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The Relationship Among Quality of Care, Government Social Protection Program and Quality of Life of People with Disability: Empirical Evidence from Dili Municipality

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ABSTRACT

This research investigates the indirect effect of government social protection program on the relationship between quality of care and the quality of life of the people with disability. In addition, the study also tests the direct effect of quality of care and government social protection program on the quality of life of people with disability. Through empirical analysis using SMART-PLS 3.0, we found that government social protection program has insignificant direct effect on the relationship between quality of care and quality of life of people with disability. In addition, both quality of care and government social protection program have direct significant effect on quality of life of people with disability. Our study enriches theoretical and empirical debates on quality of care, government social protection program and quality of life of people with disability. These findings provide managerial implications and research direction.

Keywords: Quality of care, government social protection program, quality of life, people with disability.

1. Introduction

Globally disability issues have gradually been understood and considered in development, therefore since 1990s United Nations has recognized disability has relations with poverty and subsequently in 1992, and declared an annual observance of the International Day of Disabled Persons was proclaimed by the United Nations General Assembly resolution 47/3 (Gul, 2020). The observance of the Day aimed at promoting better understanding of disability issues; similarly mobilize support for the dignity, rights and well-being of persons with disabilities. It also pursues to increase awareness of gains to be derived from the integration of persons with disabilities in every aspect of political, social, economic and cultural life (Etieyibo, 2020, Elwan, 1999). In addition United Nations Convention on the Rights of People with Disability (UNCRPD) was approved by UN general assembly in 2007 to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity (UN, 2007).

The governments over the world are progressively implementing programs and disability specifics policies to meet the needs and rights of people with disabilities countries such as Uganda, Kenya, Indonesia, and among others have developed disability policies and some have rectified UN Convention on the Rights of People with disabilities (Fisher & Purcal, 2017; Shogren & Turnbull, 2014). However, these rights and needs will only be met fully unless the root causes of poverty are addressed and people with disabilities are given tools, they need to achieve access to education, health care, a livelihood, and full participation in social life by their governments in order to enhance quality of life of people with disability.

Quality of life is a degree to which an individual is healthy and comfortable, comprising equity, equality, social inclusion and participate in or enjoy life events, respecting cultural uniqueness and variability requires an awareness of and sensitivity to the different systems and contextual factors that impact our lives and well-being (De Boer et al., 2017, Michalik, 2015; Mattevi et al., 2012; Wan, 2011; Schalock, 2004; Zekovic & Renwick, 2003). The quality-of-life addresses issues that make the life of people feel satisfied and happy about their lives and equally ensuring that citizens with disability experience the same human rights and a life of quality as any other member of society. Quality of life is influenced by personal and environmental characteristics with the purpose of understanding people holistically (Schalock et al., 2018; Verdugo et al., 2005; Schalock, 2004). While quality of life of people with disability also influenced by quality of care and government policy.

Quality of care is the degree to which services received by individuals and populations from formal institutions or services providers that may increase their quality of life (Campbell et al., 2019). Quality of care has great impacts on the quality of life of the people with disability due to service delivery (Wang & Brown, 2009). The more quality of care will enhance the quality of life of the people with disabilities. This is consistent with the view of Yoong & Koritsas (2012) that people with disabilities will get good care from the government, parents and the society will enhance economic, social and physical well-being of the people with disability. Empirical studies also revealed that quality of care has significant impacts on quality of life of the people with disability (De Waele et al., 2005) because good enhanced acceptance, social inclusion, self-determination, interpersonal relations and personal development among people with

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disabilities in their communities (Mattevi et al., 2012; Schalock et al, 2002). However, other studies also show that quality of care has insignificant effect on the quality of life of the people with disabilities (Leroi et al, 2012) because quality of care primarily focuses on staff and organizational processes are usually more influential than clients (Kamau et al., 2017; De Waele et al., 2005).

Government social protection program is as the set of policies and programs designed to reduce poverty and vulnerability by promoting labor market functioning, diminishing people's exposure to risks, and enhancing their capacity to protect themselves against hazards and the interruption and loss of income (Barrientos, 2019). It confirmed that investment in social protection improves the productive capacity of individuals, contributing to inclusive, equitable, and sustainable economic growth (Bárcena, 2020). The government social protection programs and the quality of life of the people with disability are looking at core functions of social protection programs namely opportunity resilience and equity that incorporate indicators of quality of life (Hassan, 2020; Starr, 2018; Porasac, 2013). Numerous empirical studies have been done on the impacts of government social protection program and the quality of life the people with disability, but the results show inconsistency. Studies revealed that government social protection programs have significant impacts on the quality of life of the people with disability (Hassan, 2020) because governmental and private institutions offering social protection services in rehabilitation of people with physical disabilities to achieve social inclusion through improved working physical abilities (Hassan, 2020; Devandas Aguilar, 2017). However, a group of researchers also found that government social protection program were not providing a great impact on the quality of life the people with disability (Dauwan et al., 2021) because Disability benefits are critical for fostering the inclusion and active involvement of people with impairments; but, if they are misunderstood, they may operate as a deterrent. When disability benefits combine assistance for disability-related extra expenditures or access to health care with income support targeted at decreasing poverty, disabled people may lose their entire benefit package if their income rises beyond the poverty line or minimum income threshold. Persons with disabilities face a dilemma, as they must choose between securing a minimum but secure income and finding employment and increasing their socioeconomic participation in the society (Muis et al., 2020; Devereux, 2012).

