WHO 2019).

In line with the plan, in July 2015, the Health in the Family Programme (Saude na Familia) was launched to cover reach hard-to-reach populations by providing basic health care to every household within the country. The programme, modelled on the Cuban system, proactively sends medical teams (comprised of a doctor, midwife and nurse) to every household in the nation, which is considered a transformative primary health care reform in Timor-Leste (Government of Timor-Leste 2017). In the same year, the Vulnerable Patients Programme was introduced to provide financial assistance for vulnerable patients who are transferred to referral hospitals. The programme aims at enabling family members to accompany beneficiaries during the period of hospitalization (UN et al. 2018). The Health Care for National Liberation Combatants Programme was later introduced to finance overseas health care utilization for National liberation combatants who fought in the independence conflict with Indonesia.

In 2019, the country launched the Health Financing Strategy 2019–2023, which envisions the following four main objectives: "ensure financial protection for the population; increase health funding to cover unmet needs such as coverage of essential services, strengthen hospital care and tackle financial needs associated with non-communicable diseases and others; reduce inequities in resource availability and service utilization across territories and population groups; and improve system-level allocative and technical efficiency" (WHO 2019). Despite these efforts, 2020 was a particularly challenging year for Timor-Leste in terms of progressing social policy. In addition to the COVID-19 situation, the Social Security Reserve Fund (SSRF) was established and its management models were approved. The autonomous fund was created to reinforce the financial sustainability of the system and promote intergenerational solidarity.

3. Design of the social health protection system

- Financing

Timor-Leste has a non-contributory national health service system in which health services are publicly financed and provided. The health sector is heavily dependent on external funding through international development assistance for health (DAH), while national government budgets are generally heavily dependent on revenues from oil extraction. However, in the last few years donor health spending has notably declined, and is projected to continue this trend in the medium term. This will place significant pressure on the total health budget, as the MOH will be forced to fund priority health projects previously funded by donors (World Bank 2014).

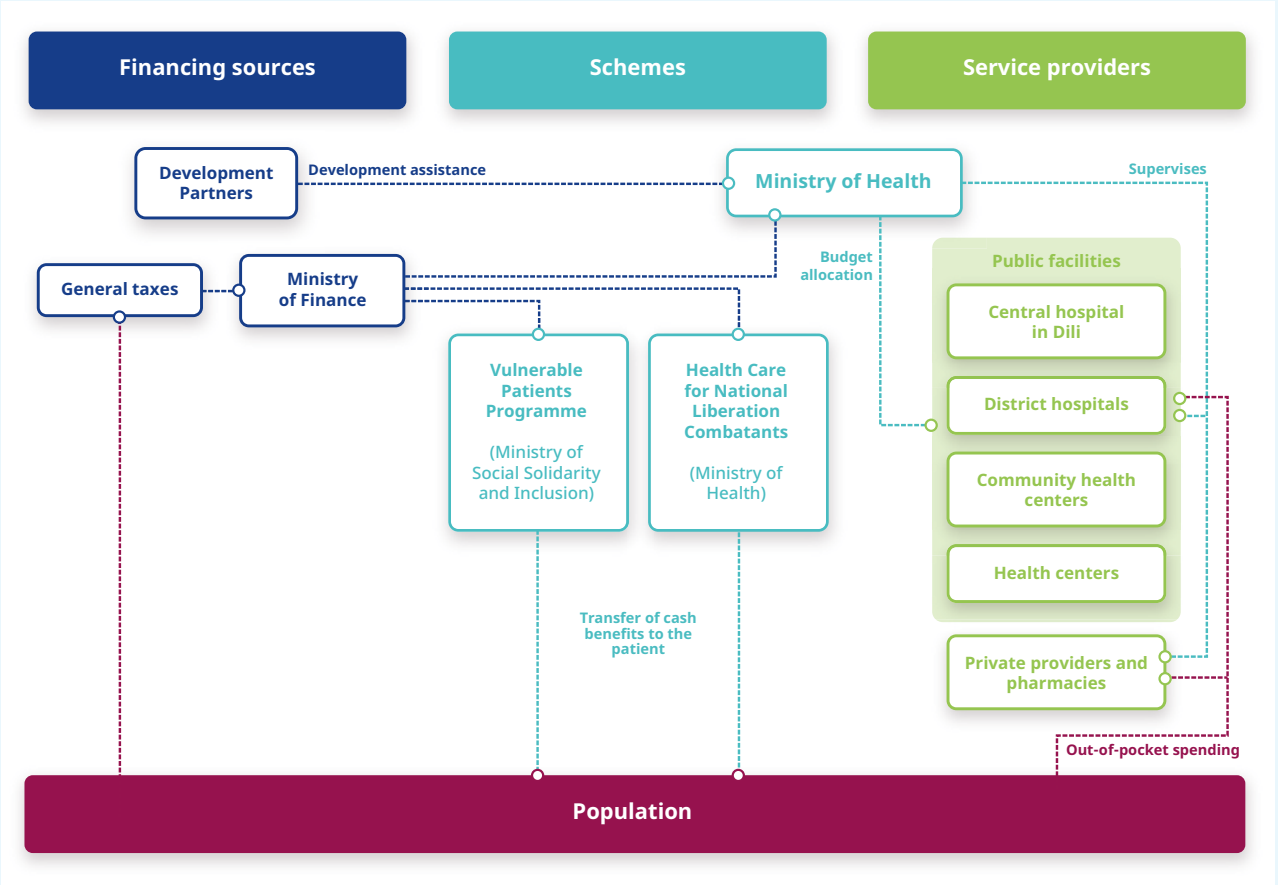
In 2017, public health care financing schemes accounted for 86.63 per cent of current health expenditure, OOP spending accounted for 8.3 per cent and voluntary health care payment schemes accounted for 5 per cent (WHO n.d. a). The health sector budget was equal to US$73 million in 2017, and accounted for only 5.4 per cent of total national budget (Kelly et al. 2019). In the same year, per capita spending on health was US$83.20, which amounted to 3.88 per cent of GDP (WHO n.d. a).

