The influence of policy, law and regulation on self-managing teams in the Dutch healthcare sector: a qualitative study

Bachelor Thesis

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ABSTRACT

The Dutch healthcare sector is slowly changing its structure towards self-managing teams. These developments are especially visible within care organizations like residential and homecare. Nurses are now expected to take the lead and have the authority to manage their work themselves. At the same time, the Dutch healthcare sector in general is one that operates in an increasingly regulated environment. Consequentially, this has an influence on the actors within the Dutch healthcare sector, like healthcare providing organisations and their employees, including nowadays the self-managing teams. The purpose of this research is to explore and identify the influences of policy, law and regulation on the operations of self-managing teams in the Dutch healthcare sector. Not yet has there been paid attention to this matter in literature, and thus this research aims to start this conversation. To do so, a single case study was conducted within a homecare organization. The results of six interviews identified the first ideas about influences of policy, law and regulation on performance of self-managing teams in the Dutch healthcare sector, which were divided into five main categories: organisational interference, the distance between the work floor and policy makers, financial cuts, quality of care and self-managing teams, and the influence of health insurers. The research concludes that the main cause for the challenges that self-managing teams in the healthcare sector encounter, is the distance between the work floor and the policy makers, whereas the biggest malefactor in these challenges is identified to be the financial cuts. Furthermore, the research opened up doors to future research on how to deal with these influence of policy, law and regulation on self-managing teams in the healthcare sector.

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1. INTRODUCTION

Healthcare is a popular topic in the Dutch media and everyone that has read about it is probably familiar with expressions like: "The homecare sector is sounding the alarm" (Nieuwsuur, 2015); "District nursing under pressure due to shortages" (Gemeente.nu, 2016); "The crisis in the homecare can barely be seen as a surprise" (Correspondent, 2016); and "Emergency rooms falter due to limited purchasing in homecare" (Bestuur, 2016).

Anyone who follows Dutch media, public, political, or economic debates, has noticed that homecare in the Netherlands has been under pressure over the last few years, and a significant amount of its blame has been argued to go to healthcare policy, regulation and laws. In particular, the financial cuts has been directed as malefactor (de Rijk, 2016). The healthcare sector is one that operates in an increasingly regulated environment (Cooke & Bartram, 2015), where rules, regulation, and policy regarding safety, hygiene, privacy, equality, and so on, have to be taken into account. The healthcare sector is extremely dynamic, as it concerns the wellbeing of people. Due to the pressure put on the healthcare sector, employees in the Dutch homecare sector have to work with limited resources, like time and money, on a daily basis. Enablers of homecare have to work with and around many strict laws and policies not only on a national, but also on European Union level (PW., 2016).

In the Netherlands, like everywhere in Europe, the government is struggling to meet the competing goals of an efficient, equitable, and universally accessible healthcare system (Helderman, Schut, van der Grinten, & van de Ven, 2005). The Dutch healthcare system has to deal with a complex interdependency between public and private actors, which have had important consequences for its governance structure. Even though the government has the responsibility for the efficiency, accessibility and quality of its healthcare, it is argued that it is not equipped to live up to these responsibilities under its own strength (Helderman, Schut, van der Grinten, & van de Ven, 2005). Consequentially this might have an influence on the actors in the healthcare system of the Netherlands, which I aimed to gain more knowledge about with this research.

Within the healthcare sector, a substantial proportion of the expenses comes from labour costs. According to the figures published by the Dutch Central Office of Statistics (CBS), 48% of the health expenditures in the Netherlands in 2012 came from labour expenses (Centraal Bureau voor de Statistiek , 2017). As mentioned earlier, the financial cuts in the healthcare sector are causing pressure within organizations. Considering the great labour expenses, this asks for high efficiency in Human Resource Management (Cooke & Bartram, 2015). This is an interesting statement, considering the growing appearance of self-managing teams in the healthcare sector.

The aim of my research therefore was to investigate the influence of policy, law and regulation on the operations of self-managing teams in the Dutch healthcare sector. Within my research, I looked for possible conflicts between what homecare providers desire to achieve or do in their operations and the relevant laws, regulations and policies. Furthermore I tried to identify what influence policy has on self-managing teams, or vice versa: what influence does the change to self-managing teams have on policy pressure.

The research question of my thesis is: *"What is the influence of policy, law and regulation on the operations of self-managing teams in the Dutch healthcare sector?"* Literature on this matter is not yet available. Therefore, this is a gap in literature regarding the Dutch healthcare sector in general, and more specifically in literature regarding self-managing teams in this sector. I believe that this gap is worth filling, since the healthcare sector is such a highly regulated one and in my opinion, it is very interesting to see how this regulation impacts the operations of people that work in the healthcare sector, especially with the changing structure to self-managing teams. Furthermore, answering my research questions and starting the conversation about the influences of policy, law and regulation on self-managing teams in the healthcare sector, can open doors to further research on how to best deal with these influences and possibly solve problems that come from these influences.

2. THEORETICAL FRAMEWORK

2.1 Self-managing teams

As the name already suggests, self-managing teams are teams that manage themselves rather than being managed by an external manager (Stephens & Lyddy, 2016). Self-managing teams differ from traditional teams in terms of team-member authority in decision making and handling internal processes. Members of self-managing teams make decisions together, that are traditionally the responsibilities of supervisors and managers (Alper, Tjosvold, & Law, 1998). The team has the authority to determine the organization, monitoring, and management of member efforts, to accomplish the team's work and meet the collective goals (van der Vegt, Bunderson, & Kuipers, 2010). With the absence of external control, team members need to determine themselves what to do, how to do it, and when to do it. By allowing self-management, employees are encouraged to develop their initiative and innate creativity (Banner, Kulisch, & Peery, 1992). It is argued that while implementing the structure of a self-managing team, employees may experience an unpleasant feeling of not having an authority figure that tells them what to do. However, after this initial feeling of unease, employees seem to grow to enjoy their new power (Donovan, 1987). Self-managing teams are argued to move and change more fluidly and quickly, responding to the needs of the particular situation (Banner, Kulisch, & Peery, 1992).