This research was carried out in Dili, Timor-Leste with particular focus on quality of care, government social protection program, and quality of life of people with disability (PwDs) because Dili is 3rd municipality with the highest number of people with disabilities (4016), Ermera (4,421), Baucau (5,316), and Viqueque (3,416). Overall Timor-Leste has a total number of 38,118, people with disabilities, out of that men (20,140) and women (17,978) (Ministry of Finance, 2015). These statistics demonstrate that persons with disabilities are a significant part of Timor-Leste's population. Therefore, the government has to have proper programs and policies for people with disability, aiming to enhance their quality of life. This is because people with disabilities face obstacles in accessing public services and registration mechanisms, they are likely to be under-represented by these statistics, on the other hand taking global percentage of 15% of any population has a form of disabilities, this means Timor-Leste has to develop programs and policies to respond to the needs of people with disabilities (MSSI, 2018, 2020).

Timor-Leste social protection programs are aiming at preventing the population from falling under poverty line and social protection are increasingly become popular strategy for addressing disability and poverty in many low- and middle-income countries (Kuper, 2018), and similarly Timor-Leste social protection covers a wide range of policies and programs needed to reduce the lifelong consequences of poverty and exclusion. Programs like cash transfers – including child grants (Bolsa da Mãe new generation), veterans' pension, elderly pension, disability pension, and more so recent programs in response to covid-19 pandemic such as cash transfers of USD 200.00 to family households. These social protection programs to help target population to take care of their daily needs such health care, nutritious food and be able send their children to school. Evidently the social programs have an impact on the quality of life of beneficiaries including people with disabilities.

Our study focusses on testing the influence of quality of care and government social protection program on the quality of life of the people with disability in Dili, Timor-Leste, as well as to test the mediation effect of government social protection program on the quality of care and the quality of life of the people with disability in Dili, Timor-Leste.

2. Theoretical Frameworks, Conceptual Model, and Hypothesis

2.1. People with Disability

People with disabilities (PWD) is a large and diverse group encompassing individuals with a range of functional impairments, from mobility limitations to blindness or low vision and intellectual disability (Sabatello, Burke et al., 2020). Burgdorf (2017) defines people with a disability have physical or mental impairment that substantially limits one or more major life activity. According to Saran et al. (2020), there are approximately 1 billion people worldwide who have disabilities which translates to about 15% of the world's population. From this, 80% live in low- and middle-income countries (LMICs), where disability has been demonstrated to disproportionately affect the poorest people (Shogren et al., 2021).

People with disabilities face physical, environmental, social and attitudinal barriers to participation in employment opportunities, health, education and development processes (Szumski et al., 2020). People with disabilities are among the poorest of the poor, and those who live in poverty are more likely to develop a disability than others. People with disabilities have limited access to health care and education, have trouble obtaining work, are stigmatized and discriminated against, and their rights are frequently denied or abused (CBM,

2012). All of these elements contribute to economic insecurity and social marginalization. Poor households, on the other hand, have limited access to adequate food, shelter, hygiene and sanitation facilities, drinkable water, and preventative health care services, all of which are known to compound poverty and increase disability risks (Forber-Pratt et al., 2017; Sabatello, Landes, et al., 2020)

In this study people with disability shall mean people with disabilities/impairments include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others as defined by in article 1 of United nations Convention on the Rights of Persons with Disabilities and Optional Protocol (UN, 2007).

2.2. Quality of Care (QoC)

Quality of care (QoC) is the degree to which health services received by individuals and populations to increase the likelihood of desired health outcomes (Campbell et al, 2019). Furthermore, quality of care (QoC) is defined as a human right to access adequate medical care, rehabilitation care, and support services aimed at increasing independence of people with disabilities (Mattevi et al., 2012). According to Michalik, (2015) defined QoC for a person with disability as provision of services and varying dependency on service provider by people with disability.

QoC is a dynamic concept that is shaped by interactions between service users and providers (Shin & Moon, 2008). Thus, types of quality-of-care services varies with healthcare processes comprising numerous technical and interpersonal aspects, including outcomes, patient perceptions, organizational structures or systems that are associated with the ability to provide quality health care and/or that relate to one or more quality goals for health cares (Jazieh, 2020; Adirim et al., 2017). QoC necessitates consideration of various levels, including the level of the people serviced, the organizational level, / the system level (Chan et al., 2008). It has been stated that QoC should be 'adapted' or personalized based on the individual needs, experiences, behaviors, feelings, and perceptions of each individual (Den Oudsten et al., 2011). Previous studies on QoC and role of health insurance among non-elderly women with disabilities in USA reported that health insurance was highly associated with improved health care system, access to treatment, program eligibility and reduced unmet or delayed care needs among women with disabilities (Shin & Moon, 2008; Chevarley et al, 2006). QoC is responsible for attaining and maintaining optimal health care services (De Boer et al, 2017; Knaul et al, 2012). The QoC emphasis is place on people working on systems and organizational process to deliver services/outcomes to the client/service user (Forder et al., 2018).

The QoC can be measured with domains as such as Meeting Needs Domain, Staff Quality Domain, Accessibility of Care Domain, and Information Domain (Lucas-Carrasco et al, 2011).

2.3. Government Social Protection Program

Social protection program is defined as its role in protecting and helping those who are poor and vulnerable, such as children, women, older people, people living with disabilities, the displaced, the unemployed, and the sick in order strengthen inclusive social development and equitable economic growth (Istiqomah et al., 2020). Other authors have defined social protection programs as “public actions taken in response to levels of vulnerability, risk, and deprivation which are deemed socially unacceptable within a given society (Banks et al., 2019). While according to (Gazdar, 2011) Social protection program is a combination of policies and programs aiming to eliminate and prevent poverty and vulnerability throughout the life cycle as while as a human right. Benefits for children and families, maternity, unemployment, job accident, sickness, old age, disability, and survivors, as well as health protection, are all covered under social protection program. In addition, social protection is defined as public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalised; with the overall goal of reducing the economic and social vulnerability of poor, vulnerable, and marginalised groups (Browne, 2015; ILO, 2016).