The national health service system is predominantly financed by the general government budget, which is primarily comprised of revenues from the extraction of oil. External financial sources also contribute to strengthening the system, including via vertical programmes. The total budget allocated to hospitals, municipal health services, laboratories and service delivery units in 2015 was estimated at US$33,945,000 (UN et al. 2018).

The SISCA programme is also entirely financed by the general government budget, though it does not have a specific budget, because each health centre or hospital, responsible for several villages in its area, uses its operational budget for this programme (UN et al. 2018). Similar to SISCA, the Health in the Family Programme does not have separate budget allocation, which leads to unpredictability of service provision (UN et al. 2018). The vulnerable Patients Programme, which is non-contributory, and the Health Care for National Liberation Combatants Programme are also financed by the national budget. In 2015, the Vulnerable Patient's programme was allocated US$25,000 and in 2018, the National Liberation Combatants programme was allocated US$750,000 (UN et al. 2018).

The financing flows of the health protection system are schematically presented in figure 1.

▶ Figure 1. Overview of main financial flows of the social health protection system in Timor-Leste



Source: Authors.

- Governance

The Health System Law of 2004 [1] establishes the legal basis for the national health service system, ensuring health protection through prevention, promotion and treatment activities. According to the law, health policies are defined by the Government, with the MOH proposing, promoting and following up on their execution and coordination, and international health organizations and ministries overseeing related areas. In line with the Health System Law, the national health service system operates under the direction of the MOH and, in each district, under the guidance of the respective district chief of health. Each District Health Service has a District Health Council, to provide support, consultation and coordination for the provision of primary health care.

The SISCA programme operates on the basis of ministerial orders, namely the Organic Law of the VI Constitutional Government and the National Strategy of the Health Sector 2011–2030 (UN et al. 2018). Similar to SISCA, there is no specific legislation to regulate the Health in the Family and the Vulnerable Patients programmes. The Health Care for National Liberation Combatants Programme operates under the National Liberation Combatants' Statute and is implemented by the Ministry of Social Solidarity (MSS), the National Directorate of National Liberation Combatants Affairs, and the Department of Programmes (UN et al. 2018).

- Legal coverage and eligibility

The 2004 Health System Law establishes the legal basis for the national health service system, which covers all Timorese citizens, residents and stateless persons. SISCA targets all the residents of visited communities, with special attention given to children younger than 5 years of age, pregnant women, adolescents of reproductive age, older persons and people with disabilities (UN et al. 2018). The Health in the Family programme targets all Timorese families, especially those in isolated locations. The Vulnerable Patients programme targets vulnerable patients who are transferred to referral hospitals, as well as their families. The Health Care for National Liberation Combatants Programme finances overseas health care utilization for National liberation combatants who fought in the independence conflict with Indonesia.