2.2 Self-managing teams within the healthcare sector

In Europe, several companies, among which Volvo and Saab, have been working with self-managing teams for years (Tichy & Nisberg, 1976). However, it has been just recently that self-managing teams have entered the healthcare sector, as a means to cope with the changing environment (Smets, 2014). Care is becoming more demand-driven and has to be customized to the wishes of clients, who demand higher quality, shorter waiting time, and more diverse and flexible care (Almekinders, 2006). It is argued that a way for organizations to deal with this increasing complexity, is to transform into a more flexible, client centred organisation, which can be achieved by decentralization and assignment of responsibility to employees, and thus by implementing self-managing teams(Smets, 2014). Another reason discussed by researchers for self-managing teams to be implemented in the healthcare sector is increased quality of healthcare (Lusky & Ingman, 1994). Self-managing teams have been found to have a positive effect on quality, caused by the fact that it enables the employees, who have the most first-hand knowledge, to use this knowledge towards improvement of quality (Yeatts, Cready, Ray, DeWitt, & Queen, 2004).

It is argued that, in general, a team should grow gradually towards self-management, for the implementation of self-managing teams to be successful (Wageman, 2001). Furthermore, it is important that team structure is aligned with organizational structure, and that the organizational environment

is supportive (Smets, 2014). In the healthcare sector, successful implementation of self-managing teams is argued to depend on a few factors: the support from top management, thorough training for the team members on management, the availability of information needed for good decision making, regular team meetings, and interaction of management with the teams to provide feedback (Yeatts, Cready, Ray, DeWitt, & Queen, 2004).

2.3 Legal framework

In this study, I aimed to identify the influence of policy, law and regulation on self-managing teams in the healthcare sector. These influences can both be of a positive or negative nature. For example, negative influences could restrict the self-managing teams from performing desirably, whereas a positive influence could be the improved quality of care, according to Cooke and Bartram (2015). To study the influence of policy, law and regulation on self-managing teams in the healthcare sector, I needed to know what policy, laws and regulation are relevant for self-managing teams in the healthcare sector. In the second part of my theoretical framework, I will therefore give an overview of the Dutch healthcare system and its corresponding laws. After that, I will explain some additional relevant laws (Ministerie van Volksgezondheid, 2016). Different levels of policy, law and regulation are distinguished based on their institutional actors: the Dutch national law, the United Nations laws and regulations, and the European Union laws and regulations.

2.4 The Dutch healthcare system

The current Dutch healthcare system is based on the principles that healthcare is openly accessible for everyone, that solidarity is present via health insurance that is obliged and accessible for everyone, and that healthcare is of a good quality. The care system is regulated with four system laws: The health insurance act (Zvw), the act on long-term care (Wlz), the social support Act (Wmo) and the youth act. Besides these laws, there are some other general laws and a few more specific healthcare laws, like for example the quality law for care institutions. These laws together form the regulative foundation of the Dutch healthcare system. Drivers to these laws are the chances of improving quality of care, promoting an integral approach and keeping the care in times of aging and chronic conditions accessible and affordable. Initially, the existing network and resources for support are called for, however, support is always available to those who are not able to provide themselves. For homecare providers, the Zvw, Wlz and Wmo are relevant, and therefore I will explain their features shortly.

2.4.1 The Health Insurance Act (Zvw)

The reimbursement of curative care in the Netherlands is governed by one health insurance act (Zorgverzekeringswet). The system of the Zvw has both public and private elements. The government is directly involved in the implantation of the Zvw and proposes a number of public preconditions that ensure the social nature of health insurance: citizens are required to have a (basic) health insurance policy and are free to choose their own insurer; health insurers are obliged to accept citizens regardless of their state of health; the premium of an offered policy is the same for each insured citizen, regardless of his or her health, age, or background; health insurers have a duty of care: they must ensure that the care provided in the basic package is available to all their insured persons; and the content of the insured basic package is legally determined.

The government is not directly involved by the execution of the Zvw, that is up to the healthcare providers, health insurers and insured citizens. This approach should lead to freedom for care parties and ensure competition and market forces for incentives to work with high quality and efficiency. The government is ultimately responsible for the content and scope of the statutory healthcare package that is accessible to all. Within the government-defined package, health insurers have the ability to regulate within the prescribed frameworks who provides care and where care is provided. They do this by negotiating well and selectively contracting on the basis of the high volume (anonymized) information they have about, among other things, quality, efficiency and customer experiences.

Citizens, health insurers and healthcare providers are the central parties in the Zvw and all three of them have an important function in controlling the quality of care provided and the quality of insurances.

First of all, the citizens: they have the possibility to choose a new health insurer each year, which is better or cheaper. This dynamic ensures that the health insurers must work for the benefit of the citizens, in order to keep having clients. Furthermore, citizens can also influence the policy of insurers through representative bodies.

Second, the health insurers: they check the quality and efficiency of care when they buy it. If the care is not good enough, they can decide to not conclude a contract with a specific care provider. This decision is made on the basis of the amount of information the insurer possesses. Due to the budget available for care, the health insurers are also encouraged to purchase effectively. In addition, insurers will ensure that the care provider's declarations are correct and that the declared care has also been effectively and efficiently delivered.

Third, the role of healthcare providers: they determine how care is provided. They ultimately decide, and have also drawn quality guidelines for this as a professional group.

2.4.2 The Act on Long-Term Care (Wlz)

People in the Netherlands who require permanent supervision or need 24-hour care rely on the act on long-term care (Wet Langdurige Zorg). The heavy and intensive care that citizens within the Wlz can get is described in a number of treatments, which are broadly defined. The most common are:

- Residence in an institution: long-term admission, but also housing in a nursing home.
- Personal care: help with washing, dressing, toilet facilities, and eating and drinking.
- Guidance that enhances self-reliance: help in organizing the day, gaining better control of life and learning how to do the household.
- Nursing: medical assistance in case of wound care or injection.
- Wlz-treatment: a medical, paramedical or behavioural treatment that helps to restore or improve a condition.

2.4.3 The social support Act (Wmo)

With the social support act 2015 (Wmo 2015), municipalities have been commissioned to support people with disabilities (Wet Maatschappelijke Ondersteuning 2015). Examples are people with physical, mental or psychological impairment, such as (light) disabled people and elderly. This support is aimed at helping people to live in society and to live at home. In addition, the municipality can provide shelter for people who are unable to live at home. The Wmo defines that every municipality is responsible for supporting the self-reliance and participation of residents that are limited by health issues. This includes for example guidance and day-care. For homecare providers, this is important because it means that they have to work with municipality specific policies, and that if they provide care in more than one municipality, they might need to adjust to different policies.

With the support from the Wmo, municipalities distinguish between general facilities and custom facilities. There is a general provision for everyone, for example a coffee morning in town or a meal service. A customized facility is tailored to one person, for example help with housekeeping or administrative assistance (Wet Maatschappelijke Ondersteuning 2015).

