A Legislative Amendment Within Dutch Mental Healthcare Increases the Administrative Burden: A Follow-Up Study

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Abstract: *Background:* To be accountable to laws and regulations, healthcare professionals spend more than 40% of their time on administrative tasks. The Compulsory Mental Healthcare Act (CMHA) was introduced in Dutch mental healthcare in 2020. It was hypothesized that this legislative amendment would raise the administrative burden for some care professionals. Pilot studies in 2020 and 2021 visualized the exponentially rise of the administrative burden for care professionals, especially psychiatrists due to the transition. However the total response was too small and not generalizable. *Aim:* gain more nationwide insight in the hypothesized raise of administrative burden of psychiatrists due to the implementation of the CMHA. *Method:* Under the leadership of an advisory board of three medical director psychiatrists, a Likert scale questionnaire was further developed to investigate the administrative burden of psychiatrists in the Netherlands before and after transition. Open-ended questions provided the opportunity for feedback from the psychiatrists. The study was supported by the Department of Medical Directors (DMD) of The Netherlands Psychiatric Association (NPA). *Results:* all mental health institutions members of the DMD of the NPA received an invitation to participate. 14 institutions (total N=158) responded. The data show a significant change in the time spent on administrative tasks, the usefulness of the administrative actions, the fit for use and ease of use of supporting systems. The forementioned all decreased significantly after the implementation. *Conclusion and discussion:* Psychiatrists spend more time on administration than before the legislative amendment instead of helping vulnerable patients. None of the institutions has been able to use the transition to its advantage given the time spent on administrative tasks and the usefulness of these tasks. This is an unacceptable development in the field of mental health in the Netherlands and should be addressed to those who are responsible for the decision making, especially policy makers. These results show that the introduction of the CMHA have made the field of Dutch mental health an impossible area to work for.

Keywords: Dutch Mental Healthcare, Administrative burden, Legislative amendment, Public governance, Information Management

1. Introduction

Healthcare professionals are experiencing increasing friction between complying with law regulations and providing the necessary care to their clients. These frictions are classified in the literature under concepts such as red tape, ordeal mechanisms and administrative burdens (Madsen, Mikkelsen and Moynihan, 2022). In the case of reducing administrative burdens, there is already quite a lot of research, however these studies mainly focus on reducing the measurable 'costs' incurred by an institution or company and less on the governance of administrative burden experienced by the individual (Nielsen et al., 2017; Larjow, 2018).

Before the COVID-19 pandemic, 40% of the working time was spent on administrative tasks and despite all the improvement initiatives, this burden have increased for decades (Veenendaal, Waardenaar and Trappenburg, 2008; Joldersma, Laarman-Wierenga and Brink, 2016; Ministry of VWS, 2018; Lint, 2019; Hanekamp, Heesbeen and Taks, 2020; Keuper, Batenburg and Verheij, 2022). Various studies indicate that this problem is an international issue (Cebul et al., 2008; Brown, Enticott and Russell, 2021; Chernew and Mintz, 2021). This issue has a severe impact on the functioning and satisfaction of healthcare staff (V&VN, 2019) and appears to be one of the reasons for resigning (Ahli, 2019).

The Dutch ministry of Healthcare indicates that the administrative burden is due to the interpretation of legislation and regulations by the healthcare institutions and its employees. The legislation and regulations themselves can provide additional registrations in the actual time spent, but the experienced burden cannot be attributed to the legislation (Ministry of VWS, 2020a). This perspective was not recognized in healthcare institutions.

Healthcare professionals within mental healthcare institutions experience the highest administrative burden (Bronkhorst, 2019; Hanekamp, Heesbeen and Taks, 2020). In order to better protect the needs and legal rights

of patients and their relatives, the Special Admissions Act in Psychiatric Hospitals (SAAPH) was replaced by the Compulsory Mental Healthcare Act (CMHA) on January 1, 2020. The SAAPH was aimed at arranging compulsory admission, while the CMHA focuses more on the treatment of the patient (The Dutch mental healthcare, 2020). Before this legislative amendment, psychiatrists indicated that mandatory administration was the main cause of the extreme workload they experienced in their daily clinical practice (Joldersma, 2019). Maris et al. (2021) indicated that this legislative amendment has consequences for the perceived administrative burden in mental healthcare, especially in the case of psychiatrists. However, this result was insufficiently generalizable for the entire sector.