- Benefits

The national health service system provides an implicit benefit package defined by law, with publicly funded services free or affordable at the point of service in public facilities, covering a wide range of interventions including specialized and emergency health services, drugs and physical examinations and laboratory tests. The benefit package also includes the possibility for overseas referrals, partly financed by the national health service. User fees are stipulated by article 20 of the Health System Law and the schedule for such fees is jointly approved by the Ministry of Finance and the Ministry of Health. Fees are applied to the following:

(a) payment of health care provided in a private room or by any other modality that is not provided to users at large
(b) payment of health care by third parties which are legally or contractually liable, notably health subsystems or insurance companies
(c) payment of health care provided to people who are not beneficiaries of the National Health Service, where there are no liable third parties
(d) payment of affordable contributions for health care provision
(e) payment of charges for other services provided, notably within the scope of sanitary surveillance, or for the use of facilities or equipment
(f) proceeds from own goods
(g) proceeds from donations
(h) proceeds from payments by users or third parties, with respect to infringements of the applicable rules or the fraudulent use of services or materials.

The SISCA programme provides community visits to the population. During community visits, medical teams often provide a free-of-charge set of basic primary care services, including: (i) general health care, including medical consultations, and health and hygiene education; (ii) medical care for children, including birth registration, nutritional assessment and education for parents on healthy practices; and (iii) maternal care, including

[1] Law No. 10/2004 of 24 November 2004 on the Health System, available at: https://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=fr&p_isn=89769&p_country=TLS&p_count=70&p_classification=15&p_classcount=11

nutritional assessment, treatment and primary health care education.

The Health in the Family programme carries out home visits in order to identify the health conditions and risk factors of each family, and offers preventive and curative care. In theory, the programme sends a team of health professionals to each household in the country. The following services are included in a home visit: (i) delivery of medicine and dietary supplements based on patients' needs; and (ii) consultation with medical professionals on the personal health of each family member and on healthy habits and disease prevention (UN et al. 2018). The service has a strong educational component and also aims to contribute to the development of a single registration database for health care at all levels.

The Vulnerable Patients programme provides a range of cash benefits depending on the patient's situation, which are paid on a daily, monthly or lump sum basis. The Health Care for National Liberation Combatants pays all costs of health care provided abroad to beneficiaries.

- Provision of benefits and services

Timor-Leste's public health system is decentralized, with three levels of care. Primary health care is provided through a network of health posts, Community Health Centres (CHCs), and the integrated community health services under the SISCA program. The district-level health system is hierarchical and clustered in three layers: a district health office, CHCs and health posts. The health posts report to CHCs, which in turn report to the district health office (WHO 2016). The public network includes a national hospital in the capital providing tertiary care, five district-level hospitals, a network of 68 CHCs, 280 health posts, and 43 maternity clinics delivering primary health care services (UN et al. 2018). In 2013, the primary level delivered approximately 90 per cent of the outpatient visits, and employed 45 per cent of doctors and 52 per cent of other technical personnel (Cabral et al. 2013).

Non-governmental Organizations (NGOs) also provide a limited number of health services in several parts of the country via vertical programmes/projects, and private medical clinics are operating in Dili and towns in some districts. However, these services are not incorporated into the government-funded system and despite legislation in place, their regulation could be further strengthened. Although many international NGOs have ceased health work in the country, as of 2010 there were 60 national and international NGOs working with the MOH in areas such as nutrition, maternal, newborn and child health, family planning, delivery of primary care and specialized services, mental health, and interventions for HIV/AIDS (Mercer et al. 2014).

4. Results

- Coverage

Although the government-funded national health service in Timor-Leste provides free or affordable health care to the whole population, there are significant gaps in rural areas in particular, due to inaccessibility. In 2017, the overall proportion of the population with access to health services was estimated at 52 per cent (WHO n.d. b; WHO and World Bank 2017).

Several of the complementary social health protection schemes reach a large share of their targeted population, even if they do not offer benefits to a large number of people; specifically, in 2015, SISCA had 812,870 beneficiaries, representing 68.6 per cent of the total population (UN et al. 2018). In 2015, the Vulnerable Patients Programme covered 400 beneficiary patients (1.7 per cent of all hospitalized individuals) and 200 beneficiary families (0.1 per cent of total households). The Health Care for National Liberation Combatants Programme covered around 52 beneficiaries in 2015. As for the Health in the Family programme, in 2017, the Prime Minister of Timor-Leste reported that, since the launch of the programme on 22 July 2015, medical teams had visited 94 per cent of households and had registered the details of 84 per cent of the population at the individual level (Government of Timor-Leste 2017).