2.5 Other relevant national laws

Within the Dutch national law, there are a few more regulations that are especially relevant for the healthcare sector, or more specific, for homecare. To start, we have the constitution (De Grondwet), where the basic fundamental laws are stated. Important here is for example article 1, which says that everyone should be treated equally and that discrimination on any ground is forbidden. So in the case of homecare providers, they are forbidden to treat a patient differently or even refuse to give care to a patient, based on the patient's personal characteristics like gender, origin or religion. Other articles within the constitution that have a more direct relevance for homecare are articles 10 and 11. Article 10 explains that everyone has the right to be respected in his or her privacy. This is important for homecare providers as it restricts their caregivers from passing on personal information of their patients to third parties. Lastly, article 11 says that everyone has the right on inviolability of his or her body. This is also crucial for homecare providers since it means that nurses can only perform medical procedures that are accepted by the client. So regardless of whether the client needs a certain procedure or medication, if the client does not approve it, a nurse is forbidden to give the client that care. This law is related to the WGBO, which will be discussed later.

2.5.1 The Act on Occupations in the Individual Healthcare (Wet BIG)

The Act on Occupations in the Individual Healthcare (Wet BIG) aims to focus on promoting and monitoring the quality of care provided by professionals on the one hand, and the protection of the patient against the illicit and careless act of professionals (Wet op de Beroepen in de Individuele Gezondheidzorg). Besides the rules on quality of care, this act also enables the so called 'BIG-register', where caregivers from eight occupational groups can register themselves if they meet the legal training requirements applicable to their profession. Since nurses are also included as one of the eight occupational groups, it is important for homecare providers to make sure that their employees meet the applicable requirements and that they are registered in the BIG-register, so they can prove that their employees are legally authorized to provide care.

2.5.2 The Act on Medical Treatment Agreement (WGBO)

The Act on Medical Treatment Agreement (WGBO) is intended to strengthen the position of patients that need medical care (Wet op Geneeskundige Behandelingsovereenkomst). The WGBO regulates for example the right to information about the medical situation, permission for medical treatment, the right of privacy and confidentiality of medical data (professional secrecy) and the right of freedom to choose a doctor/caregiver. In addition to right, patient also have duties. For example the patient must inform the healthcare provider properly, fairly and completely of his problems. Also the patient has to cooperate with the healthcare provider as much as possible. This law is relevant for homecare providers because when a nurse provides care to a patient, there is a medical treatment agreement.

2.5.3 The Law on Quality, Complaints, and Disputes in Care (WKKGZ),

Lastly, there is the Law on Quality, Complaints, and Disputes in Care (WKKGZ), which regulates the meaning of 'good care' and what someone can do if they are dissatisfied with the provided care (Wet Kwaliteit, Klachten en Geschillen Zorg). Each healthcare provider is obliged to provide good care on the basis of the WKKGZ. According to the law, 'good care' means: care of good quality, of a sufficient level which is at least safe, effective, efficient and client-oriented, timely and tailored to the client's real needs. Furthermore, based on the WKKGZ, the healthcare provider must make written arrangements for effective and low-threshold reception and handling of complaints. The WKKGZ applies to healthcare institutions as well as independent care providers and is therefore also relevant for homecare providers.

2.6 United Nations and European Union

There are two different documents from the United Nations that are considered to be relevant in homecare. First we have the Universal Declaration of Human Rights (Universele Verklaring van de Rechten van de Mens). Article 5 of the declaration says that nobody will ever be subjected to torture or to cruel, inhuman or degrading treatment. In homecare, this for example means that nurses are not entitled to force patients towards certain medical treatments. Then there is article 25a, which says that everyone is entitled to a living standard high enough for the health and well-being of themselves and their family, including food, clothing, housing, medical care and the necessary social services. For homecare providers, this means that they are obliged to provide their care in a way that contributes to a certain living standard for their patients. Furthermore, for example, in some cases nurses are responsible to keep an eye on the living conditions in a patient's home. In this case, they need to make sure that these conditions live up to a decent living standard. Article 12 of the International Convention on Economic, Social and Cultural Rights of the UN (Internationaal Verdrag inzake Economische, Sociale en Culturele Rechten) says that everyone has the right to have the best possible physical and mental health, and therefore the best possible healthcare. This can be referred back to the WKKGZ, which regulates 'good care' in the Netherlands.

Lastly, article 35 of the Charter of Fundamental Right by the European Union says that everyone is entitled to access to preventive healthcare and to medical care under the condition laid down by national laws and practices. This means that in principle, a care provider is not able to refuse to provide care to anyone.

2.7 Application of the legal framework

The above framework is only a selected part of laws and regulations in the Dutch healthcare sector (the most important part for my specific research), and it shows the complexity of these laws and regulations in the sector. It shows that within the Dutch healthcare sector, you have to deal with more actors than 'just' the Dutch government. This whole network of rules and laws is created to protect the accessibility and quality of healthcare for citizens, yet it might also constrain the people that are responsible for providing this care. My research aims to find out about both sides of the coin, from the perspective of care givers in self-managing teams. This legal framework forms a foundation for this research as it elaborates on the regulations that, in theory, seem to be the most relevant ones. It creates a starting point for the empirical research that now follows, where I aim to find out how this framework landed in a real life care

organisation, and what it means for care givers that work in self-manging teams.

3. METHODOLOGY

The research question of my thesis is an empirical question, meaning that it could only be fully answered with the usage of observations. The chosen approach for this thesis was a 'case study' research, based on a single case: Livio, a Dutch homecare provider located in Enschede. The main reason for choosing the case study approach is that my research focusses on the influence of policy, law and regulation on the operations of self-managing teams in the healthcare sector. In order to find out about these influences, I need to know the experience of the members of self-managing teams in the healthcare sector. The needed information cannot be found in literature, I need to discover the influences from a primary source, within the relevant context.

3.1 Data collection

Primary data was collected via interviews with employees of Livio. I chose to use interviews because I was interested in finding out thoughts and feelings of the employees, on the matter of how they experience possible influences that come from policy and regulation. Considering the research question, I wanted to gain information directly from the members of the self-managing teams in Livio, since they are also my units of analysis and more than anyone able to provide me with information regarding their own experience. Therefore, my units of observation were respondents. I conducted interviews with 6 employees of Livio, divided over 4 different self-managing teams. The employees were all nurses, with diverse levels of education: from MBO level 4 to HBO V. The interviews were planned by my supervisor, in close collaboration with Livio. An overview of the interviewees is provided in the table below.