Government social protection programs have firmly established itself as a core function of development policy, but it remains firmly rooted in its origins in social safety nets, human rights development approach and humanitarian relief, where welfare/social assistance is provided on a 'discretionary' rather than a 'entitlement' basis, usually for a limited time period, often in the form of food, and recipients were referred to as 'social aid beneficiaries'(Côte, 2020). Undoubtedly government social protection programs have progressed beyond welfare programs to social pension schemes providing regular cash transfers which have displaced or supplemented food aid in both emergency and non-emergency situations; and 'beneficiaries' are now referred to as 'recipients,' 'participants,' or even 'claimants’ (Devereux & White, 2010; Devereux et al., 2011; Haan, 2011).

In this study Government Social protection programs shall include all policies and programs of government that addresses economic, environmental and social vulnerabilities to food insecurity and poverty by protecting and promoting livelihoods, improving the quality of life of people with disabilities. Nhapi (2021) indicated three dimensions of GSPP are social assistance, social care and social labour market policy.

2.4. Quality of Life of People with Disabilities

QOL is defined as a person's perspective of himself or herself, taking into account the cultural environment and values that influence his or her objectives, expectations, standards, and concerns (Ruta et al, 2007). This definition is consistent with the understanding that satisfaction and wellbeing start from the degree of fit between an individual's perception of their objective situation and their needs or aspirations (Van Hecke et al., 2018; Felce & Perry, 1995). In the essence QOL is the gap between what a person is capable of doing and being, and what they would like to do and be in

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the future happening within a certain culture and environment (Sultan et al., 2018). It does not appear unreasonable to assess quality of life in terms of the gap between what a person is actually capable of doing and being, and what they would like to be. Thus, the balance of people's positive and negative emotions contributes to judgments of life satisfaction (Fredrickson & Joiner, 2002). Indeed, positive emotions not only feel good in the present, but also increase the likelihood that one will feel good in the future. Positive emotions trigger upward spirals toward enhanced emotional well- being (Abramis & Caplan, 1985).

Besides people with disabilities have various forms of disabilities ranging from long-term physical, mental, intellectual or sensory impairments, their interaction within the environment create barriers that hinder their full and effective participation in society on an equal basis with others (UN, 2007). With this in mind, noting that disabilities have an effect on the quality of life of people with disabilities both physically and mentally (Oliveira & Martins, 2016). In fact, according to Hassan, (2020) in his study observed that quality of life of people with disability can be improved by implementing integrated social programs that enhance psychological well-being, personal satisfaction, economic well-being, interpersonal relationship, social networking, fulfillment of social needs, family cohesion, life satisfaction, employment, form part of quality of life of people with disabilities. In contrast (Hall et al, 2017) stated that living with disabilities may not have as much of an impact on a person's quality of life as their perceptions about their capacity to cope with their needs and circumstances.

QOL of people with disability measurement involves the degree to which people with disabilities have life experiences that they value and desire, using the following indicators emotional well-being, interpersonal relations, material well-being, physical well-being, Self- determination, personal development, social inclusion and rights (Schalock et al., 2008, Petry et al., 2005).

2.5. Conceptual Framework and Research Model

This study carried out based on empirical approach that quality of care and government social protection program has strong linkage with the quality of life of the people with disability. As government is the one has better resources to assist disable people to enhance their quality of life (Abd Samad & Mansor, 2013). This will help to enhance community inclusiveness which allows people with disability have better life Janet, (2016). The need of quality of care for people with disability will stimulate various government programs to enhance the quality of life the people with disability. Numerous empirical studies revealed that both quality of care and government program enhance quality of life of people with disability (Hassanein et al., 2021)

In this research, the variable of government social protection program was measured by using dimensions and indicators adopted from Nhapi, (2021), while quality of care used indicators from (Lucas-Carrasco et al, 2011). In addition, quality of life of the people with disability was measured by using dimensions and indicators from (Schalock, 2004) (See Figure 1).

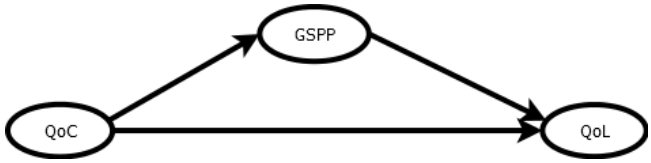

Figure 1. Conceptual and Research Model (QoC = Quality of Care; GSPP= Government social protection program; QoL = Quality of life of people with disability).

2.6. Hypothesis

Quality of care has great impact on the quality of life of people with disabilities, which is related to the health outcome and practice of the service received by the people with disabilities (Makris et al, 2021). Amundson (2005) found that quality of life of people with disabilities was influenced by quality of care. Empirical evidences from a study of QOL, perceived QOC and support, personal attitude towards disability among people with physical disability in China, showed that quality of care and support was playing a more important mediating role than PWPD's attitudes towards their own disability on the quality of life for people with disability (Zheng et al, 2014). Signifying that rehabilitation is an outcome of quality of care and more importantly improved quality of life was reported among people who received rehabilitation services compared to people with disabilities never received rehabilitation care (Seves et al, 2021). Quality of care is significant on quality of life of people with disabilities.

H1: Quality of Care has positive and significant effect on Quality of Life of People with Disability in Dili, Timor-Leste.

Ouma (2019) stated that government of Kenya plays hug role to secure the quality of care of people with disability through GSPP in the delivery of better services to the clients of GSPP. Andrew (2018) sighted in particular; the number of cash transfer programs targeted at poor citizens has grown substantially, with studies indicating that almost all the countries in sub-Saharan Africa have a scheme under implementation. GSPP was one of the policy tools needed to combat poverty and inequality, improve people's well-being and facilitate the participation of individuals and groups that are excluded (Malecki et al, 2020, Andrew, 2018; Parameswaran, 2012). The programs have improved quality of care overtime to provide better services to their target beneficiaries of GSPP. In Nepal utilization of disability Social protection services heavy depended on the quality of care provided by government (Banks et al., 2019). Therefore, it is proposed the following hypothesis:

H2: Quality of Care of people with disability has positive and significant effect on Government Social Protection Program in Dili, Timor-Leste.