- Adequacy of benefits/ financial protection

OOP payments in Timor-Leste are relatively low compared with other Asia and Pacific countries (Hou and Asante 2016), accounting for only 8.34 per cent of current total health spending in 2017 (WHO n.d. a). However, it is important to highlight that the low level of OOP payments is likely to reflect limited infrastructure and availability of health services rather than low-cost access to

a full range of health services. According to the 2007–2008 Timor-Leste Survey of Living Standards (TLSLS), most of those who incurred OOP spending did so due to utilization of the private sector. Most households (89 per cent) that sought health care reported visiting a public health care provider and only 3 per cent of visits to public providers incurred a payment. Conversely, more than half of patients who went to private providers made a payment to a provider (World Bank 2014). Nonetheless, evidence suggests that catastrophic expenditure in Timor-Leste is moderate, with around 3.5 per cent of the population spending more than 10 per cent of the household budget on health and 1.1 per cent of the population pushed below the poverty line of US$1.90 per capita per day because of health spending (WHO 2017).

- Responsiveness to population needs

  - o Availability and accessibility

Transportation costs are reported to add to patient costs when seeking care, which poses significant barriers to care seeking, with distances to the nearest health facility disproportionately affecting rural and poor populations (World Bank 2018). As such, inequalities in health care access exist between rural and urban regions, which is also reflected in an uneven allocation of medical professionals, medical facilities and equipment. These factors mean that rural households less likely to visit hospitals than urban households (Guinness et al. 2018). In addition, the poorest quintile has been found to be less likely to use more expensive hospital services than other socio-economic groups (Guinness et al. 2018). According to a study that used a representative cross-sectional survey of health care utilization among 1,712 households in Timor-Leste, medical need was found to be the key driver in seeking both primary care and hospital services (Guinness et al. 2018). Overall, evidence suggests that the distribution of health service utilization in Timor-Leste is inequitable, with variations in access to health services between urban and rural, rich and poor, and educated and uneducated populations (WHO 2019). However, over the years, there has been an expansion of public health services catering to urban areas, which effectively improved access in some regions (World Bank 2018).

In addition to individual and contextual constraints, such as income and access to affordable and reliable transportation, utilization is affected by the limited availability of medicines and trained health workers (Guinness, et al., 2018). In 2010, the Demographic and Health Survey programme (DHS) reported concerns about the availability of health care staff and drugs at facility level, which hinders the range of benefits effectively provided (National Statistics Directorate et al. 2010).

  - o Quality and acceptability

Despite limited availability of health staff and drugs, Timor-Leste has progressed rapidly in the area of maternal health, increasing the number of deliveries attended by a skilled health professional. In areas this indicator reached almost 87 per cent in 2016, demonstrating an increase of 27 percentage points compared to 2010 (WHO n.d. b). This is encouraging, and reveals efforts to adapt to the population's needs. However, more efforts are needed to extend such progress to rural areas, and improve child health indicators, which remain below the regional average (World Bank 2018). In addition, there is an insufficient supply of specialized health care services for certain types of diseases (such as mental illness) or for vulnerable groups (such as older persons and persons with disabilities).

Overall, several challenges are faced in ensuring the quality of the services or the in-kind benefits (UN et al. 2018). While a Quality Control Unit exists under the MOH, intermittent or unreliable service provision in public health facilities and lack of human resources, medical supplies and drugs are key constraints leading to poor service delivery (Kelly et al. 2019). To address this, the Strategic Development Plan 2011–2013 proposed that all health posts should have at least one doctor, two nurses and two midwives by 2020 (Government of Timor-Leste, 2011). As a result, the presence of doctors in rural areas has hugely improved, from less than 2 per 1,000 population in 2012 to more than 6 in 2014 (World Bank 2018). Nonetheless, the presence of doctors on the ground does not automatically translate to improved service delivery. Furthermore, women have concerns that they may not be able to be attended by a female health professional, which remains a significant issue to address.

- Coordination

There are limited mechanisms for the coordination of social protection and health policy formulation, implementation, operations, resources or information sharing (UN et al. 2018). This has led to a fragmented system in which

different programmes collect information on potential beneficiaries. Most programmes suffer from a lack of financial and human resources, a lack of mechanisms for quality assurance and monitoring and evaluation, and the late release of funds for operations (UN et al. 2018). These issues often relate to other underlying problems, such as inadequate management and information systems and lack of coordination mechanisms, resulting in limited institutional capacity to better manage, deliver, monitor, and evaluate social protection programmes. In addition, several programmes operate based only on ministerial orders, failing to ensure their long-term continuity or the establishment of rights to beneficiaries (UN et al. 2018).