Person	Team	Extra- or intramural team	Date and duration interview
1	A	Extramural	22-05-17 / 01:05
2	A	Extramural	22-05-17 / 01:05
3	B	Extramural	29-05-17 / 00:55
4	B	Extramural	02-06-17 / 00:37
5	C	Intramural	06-06-17 / 00:26
6	D	Extramural	10-06-17 / 00:40

Table 1: Overview interviewees

The aim of the interviews was to gain knowledge on the operations and visions of the team members in general with regard to the self-managing teams. Furthermore, for this particular research there were also questions asked about policies and regulation and their influence on the teams and its members. The information that I wanted to gather consists Livio's company policy, as well as possible bottlenecks within the working of the teams that are created by policy and regulation.

An interview protocol was created together with my peer junior researcher, to serve as a guidance for the interview. It contained opening and closing statements, and the key questions. My interview protocol can be found in Appendix 1. The aim was to construct the interview with open questions regarding both factual matters (e.g. the company policy) as well as the interviewees' visions and understanding about them. Furthermore, a semi-structured nature of the interview allowed the interviewee to have more freedom in answering the designed questions and engage in conversation.

3.2 Data analysis

After conducting the interviews, these were analysed in order to come up with my results. The combination of analysed literature and the results from the interviews is believed to be enough to come up with a proper answer to my research question.

Regarding my primary data analysis, the first step was to organize my data properly. For data storage, I asked permission to record the interview. In that way, I was able to focus on the conversation and react to the answers that the interviewees gave, instead of focusing on making notes. After the interview, I transcribed all recorded interviews, to make the data easily analysable. This was also done in collaboration with my peer junior researcher. In total, it took around 30 hours to transcribe all the interviews, which produced 58 pages of text, consisting of 36.664 words.

I used the transcripts to analyse the data gathered in the interviews, by making use of coding. I created a coding scheme, which can be found in Appendix 2. The coding scheme is build up with seven themes, of which four are split up in several sub-categories. The codes originated in two different ways. First, there were the subjects that I knew I was going to ask questions about and the subjects that I expected to hear in answers. These were for example the money shortages (MS) and the positive and negative aspects of self-managing teams (PA and NA). Next, there were also topics that I happened to hear about during the interviews, and therefore decided to give them their own code as well. The main example here is health insurance (HI). An explanation of all codes can be found in Appendix 3, whereas examples of coding can be found in Appendix 4. Within my analysis, I coded the quotes with a number, depending on which interviewee made the comment. The numbers per person correspond to the numbers in table 1.

After coding the transcripts, I created a table in which all the quotes were put together with their corresponding codes. This table resulted in a large data source, and therefore I decided to isolate each column of the table in order to start the analysis code by code. After doing this, I connected these separate analyses by dividing the main results over five main topics: company policy, governmental regulation, cuts and shortages, quality of care, and health insurers. These five main topics of my results in turn lead to the identification of the main findings. An overview of my approach to data analysis can be found in the figure below.

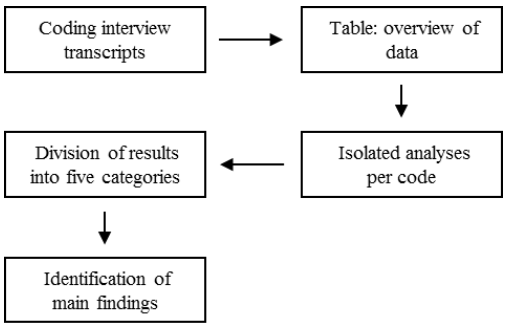

Figure 1: Approach to data analysis

Finally, the data analysis and the therefrom derived results formed the basis for my discussion, whereas the discussion led directly towards the conclusion of my research.

3.3 Trustworthiness of research

To ensure credibility of my data, I went to the interviews with a peer junior researcher. In this way, I made sure that the interview was as un-biased as possible by my own ideas and research direction, since she was there as well to ask questions and respond to answers. Furthermore, we wrote the transcripts together, which ensured that we could check if everything was written down correctly. Another way in which I ensured the quality of my research, is the usage of several sources to collect data from. Furthermore, I monitored and documented my research procedures, to make sure that future researchers that wish to repeat this research are able to do so in the exact same manner. I left an audit trail that includes raw data (e.g. recordings and notes), this raw data is initially only shared with my supervisor. Lastly, I regularly had professional debriefings about my research with my supervisors and peer junior researcher to enhance the quality of my research, for example by practising the interviews and discussing the results.

4. FINDINGS

The findings of my research are divided over five main topics that I identified from the results of the interviews. First, I will summarize the findings regarding company policy, where I will explain what the employees of Livio said concerning the policy of the organisation itself. I will continue with the second topic, governmental regulation, where I will show what influence this has on the healthcare, according to the interviewees. The third topic will cover the thoughts of the interviewees on cuts and shortages, and how this influences their operations. After that, the fourth topic is quality of care, where I will discuss what the influence of both the self-managing teams and law and regulation are on this matter. I will finalise with issues regarding the influence of health insurers on healthcare providers. In this section, I will refer to the transcripts of my interviews, the quotes from my interviewees will be indicated by an italic typeface and quotation marks.

4.1 Company policy

Introducing self-managing teams was the decision of the organisation itself, and therefore company policy. The idea is that the homecare teams organise everything themselves, according to the guidelines provided by the organisation. Generally, these guidelines can be found in the manual that the organisation created. If employees are uncertain about certain guidelines, or don't know where to find them, they say they can always go to their coach-manager for help. Yet, there are some features regarding the company policy that employees have issues with.