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Government plays important roles to secure the quality of life of people with disability in order to promote social inclusion in the community. This aims to improve the quality of life of the people with disability. Empirical studies revealed that government social protection programs have strong relationship with the quality of life of people with disability (Knaul et al., 2012) because external resources from the government such as cash assistance, extra care services, scholarship, house assistance and pension to settle the life of the people with disability (Schneider et al., 2011). Numerous empirical studies revealed that government social protection program influence significantly on the quality of life of people with disability (Drake et al., 2013). Therefore, the hypothesis can be formulated as below:

H3: Government Social Protection Program has positive and significant effect on the Quality of Life of People with Disability in Dili, Timor-Leste.

The effects of quality of care are critical on GSPP and the QOL of people with disability. The QOC influences the extent to which governments provides effective social policies, government social protection program and contribute to quality of life of people with disabilities (Byndyu, 2014). The QOC and GSPP will influence the strongly the QOL of people with disability (Travis et al., 2020). Evidence show that social protection scheme increased access to health care services and reduced the health expenditures, among the poor, and subsequently increased the quality of life for the people with disabilities (Knaul et al, 2012). Thus, the hypothesis is formed as:

H4: Government Social Protection Program has significant role in the relationship between quality of care and the Quality of Life of People with Disability in Dili, Timor-Leste.

3. Research Method and Data Collection

This study was conducted on people with disabilities, who are recipient of government social protection programs (GSPP) and living in Dili Municipality for the last 12 month. The target GSPP is elderly and disability Pension scheme, disability subsidy, bolsa de Mae program. According to Ministry of Finance (2015), there are 4016 people with disabilities in Dili municipality based on Timor-Leste population Census 2015. From this, we calculated sample size using Slovin formula with a margin of error of 5%, giving the total sample size of 364. We applied accidental sampling method to select respondents to fill up the questionnaires.

Data was collected by using questionnaires which adapted from Nhapi (2021) for government social protection program (GSPP), while quality of care (QoC) from Lucas-Carrasco et al. (2011), and quality of life of the people with disability (QoL) from Schalock (2004). All measurement items of quality of care (QoC), government social protection program (GSPP) and quality of life of people with disability (QoL) were developed using five Likert scale, ranging from strongly disagree (1) to strongly agree (5).

The questionnaires were firstly translated to Tetun, the national and official language of Timor-Leste which is widely used in Dili. We worked closely with organization of People with disabilities (OPDs) to distribute the questionnaires because they are the one that close to the respondents. Before that, we brief the OPD staff to understand the questionnaires and techniques to approach people with disability in order to minimize the bias. The questionnaires were filled up and returned within one to two days. A total of 400 questionnaires were distributed, but only 364 returned and used for data analysis.

Data analysis was carried out using SMART-PLS 3.1. Initially we develop research model based on previous empirical studies. We tested validity and reliability of the model based on the parameters recommended by Hair et al. (2014). We tested convergent validity using outer loading (OL), and average variance extracted (AVE), and discriminant validity using Fornell-Larcker criterion (FL) (Hair et al., 2014) and Heterotrait-Monotrait (HTMT) (Henseler et al., 2015). To test internal consistency, we used Composite Reliability (CR), and Cronbach Alpha (Hair et al., 2017; and Saldanha et al., 2020).

4. Results and Discussions

4.1. Demographic Characteristic of Respondents

The data was collected from a total sample of 364 respondents composited of people with disability who have accessed government social protection programs in the last 12 month. The questionnaires were distributed with gender representation of 58.5% and women 41.5%. Reaching out to respondents of all age's groups (<20 but only who have accessed government protection programs in the last 12 month throughout to over >51) were represented, with slightly high numbers in the age group (21-30) representing 55.8% and age group >51 years accounting for only 4.1%. The large number of 28% of respondents attained Junior Secondary School while the smallest number of 4.4% of respondents had a university degree. In addition, 55.5% of people with disabilities (PWDs) that accessed GSPP in the last 12 month stayed with their families, followed by the PWDs staying in organisational residences with friends 28.6% and only (11) stay with their wives. The majority of (165) 45.3% PWDs in the sample were visually impaired followed by people with learning difficulties (3) 0.8% as represented in Table I.

4.2. Validity and Reliability Test

The validity test is used to ensure the accuracy of the instrument to measure the model, used Convergent validity and discriminant validity.

The convergent validity is measured by using two parameters namely Outer loading (OL) or indicator out loading and average variance extracted (AVE) and discriminant validity use Fornell-Larcker criterion (FL), heterotrait-monotrait (HTMT) (Hair et al., 2014). An Item is valid when OL and AVE value are well above the minimum value of 0.7 and 0.5 respectively.

Figure 2 reveals the results from SMAR-PLS 3.0 the OL and AVE values of items in three variables are above 0.7, only few indicators (GSPP11, GSPP31, QoL44, QoL53) with the OL values below the minimum threshold value. Nonetheless, this can be acceptable since this research is explorative research (Hair et al., 2014). Therefore, all items can meet the requirement of convergent validity in PLS analysis to use for inner model measurement.