The aim of this study is to conduct a nationwide study in the field of psychiatry with the main research question: *To what extent does the perceived administrative burden of care professionals within Dutch mental healthcare, specifically that of psychiatrists, differ before and after the legislative amendment from the SPAAH to the CMHA?*

In the remainder of this paper, the core concepts of this research, 'administrative burden', 'change in law' and 'Dutch mental healthcare' are discussed, followed by a description of the research method. The results of this study are presented in the results section. Conclusions, recommendations for further research and limitations are described in the last sections.

2. Theoretical perspective

2.1 Administrative burden

Wilson (1887) wrote that administration is 'the most obvious part of government; it is government in action; it is executive; the operative, the most visible side of government'. Nowadays, several terms are used when referring to the concept of the burden of these administrations. The Dutch Ministry of Health (2017) commissioned research into the relationship between these concepts (figure 1).

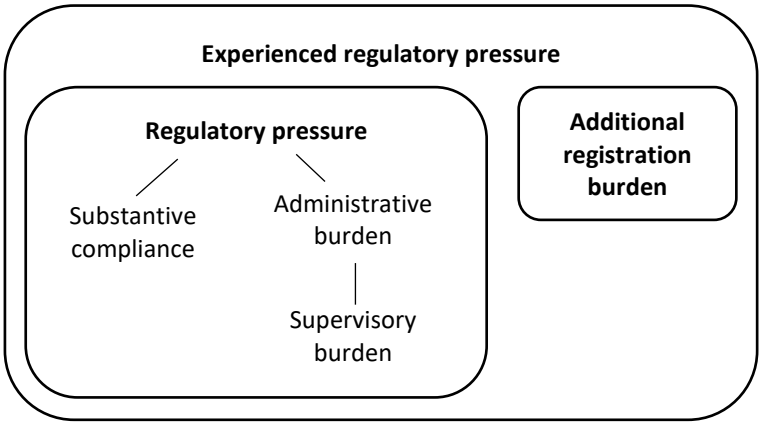

Figure 1: Relationship between concepts (Berghuis, Schimmel and Zuurbier, 2017)

Within the concept of regulatory pressure, the Dutch Ministry of Health distinguishes between administrative burden and substantive compliance burden. Administrative burden involves the collection, processing, registration, storage, and provision of information required by the central government. Supervisory burden concerns information obligations that are necessary in the context of supervision by the central government. This is about complying with governmental laws and regulations.

Substantive compliance burden on the other hand includes compliance with norms, standards and codes of conduct set by central government. Additional registration burden includes all (information) obligations to parties other than the central government, such as municipalities, insurers and care offices. All concepts are about experienced regulatory pressure and they do contribute to the 'experienced regulatory pressure' by healthcare professionals.

Boog, Suyver and Tom (2004) understood 'regulatory pressure' as the experienced burden of an individual to comply with information obligations resulting from legislation and regulations. In this description is the emphasis placed on how the individual experiences complying with information obligations. The registration pressure

experienced by healthcare professionals is mainly determined by the time required for registrations, the rate at which this individual performs the registration tasks and the frequency with which the registration tasks must be performed.

Michel (2017) shows in her thesis 'Into the black box of a nursing burden', that nurses especially have difficulty organizing administrative tasks in addition to care tasks. Moreover Vilans, one of the research offices commissioned by the Ministry of Public Health, recognizes that healthcare professionals as end-users of administrative rules have difficulty streamlining administrative work processes and care processes (Stekelenburg and Smit, 2022). Bronkhorst (2019) sees the perceived regulatory pressure of healthcare professionals as *'the perceived pressure that arises from the accumulation of administration, unnecessary bureaucracy and procedures that do not contribute to the goal of insight into care'*.

According to De Veer et al. (2017), this high administrative pressure can be felt in all sectors of healthcare. Two types of administration are distinguished: patient-related administration and non-patient-related administration. Patient-related administration is, for example, writing reports, writing a care plan, or completing checklists. Non-patient administration is, for example, recording hours worked or recording reports of incidents.