To start, it seemed that in practice, despite being a self-managing team, they "*still have to have permission for many things*" whereas usually they think it takes a long time before the organisation judges whether they get permission or not. An example was given that a team wanted to add an extra team member due to an increased workload, yet in the end the organisation decided not to go through with that. According to the employees, they should leave those decisions, as well as decisions on other operational matters, to the self-managing teams. An employee mentioned: "*it is so easy for them to regulate it there at a distance, but it has not been said that it per definition will work in the organization.*"

As a result, the teams sometimes have to sit together, look at the protocols and decide how to really execute them in practice. This turned out to be difficult sometimes: "*We always try to show our right side and work through the protocols, as much as possible. But that is not always possible, sometimes you have to go outside the protocols, and then you just have to do things that you have to condone.*" Furthermore, the team members now have to deal with a lot of administrative forms. Most interviewees explained that they find that too time consuming, also because they believe that sometimes it is not even necessary, like one of the interviewees explained: "*if the basic information is there, I believe it is fine. All the rest, I think is a hassle. And nobody even looks at it.*" These administrative tasks are additional to their main task, providing care, and sometimes is felt to increase the pressure on employees. This is also because the employees always have to be accountable for every hour that they work: "*we are sometimes still beaten by the administration though, with production figures. Well I am quite negative about that, I think, we all work, we all do our best and that's what we have.*", was the opinion of one of the employees. More employees agreed to that, saying that sometimes the obligation to justify for each of their hours is a bit too much, since "*you are not picking your nose here for half an hour. We always have something to do.*"

4.2 Governmental regulation

Regarding governmental regulations, the employees also had some things to say. Most issues concerned the financial cuts, which will be discussed in the next topic. Yet, about regulation in general, most employees agreed that "*currently, regulation and legislation is much stricter and more*" and some had the feeling that the government is "*searching for issues behind everything*". Generally, the employees have the feeling that taking account these rules can be quite a burden. One employee even stated that "*it is a real puzzle*".

An example of stricter regulation was named in the field of indications, which are the provisions for the care that a patient can receive, for example regarding available time and money. The rules for indications have become stricter and "*you have to make sure that you have delivered it all well or have requested it correctly, otherwise the care will not be paid.*" The teams always have to check very carefully whether an indication should be raised or could go down. Employees have a phone, which they need to keep in front of the card that all clients have on their front door, in order to keep track of the begin and end time of the visit. This time is registered because Livio will need to pay for extra time.

The interviewees also gave some examples of situations where they were in direct conflict with laws and regulation. For example, an employee described that she had a customer who was very difficult, and the care that she provided at that customer was at one point "*clearly irresponsible*". The team wanted to stop providing care to this client, "*but then there you are again with all kinds of rules, legal rules, because you cannot just stop providing care. That is not allowed*". Therefore, it took a lot of time and effort to take care of that particular situation. Regarding the fact that care institutions are not allowed to refuse providing care, another team also faced a problem: "*At one point, we had a shortage in employees, and then we could not get around with all the incoming clients anymore*". They explained that at that moment, Livio introduced a so-called 'phased stop', where they actually did refuse care to some clients, due to the lack of resources.

Other examples had to do with perceived limitation of freedom. First, there was a client that slept with bed racks up, otherwise she would get stressed and would not sleep. Officially, the employees were not allowed to put those racks up, because it would limited this lady in her freedom. In the end, they decided to keep the racks up, for the sake of peace for that lady, even though it was actually against the law. In line with this, there

were situations where the employees were asked to lock the door of a client's home in the evening. "*So you lock the door, then the key goes out into the key cabinet and we go away, while some people are not able to open the door again themselves. Those are things that the client wants you to do, because they have an unsafe feeling when they are alone at home at night, when the door is not locked. I can understand that, but again it has to do with these freedom-limiting measures*." Again, the nurses decided to do what the client asked, even though it was in conflict with the law.

Every now and then, the teams are checked on their protocols, via both external (by an external organisation) and internal (by Livio) audits. However, the teams are always aware when these audits take place and they know exactly what they need to be aware of to pass the audit successfully. Therefore, an employee said, "*I am not sure what the added value is. Because, if I had to rate someone, I would come in here unexpectedly*", as the current procedure of the audits makes the results quite unreliable.

Lastly, an often made comment about the distance between the employees on the work floor and the people at the higher offices. Most employees have the feeling that "*sometimes they do not have a clue about how we work and what we encounter*", and that should be different in their view. They think healthcare should be a bit less about business, and more about people.

4.3 Cuts and shortages

The most mentioned issue during the interviews was the financial cut in the healthcare sector. Most employees thought that saving money was the reason for introducing the self-managing teams within the organisation, an example was the dismissal of managers: "*if you look at the office for example, since we have the self-managing teams, there are no managers anymore*". It also turned out that the issue of financial cuts brings along problems for the employees, mainly regarding the experienced lack of time and means they have to provide care to their clients. Most interviewees agreed that you should not be throwing away money and you should be careful, but on the other hand "*we are people and we take care of people, and we try to do that as good as possible*", and they feel that there should be a better balance in that.

An important consequence of financial cuts is said to be the shortage in time: "*time is money and that is what they look at. We have to clock in and out, so they can exactly see how much time we spend somewhere*". At the same time, employees feel like they are often judged on the time they declare. There is a great focus on production time, the time they spend behind the client's front door (which brings the organization money) while the employees explain that, especially now with the self-managing teams, they also are busy with a lot of other tasks. These tasks are written down under so-called 'indirect' time, yet these indirect hours are limited.

Due to the restriction on indirect hours, the employees say that "*sometimes I don't know where to find the time*" and as a consequence, a lot of employees do a big amount of work in their free time. Even at home, they sometimes are contacted via their private email or phone. Some employees say that this disturbs their work/life balance. Another employee mentioned: "*you really need to be careful not to become a charity institution, because we really do many things in our own time*".

But not only has the private time of employees suffered from the financial cuts, according to the interviewees. Also the time that the nurses can spend on their clients has been reduced a lot. Indications have become a lot stricter in the view of the interviewees. These days, people have to be as independent as possible, enabling their indications to be as low as possible. "*In the past, quickly putting laundry in the washing machine or washing some dishes, we did that. But no more. Officially it is even so that you cannot open the curtains in the bedroom*", said one of the employees. However, most employees stated that they still do so, but then in their own time. Another side of this issue is the fact that there is barely time anymore for the nurses to have a chat with their clients. Most of the employees indicated to have a problem with that, since for some clients, this small social time can make a big difference: "*There is a lot being cut, they say 'oh you can do it yourself', and that is good, but there are also people that just really need a chat every now and then*". Most of the nurses believe that there should be some more time for some clients, to now and then have this chat, simple because some people are lonely and really benefit from this bit of attention. In the eyes of the nurses, "*it is okay to spend some money on that*".

Another issue resulting from the financial cuts, are the cuts in materials. Nurses and clients really need to be careful with how much they use in materials. Sometimes this can be very difficult, however "*people should also learn to deal with it*". An example that was made regarded incontinence materials, people may only use a limited amount of incontinence materials per day. Yet mostly, these are thrown away as soon as they get a bit wet and thus "*you really need to learn them not to do that, only take it away if it is completely saturated. People need to learn this, and we as well. Because before, we would also say 'just throw it away', but that is not possible anymore*". These are things that the employees state to run into. Most nurses see this as a problem, yet they agree that some part of it is also just a matter of "*getting used to it*".