Table I. Demographic Characteristic of Respondents

Variables	Characteristic of Respondents	Frequency	Percentage
Gender	Male	213	58.5
	Female	151	41.5
	Total	**364**	**100.0**
Age Group	<20	37	10.2
	21-30	203	55.8
	31-40	74	20.3
	41-50	35	9.6
	>51	15	4.1
	Total	**364**	**100.0**
Education	No Education	41	11.3
	Primary School	78	21.4
	Junior Secondary School	102	28.0
	High School	75	20.6
	Diploma	52	14.3
	Degree	16	4.4
	Total	**364**	**100.0**
person stayed with	Stay with Family	202	55.5
	Stay with Children	5	1.4
	Stay with my wife	11	3.0
	Stay in Organisational residence with friends.	104	28.6
	Stay alone	42	11.5
	Total	**364**	**100.0**
Type of disability	hard of hearing	97	26.6
	difficulty of learning	3	0.8
	mental disabilities	10	2.7
	vision impairment	165	45.3
	physical disabilities	89	24.5
	Total	**364**	**100.0**

To test the discriminant validity using the Fornell-Larcker (FL) criterion is a decision rule based on a comparison between the squared construct correlations of the average variance extracted (AVE). In that the square root of the AVE of each construct should be much larger than the correlation of the specific construct with any of the other constructs. The value of root square of AVE for each construct are valid based on the recommendation from Hair et al. (2014). Therefore, all items in Table II.

Heterotrait-Monotrait Ratio (HTMT) is a parameter to measure validity of outer model. Normally, HTMT maximum values of all items are 0.9 (Henseler et al., 2015). Table III revealed that the HTMT values of all items were below than 0.90. Therefore, all items were valid to use in inner mode

The reliability test is carried out to ensure the internal consistency of a model. This uses Cronbach alpha (CA) and composite reliability (CR) to measure of internal consistency in scale items. The items are valid if the CA and CR values are above the threshold values 0.7 each (Hair et al, 2014). Table IV shows that the CA and CR values are above the threshold values of 0.7 except for items QOL4 with CA (0,687) and QOL5 with CA (0.534) below the minimum threshold value. In conclusion others items are reliable and valid to use for inner model measurement.

4.3. Inner Model Test

R-squared (R^2). Coefficient of determination $\mathbf{R}^2$ is a statistical measurement for proportion of the variance for a dependent variable that's explained by an independent variable in a regression model. The minimum proportion of variance for a dependent variable that is explained by interdependent variables minimum values between 0.50 -0.90 Hair et at. (2017).

4.4. Hypothesis Test

This first objective of this research is to test the relationship between quality of care (QoC) on quality of life (QoL), the PLS results as shown in Table VI that the T value (8.238) which is well above the minimum allowable value 1.96, while the P value (0.000) is well-below the maximum threshold value of 0.05. This means that quality of care influences positively and significantly on the quality of life of the people with disability (QoL). Therefore, hypothesis one (H_1) is supported.

The second objective of this research is to test the relationship between quality of care (QoC) on Government Social Protection Program (GSPP), the PLS results as shown in Table VI that the T value (1.512) far below the minimum