In relation to the broader social protection system, it is also important to note that in 2016, the Government established the first General Social Security Scheme (Law No. 12/2016), which is mandatory for all workers in the private formal and public sectors, marking a historical transformation in social policy. The new social security system has been built in stages since then, offering provisions for old age, invalidity, maternity, paternity, adoption, death and, in the future, work injury (UN et al. 2018). By 2017, just one year from its implementation, around 70,000 people or 36.6 per cent of the labour force were effectively covered by the scheme. Although not part of the health protection system, the scheme includes benefits which are either directly or closely related to health conditions, such as maternity and old age.

Specifically, the scheme establishes a set of contributory provisions, in cash, that protect workers and their families through different benefits in the following cases: (i) Old age – Pensions, for workers aged 60 years or older, with benefit value based on average wage and length of the contributory career; (ii) Invalidity – Pensions for total and partial invalidity, with benefit value is based on average wage and length of the contributory career; (iii) Death – Lump-sum payments, survivor's pensions and reimbursement of funeral expenses in the event of a worker's death, with benefit values varying according to average wage of contributory career; (iv) Maternity or paternity – income substitution benefits for maternity, paternity, adoption, medical risks during pregnancy and pregnancy complications (UN et al. 2018). Given the link between such benefits and health, coordination between this scheme and health protection policies will therefore be essential moving forward.

5. Way forward

As outlined above, the Timorese social protection system is comprised of a range of programmes, including broad-based cash transfer schemes, social services to vulnerable groups, and free or affordable public health services. However, the system is fragmented, resulting in gaps which leave many without coverage or adequate support. Moreover, the country still confronts inequalities with respect to access to health services, which considerably affects rural households and reinforces their vulnerability. To address this, the Government of Timor-Leste is exploring innovative ways to increase health care access in more isolated areas. Rural road infrastructure and public transport development should be a priority in this regard, with support from donor partners through grants. Such improvements would not only help smooth the path to UHC but would also provide benefits to other sectors of the economy (Guinness et al. 2018).

In terms of improving direct service provision, such as improving the quality of essential health care services, recommendations are covered extensively in the National Health Sector Strategic Plan 2011–2030. This plan was designed in line with the Strategic Development Plan 2011—2030, which incorporates health sector goals. It aims to promote human resource development and health infrastructure development, through building hospitals and strengthening administrative capacity (Japan International Cooperation Agency 2012).

The robustness of the system has been put to the test by the COVID-19 crisis, and the investments made in public health infrastructure supported the relative containment of the virus. However, inequities between rural and urban areas in this context persist, with the vaccination roll-out reaching 70 per cent of the population in Dili by October 2021, while only reaching less than half of the overall population (Reuters n.d.; World Bank 2021). The quick political reaction and activation of the MOH plan to contain the pandemic have been effective thus far, and demonstrate the trust the population places in existing public health services.

6. Main lessons learned

- Timor-Leste has a national health service system in which health services are provided for free or at an affordable cost at the point of use. Even though government spending on health as a share of total spending is significant, with health services primarily publicly financed and provided, the absolute amount of government health spending is relatively low. As such, the Government faces challenges in securing additional funds for emerging health challenges such as the increase in NCDs.
- Timor-Leste has managed to keep OOP spending on health at a low level, with OOP expenditure accounting for less than 10 per cent of health expenditure in 2017, which is lower than most countries in the region. This contributes to reducing the likelihood of households incurring catastrophic expenditure on health services. However, it is likely that the low level of OOP payments in Timor-Leste partly reflects limited infrastructure, availability and utilization of health services, which is a threat to the achievement of adequacy of benefits.
- Ensuring adequate government funding is necessary for the achievement of UHC in Timor-Leste. Programmes such as SISCA and the Health in the Family Programme suffer from insufficient funding allocation, do not have any budget plan for service delivery and lack supplies. The lack of public funding is reflected in limited infrastructure and lack of health care supplies and equipment, especially at primary care facilities, which negatively affects quality of care at this level. Insufficient public funding is therefore a significant issue, and in light of the fact that a large share of health financing comes from oil revenues dependent on fluctuating international markets, ensuring financial sustainability is also a challenge.
- Limited coordination combined with low institutional and human resource capacity has resulted in a fragmented social health protection system, which has resulted in gaps and left many people left without coverage or adequate support. In addition, social health protection is not well integrated in the broader social protection system. Most programmes suffer from lack of financial and human resources, lack of mechanisms for quality assurance, limited monitoring and evaluation, and the late release of funds for operations. These issues often relate to other underlying problems, such as inadequate management and information systems and lack of coordination mechanisms, resulting in limited institutional capacity to better manage, deliver, monitor and evaluate social protection programmes.

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