The main cause of the problems that occur from the financial cuts, has according to the employees to do with the distance between the people on the work floor and the policy makers: "*the government does not know what we are doing. Those people there in The Hague don't know what work we do. Behind the desk, you can very well say, this and this is how we will do it. But that does not necessarily work in real life. I would say, let them walk with us, let them come in different teams and see. Not for a day, but spend a few months on it. Then they will see what we do*". The interviewees all were of an opinion that the policy makers where too far distant from the actual situation. The nurses say that cutting down costs is okay, as long as it is feasible and possible for a client. "*They can say, we have to cut down, but if the care for the client is lacking because of that, that is not the intention. I mean, we want the best for our client*", one nurse explains.

4.4 Quality of care

The Dutch law requires that care should be of a good quality. According to the employees, the introduction of self-managing teams in the healthcare sector has its influence on the quality of care. The perception of this influence, whether it is positive of negative, differs a lot per interviewee.

Some employees say that self-managing teams were introduced to increase the quality of care, because the lines to the clients became shorter and "*because you are more on top of it, you can signal more things*". Most nurses explain that for the client, it is an improved situation because "*they always see the same faces*" and that created a trustful environment for them. However, there was one employee that stated that she was not sure that this was a direct result of the self-managing teams, "*but definitely because of the smaller teams*".

There was also a big amount of interviewees that judge the influence of self-managing teams on the quality of care as negative: "*The quality of care decreases. That is not what you're trying to do, but you just have other stuff to do. You have to fill in stuff, because otherwise, you will not get a salary or the care will not be paid. You can no longer focus on care*". So according to them, the new additional administrative tasks steal away the focus from providing care.

Besides the influence of the self-managing teams on the quality of care, most employees also commented that they believe that "*due to the cuts, quality of care decreases very much*".

4.5 Health insurers

During the interviews, it was mentioned that the power of health insurers on healthcare is big, and according to some even too big: "*the influence of health insurers is too big, I think so. That does not mean that that is a bad thing, but they have to be realistic. And I always have the feeling that the health insurers earn too much money*".

Health providers have to operate according to certain rules that are made by health insurers, because otherwise they will not be recommended anymore: "*for example when people come out of the hospital, the insurers will not refer them to Livio, but to another organization. Then your name is no longer mentioned*". Thus, in order to keep getting clients, healthcare providers need to comply with those certain rules.

One of the biggest influences that health insurers have, according to the employees, is that they decide how much money a care provider gets. An example was mentioned: "*Buurtzorg has gotten a fine of 7 million euros, because they had provided too much care and they have to repay it*". And thus, like mentioned under the part about cuts and shortages, the care providers and their employees need to be very careful that they comply with the indications.

5. DISCUSSION

5.1 Organisational interference

First of all, there was a problem identified with company policy. The nurses are supposed to work in self-managing teams, meaning that they organise their work themselves and can make decision on their own. However, in practise, the nurses still experience some organisational interference, which they sometimes experience as disturbing. The cause for that feeling is the fact that it creates ambiguity: are they self-managing or not? So here lies a challenge, it could mean that either the nurses are not fully aware of what the approach towards self-managing teams is, or the organisation does not follow the approach entirely, by interfering more than planned. In theory, self-managing teams are defined as teams that manage themselves and have the authority to determine the organization, monitoring and management of member efforts. So in theory, there should be no large interference from higher management. However, it also depends on the organisations ideas on how to operate self-managing teams. I do know that the case company has a protocol regarding the approach towards self-managing teams, which is also spread out to the employees. For the issue regarding organisational interference, there are two optional solutions; either the organisation needs to explain the approach better to their employees, to make sure that everyone understands what the approach is. Or, the organisation should review how they execute the approach and see if indeed they interfere too much, and if this is case, change it to prevent themselves from ending up in a split between two approaches.

5.2 The distance between the work floor and policy makers

The employees of Livio mentioned that in their experience, it is not always possible to follow the specific protocols. Sometimes, they run into situations where they have to condone a certain issues in order to give proper care. Furthermore, some of them even gave examples of situations where their operations where in direct conflict with laws and regulation, as I described in my findings. In most cases, nurses seemed to choose to do what their clients wanted, despite what laws and regulation prescribed.

A major cause to these problems was explained to be the distance between the actual work floor and the policy makers. Among the employees, there is a compelling feeling that the government has no clue what is going on in the healthcare sector and what challenges the nurses encounter on a daily basis. As a result, policy is made without actual knowledge on what is needed within the sector. Also the main cause of the financial cuts, which will be broader discussed in the next paragraph, is said to be this distance. Policy makers should be less distant from the actual care providers and create their policies by experience on the work floor, not behind their desks. One way to make this happen is for example to let the policy makers run with the nurses for some time, so that they can actually see what policy is necessary and feasible in healthcare. Another, probably more time and money sparing, option to tighten this distance could be to create a stronger collaboration between the trade union of nurses (e.g. the "v&vn") and the government.

5.3 Financial cuts

Financial cuts are generally declared to be the biggest malefactor of the problems within the healthcare sector. This is a statement that I made in the introduction of my thesis, and the results of my interviews found the same outcome. Generally, the interviewees had the feeling that there should be a better balance between the focus on money and the humanity of healthcare.

The influence that financial cuts have on nurses is related to the introduction of self-managing teams, in a way that is saves personnel costs. There is a significant amount of managers that got dismissed due to the introduction of self-managing teams, which saves a lot of money for the organisations. It is therefore believed by most nurses that this was the reason for the case company to introduce the self-managing teams.

Other consequences of financial cuts are seen in material shortages, but mostly in time shortage. Nurses explained that sometimes they don't know where to find the time for their tasks. Furthermore, the time problem results in the issue that a lot of nurses do a significant amount of their work in their free time. This problem could be solved in two ways; first, the nurses could be given more paid (indirect) hours to complete their tasks, and second, there could be an option to reinforce the teams with more manpower. However, both these solutions will cost a lot of money, which is definitely not in line with the financial cuts.

Regarding time shortage, there also is a great impact on the clients of the healthcare sector. The nurses have very strict indications, barely leaving them time to have a short chat with their clients. Some clients really need this small attention and social interaction, which is why most nurses say that it is important to spend some money on that as well.