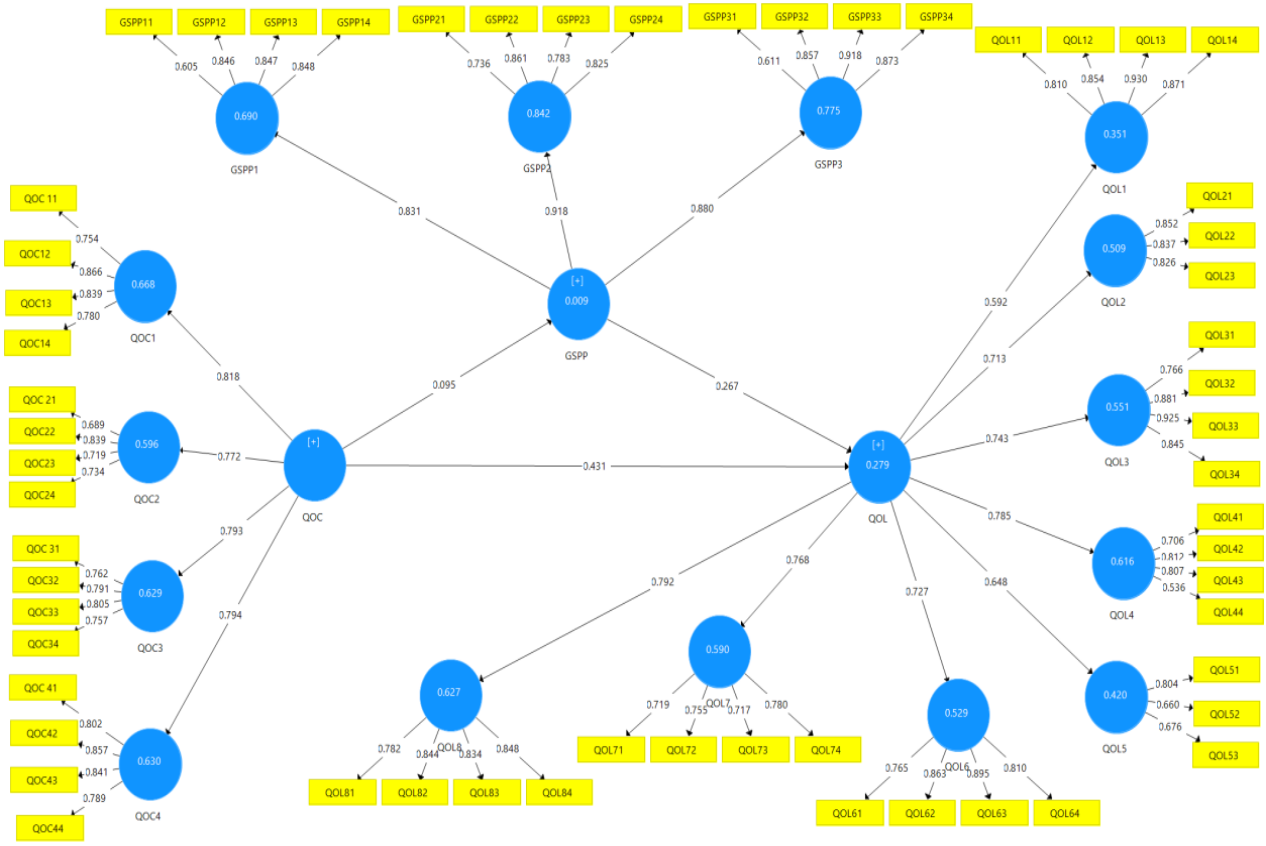

Figure 2. Outer Loading for Convergent Validity Test

Table II. Fornell-Larcker Criterion (FL) for Discriminant Validity

	GSPP1	GSPP2	GSPP3	QOC1	QOC2	QOC3	QOC4	QOL1	QOL2	QOL3	QOL4	QOL5	QOL6	QOL7	QOL8
GSPP1	0,793														
GSPP2	0,674	0,803													
GSPP3	0,552	0,737	0,823												
QOC1	0,021	-0,020	0,005	0,811											
QOC2	0,021	0,191	0,224	0,509	0,747										
QOC3	0,031	0,008	0,092	0,531	0,429	0,779									
QOC4	-0,005	-0,034	0,099	0,542	0,443	0,617	0,823								
QOL1	0,028	0,241	0,222	0,108	0,304	0,104	0,047	0,867							
QOL2	0,124	0,184	0,228	0,284	0,393	0,241	0,206	0,545	0,838						
QOL3	0,074	0,049	0,094	0,424	0,304	0,298	0,282	0,372	0,487	0,856					
QOL4	0,289	0,309	0,328	0,323	0,419	0,250	0,166	0,390	0,391	0,524	0,724				
QOL5	0,289	0,250	0,253	0,252	0,244	0,173	0,142	0,222	0,373	0,401	0,506	0,716			
QOL6	-0,038	0,040	0,150	0,202	0,343	0,062	0,074	0,414	0,489	0,488	0,486	0,285	0,835		
QOL7	0,302	0,302	0,283	0,182	0,331	0,060	0,058	0,347	0,437	0,400	0,574	0,514	0,543	0,743	
QOL8	0,067	0,101	0,152	0,363	0,356	0,236	0,229	0,302	0,422	0,592	0,558	0,448	0,585	0,612	0,828

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Table III. Heterotrait-Monotrait (HTMT) for Discriminant Validity

	GSPP1	GSPP2	GSPP3	QOC1	QOC2	QOC3	QOC4	QOL1	QOL2	QOL3	QOL4	QOL5	QOL6	QOL7
GSPP1														
GSPP2	0,814													
GSPP3	0,651	0,881												
QOC1	0,078	0,103	0,110											
QOC2	0,121	0,252	0,302	0,649										
QOC3	0,232	0,122	0,134	0,657	0,556									
QOC4	0,148	0,094	0,147	0,650	0,564	0,758								
QOL1	0,160	0,289	0,266	0,157	0,379	0,141	0,083							
QOL2	0,186	0,230	0,276	0,353	0,517	0,316	0,257	0,648						
QOL3	0,106	0,090	0,135	0,495	0,370	0,357	0,328	0,423	0,590					
QOL4	0,386	0,413	0,420	0,420	0,570	0,332	0,217	0,493	0,525	0,660				
QOL5	0,472	0,389	0,379	0,364	0,390	0,346	0,364	0,294	0,543	0,566	0,838			
QOL6	0,089	0,084	0,174	0,240	0,434	0,086	0,108	0,469	0,587	0,553	0,633	0,400		
QOL7	0,410	0,401	0,370	0,235	0,442	0,170	0,126	0,425	0,572	0,497	0,810	0,838	0,675	
QOL8	0,091	0,147	0,176	0,433	0,445	0,289	0,273	0,346	0,515	0,684	0,723	0,626	0,685	0,773

Table IV Cronbach Alpha (CA) and Composite Relibaility for Reliability Test, and Average Variance Extracted (AVE) for Convergent Validity

Item	CA	CR	AVE
GSPP1	0,799	0,870	0,629
GSPP2	0,815	0,878	0,644
GSPP3	0,835	0,892	0,678
QOC1	0,825	0,885	0,658
QOC2	0,734	0,834	0,559
QOC3	0,784	0,860	0,607
QOC4	0,840	0,893	0,677
QOL1	0,889	0,924	0,752
QOL2	0,789	0,877	0,703
QOL3	0,877	0,916	0,733
QOL4	0,687	0,811	0,524
QOL5	0,534	0,758	0,513
QOL6	0,854	0,902	0,697
QOL7	0,730	0,831	0,552
QOL8	0,846	0,897	0,685

Table V. R Square Values

Item	R Square	R Square Adjusted
GSPP	0,009	0,006
GSPP1	0,690	0,689
GSPP2	0,842	0,842
GSPP3	0,775	0,774
QOC1	0,668	0,668
QOC2	0,596	0,595
QOC3	0,629	0,628
QOC4	0,630	0,629
QOL	0,279	0,275
QOL1	0,351	0,349
QOL2	0,509	0,507
QOL3	0,551	0,550
QOL4	0,616	0,615
QOL5	0,420	0,418
QOL6	0,529	0,528
QOL7	0,590	0,589
QOL8	0,627	0,626

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Table VI. The Results of Hypothesis Test

Relationship	Original Sample (O)	Sample Mean (M)	Standard Deviation (STDEV)	T Statistics (|O/STDEV|)	P Values	Note
QOC -> QOL	0,431	0,438	0,052	8,238	0,000	Significant
QOC ->GSPP	0,095	0,102	0,063	1,512	0,131	Not Significant
GSPP ->QOL	0,267	0,275	0,060	4,443	0,000	Significant
QOC ->GSPP -> QOL	0,025	0,028	0,019	1,324	0,186	Not Significant

value allowable value 1.96, while the P value (0.131) is well-above the maximum threshold value of 0.05. This means that Quality of Care of people with disability (QoC) has no positive and significant effect on Government Social Protection Programs (GSPP). Therefore, hypothesis Two (H_2) is rejected.