5.4 Quality of care and self-managing teams

The guarantee of quality of care is regulated by law. According to the Law on Quality, Complaints, and Disputes in Care (WKKGZ), all healthcare institutions are obliged to provide 'good care'. This means: care of good quality, of a sufficient level which is at least safe, effective, efficient and client-oriented, timely and tailored to the client's real needs.

As explained in the theoretical framework of my thesis, researchers believe that a reason for implementing self-managing teams in the healthcare sector is because it would increase the quality of care. The most important argument in favour of this statement, is that self-managing teams enable the employees, who have the first-hand knowledge, to take the lead in their operations. However, one consequence of self-managing teams in the healthcare sector is that the nurses cannot only focus on providing care anymore, as they now have more secondary tasks besides that. So is it then not the opposite? The time they spend on these secondary activities might come at cost of the time they are able to spend on giving care to patients. This is an interesting discussion, as also the result of my interviews had a divided view on the matter.

On the one hand, it is believed that the introduction of self-managing teams increase the quality of care, because the lines to clients are now shorter and nurses have a better relationship with clients. On the other hand, the nurses said that the quality of care decreased by self-managing teams, due to the fact that there no longer exists a focus on providing care. The problem that I identify here, actually has to do with time shortages. See, when employees of self-managing teams have more time to fulfil their secondary (administrative) tasks, so if they are allowed to declare more indirect hours, they would have the time to do all those tasks while at the same time be able to focus on providing good care. So again, the malefactor for this problem are the financial cuts.

5.5 The influence of health insurers

As I mentioned in my results, during the interviews I learnt that the influence of health insurers on care is very important. Health providers have to comply with the rules that health insurers give them. Furthermore, health insurers decide how much money a care provider gets each year, and as a consequence the nurses have to indicate very strictly and always check whether an indication should go up or down. If they provide too much care, they will get a fine and have to repay it themselves.

So the power over the healthcare sector lies in the hands of health insurers. According to the Health Insurance Act (Zvw) of the Dutch healthcare system, this power should be evenly held by health insurers, healthcare providers and citizens, as a balanced triangle that ensures quality of care. However, the findings of my research show that in practice, this is not exactly the case. There is a general feeling among nurses that health insurers have a great power over healthcare providers and that they abuse this power to gain money for themselves.

5.6 Reflection on the research question

So it can be said that in fact employees in the healthcare sector feel the influence of policy, law and regulation on their operations. The next table shows the main influences of policy, law and regulation on self-managing teams and their corresponding consequences, identified in this research.

Nurses are supposed to work in self-managing teams, however they experience still some organisational interference	→	Creates ambiguity and a feeling of disturbance
For nurses it is not always possible to follow specific protocols	→	Results into situations where nurses feel the need to operate in a way that is conflict with the law
There is a distance between the people on the work floor and the policy makers	→	Creates a feeling that policy is made without actual knowledge on what is needed
Money should be saved (due to financial cuts)	→	Leads to the introduction of self-managing teams
Shortages in materials (due to financial cuts)	→	Causes that nurses and clients have to work with less materials
Shortages in time (due to financial cuts)	→	Causes that many nurses work unpaid hours
Lack of time (due to financial cuts)	→	Causes that clients get less attention
Legally, care should be of a good quality	→	Leads to the introduction of self-managing teams
The introduction of self-managing teams	→	Causes that nurses can no longer focus solely on giving care, which decreases the quality of care
Great power of health insurers	→	Leads to stricter rules and less money for care givers

Table 2: Main influences of policy, law and regulation on self-managing teams and their consequences

The main cause for most of the consequences above can be traced back to the financial cuts and policy, whereas the distance between the people on the work floor and policy makers is identified to be the original problem for this.

My results show that self-managing teams feel a lot of pressure coming from policy, law and regulation, which has a negative impact on them, according to the members. However, something to take into account here, is that these results only apply from the view of the self-managing teams. Meaning that it does not say anything about the influence of policy, law and regulation on the healthcare sector itself, this is a different point of view. For example, considering that the law actually ensures that everyone in the Netherlands had access to good quality of care, the influence of policy, law, and regulation might be of a more positive nature on healthcare from a citizen's point of view. This is something that goes beyond the scope of my thesis, yet it is something to keep into account when interpreting my results.

6. LIMITATIONS AND FUTURE RESEARCH

6.1 Limitations

In my research, I used a case study, based on semi-structured interviews. Due to the limited timeframe of my research, I conducted a single case study, with a small amount of respondents. My results where therefore based solely on the opinions of the employees of Livio. As a consequence, it is only possible to generalize my results theoretically. To generalize the result of my study to a population of curative health care providers, further research should be conducted, for example in the form of a multiple case study or a survey. However, the small number of interviews in this case study did allow me to identify unexplored challenges that came along with the introduction of the self-managing teams, related to the regulative aspects in the healthcare.

Another limitation to my research could be the obtrusive method of data collection; the respondents were aware that they were under observation, since I conducted interviews with them. Even though I had the impression that the interviewees were very open about their opinions, this awareness could have led them toward giving socially desirable answers. I tried to limit the influence of this bias on my results by emphasizing that the interview would be handled carefully and anonymously, and by stating that there were no false or correct answers as I was only interested in the interviewees' opinion.

Lastly, researcher bias could be a limitation of my research, since I was the only person that coded and analysed my data for the sake of my research. Of course, I had an ideal outcome in my mind, which might have caused bias in my perception of the results. I tried to be as objective as possible, but perhaps other researchers, with other perceptions, would have found different results. This bias was reduced as much as possible by professional debriefing with both my supervisors and my peer junior researcher.

6.2 Future research possibilities

I believe that my research opens possibilities for future research on the influence of policy, law and regulation on self-managing teams in the healthcare sector. In my research, I identified those influences and tried to explain how they exactly influence the self-managing teams in the healthcare sector. However, after this identification, the question arises how to deal with these influences. For example, how can the problem that these influences cause, best be solved? Answering this is a very interesting topic in my opinion, but it goes beyond the scope of my current thesis. Therefore, I view is as a future research possibility.

Another opening for future research lies a bit further from the main topic of my research, but more in the field of HR practices. As I mentioned in my introduction, a substantial proportion of expenses in the healthcare sector comes from labour costs. Considering this, plus the fact that financial cuts are causing pressure in the healthcare sector, this asks for high efficiency in HRM within this sector. Regarding the introduction of the self-managing teams in the healthcare sector, it raises the question how HR practices should be then managed, within these self-managing teams. Answering that question goes beyond the intended scope of this thesis, however I can definitely see possibilities for future research here. Furthermore I believe that the current research can be of a contributing value for those who aim to answer that question, as it will concern a major source of the problem described: policy and regulation.

7. CONCLUSION

Initially, the aim of my research was to provide an answer to the research question: "What is the influence of policy, law and regulation on the operations of self-managing teams in the Dutch healthcare sector?". As explained in my discussion, the results of my research lead to the identification of five main topics of influences: organizational interference, the distance between the work floor and policy makers, financial cuts, quality of care and self-managing teams, and the influence of health insurers. These main influences are found to have a rather negative impact on the operations of self-managing teams in the healthcare sector.

To conclude, it is found that most challenges that self-managing teams in the healthcare sector experience, arose due to the financial cuts by the government and health insurers. Furthermore, the main cause for the problems and challenges associated with the identified influences was found to be the distance between the work floor and policy makers.

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10. APPENDICES

10.1 Appendix 1: Interview protocol

Opening - Ik bedank de geïnterviewde voor de deelname aan mijn onderzoek. Ik stel mijzelf voor en vertel iets over mijn onderzoek. Ik leg uit dat dit interview vertrouwelijk behandeld zal worden en informatie die mij gegeven wordt niet door zal worden gegeven aan derden. Ik vraag toestemming om het interview op te nemen. Verder leg ik uit dat ik vooral geïnteresseerd ben in de mening van de geïnterviewde, en dat er daarom geen goede of foute antwoorden bestaan.

Vragen

Algemeen:

1. Zou u uzelf voor kunnen stellen?
2. Zou u iets kunnen vertellen over uw dagelijkse werkzaamheden?

Professioneel organiserende teams

1. Wat betekent "professioneel organiseren" in uw ogen?
2. Wat vindt u de voordelen van het werken in een professioneel organiserend team?
3. Wat vindt u de nadelen van het werken in een professioneel organiserend team?
4. Waarom denkt u dat de professioneel organiserende teams zijn geïntroduceerd?
   - Had u hier behoefte aan?
   - Hoe verliep de overgang naar professioneel organiseren? (communicatie, problemen eventueel)
5. Op wat voor manier zijn de taken verdeeld binnen de teams?
   - Wat is uw rol binnen het team?
   - Wat gebeurt er als de teamleden het niet eens kunnen worden, wie maakt dan de uiteindelijke beslissing?
6. Wat is de rol van de coach-manager bij het professioneel organiseren?
7. Heeft u het idee dat u binnen het team ondersteuning krijgt van de organisatie, bijvoorbeeld van personeelszaken of de coach-manager?
   - Zo nee: Heeft u behoefte aan ondersteuning uit deze hoek? (+ wat voor ondersteuning)
   - Zo ja: Wat voor ondersteuning en heeft u hier behoefte aan?
8. Wat is er volgens u nodig om professioneel organiseren tot een succes te maken?
9. Als u voor één dag manager van Livio zou zijn, wat zou u dan doen/veranderen?

Beleid en regulatie

1. Kunt u mij iets vertellen over de regels die u van Livio moet naleven tijdens uw werkzaamheden?
2. Hoe zorgt u ervoor dat u op de hoogte blijft van regelgeving, bijvoorbeeld wanneer er veranderingen optreden?
3. Op wat voor manier heeft zowel bedrijfs- als nationale regelgeving invloed op uw werkzaamheden?
4. In hoeverre ervaart u de regulatie van kwaliteit in zorg als zijnde streng?
5. Kunt u mij iets vertellen over de klachten procedure van Livio?
6. Op wat voor manier merkt u dat er bezuinigd wordt in de zorg?
7. Wat voor invloed hebben de bezuinigingen op uw werkzaamheden?

Afsluiting- Ik bedank de geïnterviewde nogmaals en leg uit dat mijn volgende stap het uitwerken van de opname zal zijn. Ik vraag of de geïnterviewde een kopie zou willen ontvangen van het transcript, en noteer daarbij het emailadres.

10.2 Appendix 2: Coding scheme

Themes	Categories	Codes
Self-managing teams	General comments	SMT
	Positive aspects	PA
	Negative aspects	NA
	Transition to SMT	TS
Policies	Company policy	CP
	Governmental policy	GP
	Rules	R
	Health insurance	HI
Cuts	Money shortage	MS
	Time factor	TF
Care provision	Quality of care	QC
	Increased pressure	IP
Direct conflict between law and operations	[no sub-category]	DC
Procedure regarding complaints	[no sub-category]	PC
Other relevant issues	[no sub-category]	OR

10.3 Appendix 3: Explanation of Codes

Code	Meaning	Definition
SMT	Self-managing teams general	General comments on the self-managing teams are placed under this code.
TS	Transition to Self-managing teams	All statements that concern the transition towards self-managing teams.
PA	Positive aspects SMT	The positive aspects that the interviewee experiences due to working in self-managing teams.
NA	Negative aspects SMT	The negative aspects that the interviewee experiences due to working in self-managing teams.
R	Rules (other)	Rules that are named or commented on that are not specifically necessary to place under company policy or governmental regulation.
CP	Company policy	All comments that refer directly to policy and rules from the case company.
GR	Governmental regulation	All issues that are to be linked to governmental regulation on healthcare.
QC	Quality of care	Comments on the increasing or decreasing level of healthcare quality, as well as comments on healthcare quality in general.
PC	Procedure regarding complaints	Comments regarding the complaints procedure of the case company.
MS	Money shortage	All statements made with regard to money and money shortages.
TF	Time factor	All statements concerning time, for example the lack of time.
DC	Direct conflict between law and operations	When there is a comment or example of a situation where operations of the nurses was in direct conflict with the law.
OR	Other relevant issues	Other issues that are not specifically fitting to the other categories, but might be interesting for my research anyway.
IP	Increased pressure	Comments regarding the increased pressure on employees in the healthcare sector.
HI	Health insurance	Comments regarding health insurance companies and their influence on care are coded under this code.

10.4 Appendix 4: Examples of coding

Code	Quote
R	We always try to show our right side and work through the protocols, as much as possible. But that is not always possible, sometimes you have to go outside the protocols, and then you just have to do things that you have to condone.
DC	One lady sleeps with her bed racks up. If they are down, she totally gets into stress and will not sleep, she will be restless. But officially, that is not allowed, because it is a limitation to her freedom.
MS	I think there may be some more attention for the people occasionally, because sometimes they need that attention, and I think that it is okay to spend some money on that.