The third objective of this research is to test the relationship between Government Social Protection Program (GSPP) on quality of life of people with disabilities (QoL), the PLS results as shown in Table VI that the T value (4.443) which is well above the minimum allowable value of 1.96, while the P value (0.000) is well-below the maximum threshold value of 0.05. This reveals that Government Social Protection Program (GSPP) influences positively and significantly on the quality of life of the people with disability (QoL). Therefore, hypothesis three (H_3) is supported.

The Fourth objective of this research is to test the mediation effect of government social protection program (GSPP) on the relationship between quality of care (QoC) and Quality of Life of People with Disability QoL), the PLS results as shown in Table VI that the T value (1.324) far below the minimum allowable value 1.96, while the P value (0.186) is well-above the maximum threshold value of 0.05. This means that government social protection program (GSPP) has no significant role on the relationship between quality of care (QoC) and Quality of Life of People with Disabilities (QoL). Therefore, hypothesis Four (H4) is rejected.

5. Discussion

The first objective of this research is to test the relationship between quality of care on quality of life of people with disability, the result shows that quality of care has significant effect on the quality of life of people with disability. This implies that good quality of care leads to enhance quality of life of people with disability because quality of care is important factor in healthcare, disability services and rehabilitation. The results of this study confirms the previous empirical studies that quality of care influence significantly on quality of life of the people with disability (Zheng et al, 2014) because rehabilitation is an outcome of quality of care which directly improves quality of life of people (Seves et al., 2021). However, the result of this study is inconsistency with numerous previous empirical studies that quality of care has no significant effect on the quality of life of the people with disability (De Waele et al, 2005). According to Li-Li-Korotky (2012), quality of care has a completely different indicators and orientation towards control, power, health, personality and safety of the system.

The Second research objective was to test the relationship between quality of care on Government social protection programs, the result shows in Table VI that Quality of care has no significant effect on the Government Social Protection Program (GSPP). This is particularly due to quality of care for people with disability in Timor-Leste mainly rely on government support, which in line experience of Nepal, the utilization of disability Social protection services heavily depended on the quality of care provided by government (Banks et al., 2019). The finding of this study is not in line with the previous empirical studies from Knaul et al. (2012), and Ouma (2019).

The third research objective was to test the relationship between government social protection programs on quality of life of people with disabilities. The result shows that government social protection program has significant effect on the quality of life of the people with disability. This means that good GSPP will lead to enhance the quality of life of the people with disability. This study confirms the results of the previous empirical studies that government social protection programs had strong relationship with quality of life of people with disability (Drucza, 2016; Opoku et al, 2019; Pak, 2020) because government social protection policy has dual driving forces dominating growth strategy of social protection and inclusive development that improve the wellbeing of vulnerable groups (Kosec & Mo, 2017).

The fourth objective of this research is to test the mediation effect of government social protection programs on the relationship between quality of care of people with disability and quality of life of the people with disability. The result shows that government social protection policy has no significant role on the relationship between quality of care and quality of life of people with disability. This study does not in line with the previous empirical studies that GSPP influence strongly on quality of care and quality of life of people with disability (Byndyu, 2014) because government social protection program is 'a critical tool to simultaneously achieve progress in mainstreaming disability development programs and achieving human rights development approach by ending exclusion and deprivation of people with disabilities (Browne, 2015). The results of this study agree with study of Goldblatt (2005), poor GSSPP in South Africa created barrier of accessibility to the disability grant such as lack of identification documents, inability to afford transport to government offices, illiteracy, and limited knowledge on

entitlement and procedures followed implied poor quality of life of people with disability.

6. Conclusions and Implcations

This research was carried out to test the impact of quality of care, government social protection on quality of life of people with disability, as well as the mediation effect of government social protection program on the relationship between quality of care and quality of life of people with disability. The results show that the quality of care and government social protection programs have great impact on the quality of life of the people with disability, while quality of care has no significant effect on government social protection program. In addition, the result also shows that government social protection program has no significant effect on the relationship between quality of care and quality of life of people with disability.

The results of this research provide numerous implications: (1) Redesigning government social protection programmes to be inclusive of people with disabilities requires attention to a range of factors including: raising awareness among people with disabilities and their active participation in programme design; establishing inclusive eligibility and targeting criteria for beneficiaries; attending to the accessibility of services and facilities; and providing additional services to address the specific needs of people with disabilities such as transport, this will not only address social inclusion but also human rights issues. (2) Government should develop and implement complaints redress systems that allow the public to file complaints through phone calls, text messages, or any other means of communication. Grievance redress is an integral component of most GSPP around the globe and is crucial to ensure program accountability and ensuring that all programs monitor the complaints filed and any remedial action taken. (3) GSPP should be accompanied by the development of appropriate linkages or referral systems to support access to specialised services where these are beyond the immediate scope of the programme. (4) Develop and implement effective communication strategies to improve awareness of GSPP among PWDs, their objectives, eligibility, and entitlements could improve accountability and transparency of GSPP implementation with consistency messaging. (5) Government should develop and implement Monitoring and Evaluation system to support the planning and GSPP implementation. The M and E system will inform whether benefits are reaching the intended beneficiaries or not, and a feedback mechanism.

7. Limitations and Future Research

Limitations of the study demonstrate that the researcher understands that no research project is perfectly designed; consequently, the researcher will make no overweening claims about generalizability or conclusiveness about what has been learned (Marshall & Rossman, 2015).This study was conducted in Dili Municipality, Timor-Leste. However, the following limitations were encountered;

This research used quantitative methods which are limited in its pursuit of concrete, statistical relationships of variables, which gives no room for respondents to express their feelings as answers are limited to options. The research may have missed a greater big picture of information that could benefit people with disabilities as well as give better explanation of quality of care on government social protection programs and quality of life of people with disabilities. Therefore, future research needs to qualitative research approach to get comprehensive view on the relationship between variables of quality care, government social protection program and quality of life of people with disability.

The research did not cover all categories of people with disabilities such as people with mental disabilities, people with disabilities who could not read and write as well as lacked assistants to support them to fill up the questionnaire. These categories of people with disabilities fully receive government social protection programs but due to their low-level comprehension and understanding of the research tools were not covered. Therefore, future research needs to cover of categories of people with disability in order to get comprehensive information.

The sample came from one geographical area, only in Dili, Timor-Leste. It is acknowledged that the relative importance of specific aspects of quality of care, GSPP and QoL may be different in other municipalities. For example, there are a number of factors which may be specific to this location which may have influenced our findings. First, Dili is an urban location. Those receiving disability services in rural communities may offer a different perspective of quality of care, GSPP and QoL which were not already captured in this research. Therefore, it is necessary to extend the coverage area of the research in order to get comprehensive data to do much better research findings' generalisation.

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Appendix

1. Quality of Care (QoC)

Please choose the right statement based on your trust for the following statement.
1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4= Agree; 5 = Strongly Agree.

Code	Items	Likert Scale				
		1	2	3	4	5
QoC1	**Staff quality**					
QoC11	I get a good care and support from competent staff					
QoC12	My caring staffs have adequate knowledge to look after people with disability.					
QoC13	Social service staff place people with disability as the center of their services.					
QoC14	Staff have great autonomy to provide services to people with disabilities.					
QoC2	**Accessibility of care**					
QoC21	There are many available services in country for person with disability. (like rehabilitation, pension, education, employment etc)					
QoC22	I have good access to care services					
QoC23	I get my right to access to care services					
QoC24	I get reasonable cost for care services					
QoC3	**Meeting Needs**					
QoC31	I get good care for activities for daily living					
QoC32	I get good care for leisure activities					
QoC33	I get good care for social activities					
QoC34	I get good standard of care from service provider					
QoC4	**Information**					
QoC41	It is easy to me to get information about person with disability					
QoC42	It is easy to me to get information about types of services for people with disability					
QoC43	It is easy to me to get information about service , programs, benefits for people with disability					
QoC44	I get clear information about care services for people with disability					

2. Government Social Protection Program (GSPP)

Please choose the right statement based on your trust for the following statement.
1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4= Agree; 5 = Strongly Agree.

Code	Items	Likert Scale				
		1	2	3	4	5
GSPP1	**Social Assistance**					
GSPP11	I get monthly cash from the government					
GSPPS2	I get scholarship from the government to continue my study					
GSPP13	I get food assistance from the government					
GSPP14	I get my housing support from government					
GSPP2	Social care					
GSPP21	I get social care services from the government					
GSPP22	Government supports my family to look after me.					
GSPP23	I get my child care and protection from government					
GSPP24	I get my house/accommodation from government					
GSPP3	**Labour Market Policy**					
GSPP31	I get appropriate training to enhance my job skills					
GSPP32	Government provides me internship program to improve my job skills					
GSPP33	Government helps me to get job					
GSPP34	Government provides me with job coaching (offers some to accompany me on job training)					

3. Quality of Life of People With Disability (QoL)

Please choose the right statement based on your trust for the following statement.
1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4= Agree; 5 = Strongly Agree.

Code	Items	Likert Scale				
		1	2	3	4	5
QoL1	**Self-determination**					
QoL11	Uses public transport (bus, taxi…) by himself/herself (without supervision)					
QoL12	Participates in the decisions that are made at home					
QoL13	Choose the clothes that are bought					
QoL14	Another person decides the clothes she wears every day					
QoL2	**Right**					
QoL21	They allow you to participate in the design of your individual plan					
QoL22	The people around you respect your privacy (e.g. they knock on the door before entering).					
QoL23	Has a place where he can be alone if he wants					
QoL24	They take your things without asking permission					
QoL3	**Emotional Well-being**					
QoL31	Appears self-confident					
QoL32	He is satisfied with what he can do in the future					
QoL33	Shows pride in himself/herself					
QoL34	Expresses desire to change his way of life					
QoL35						
QoL4	**Material Well-being**					
QoL41	Has access to new technologies					
QoL42	You have the things you need to develop your hobbies					
QoL43	You have access to the information that interests you (newspaper, television, internet, magazines, etc)					
QoL44	He lacks what is necessary to live in a dignified life.					
QoL5	**Social Inclusions**					
QoL51	Participates in conversations with other people on topics of shared interest					
QoL52	Goes without problems to places in your community (eg bars, shops, swimming pools, etc)					

QOL53	You have friends without disabilities.
QoL54	You receive the support you need to do your job/task well.
QoL6	**Interpersonal relations**
QoL61	Your relationships with school/work colleagues are good.
QoL62	You have good relationship with people of different ages.
QoL63	You have friends who listen to you when you have a problem.
QoL64	Shows emotions/feelings appropriately
QoL7	**Physical Well-being**
QoL71	Get enough rest
QoL72	Do sports or leisure activities
QoL73	When he feels well, he tells other people
QoL74	Receive adequate attention in health services
QoL8	**Personal Growth**
QoL81	Has the opportunity to learn what interests him
QoL82	Has an individual program adapted to his preferences
QoL83	You are provided with training activities that encourage your autonomy
QoL84	Develops their work/task competently and responsibly