All definitions consider administrative burden as a single concept. Van Loon et al. (2016) were the first researchers to unravel this concept. They distinguish two dimensions: the perceived 'lack of functionality' and 'compliance burden'. Administrative burden is defined as the excessive or unnecessary amount of time, energy or other resources spent obeying a rule.

2.2 From admission act to treatment act

In the Dutch mental health sector, the CMHA regulates all the rights of persons who come into contact with compulsory care due to mental disorders since January 2020 (The Dutch mental healthcare, 2020). This law is for persons whose mental disorder leads to behavior that can cause serious danger to themselves or their surroundings. The CMHA is primarily a care act and not an admission act. Within the SAAPH, compulsory admission was mandatory. The patient has a better legal position within the CMHA. They will have a say in their process and have the right to provide a self-written care map and a plan of action.

Only when someone is forced to be admitted to, a psychiatric hospital, for example, can compulsory care be applied by a judge or mayor for a certain period of time. So, the provision of compulsory care is only applied in extreme cases. The basic principles with which compulsory care must comply are laid down in the CMHA. These include *proportionality* - the interest in proportion to the infringement, *subsidiarity* – the best and only way to achieve this and *effectiveness* - achieve what you want to achieve with the infringement (Ministry of VWS, 2020b).

2.3 Dutch Mental healthcare

As mentioned before, healthcare professionals spend about 40% of their time on administration (Hanekamp, Heesbeen and Taks, 2020; Van Ark, 2020). As visualized in figure 2, healthcare professionals within Dutch mental healthcare organizations experience the highest regulatory pressure (Bronkhorst, 2019).

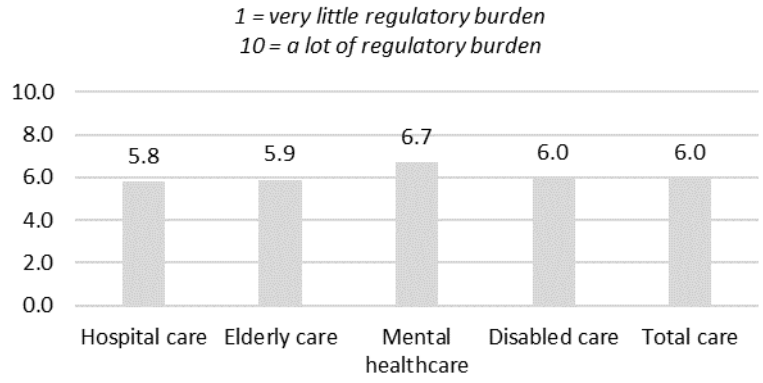

Figure 2: Measured perceived regulatory burden by Dutch healthcare professionals (Bronkhorst, 2019)

Seen separately, the lack of functionality and compliance burden are also appear to be greatest in mental healthcare (figure 3).

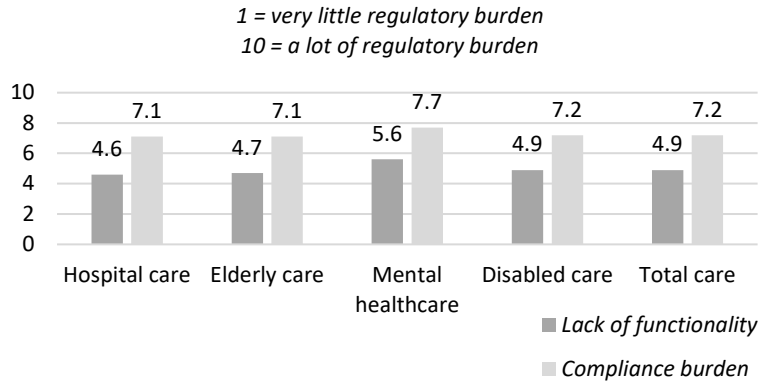

Figure 3: Measured lack of functionality and compliance burden (Bronkhorst, 2019)

Psychiatrists indicate that they see mandatory administration as the main cause of the extreme workload they experience in their daily clinical practice (Joldersma, 2019). Such a high perceived workload has a negative effect on the job satisfaction of psychiatrists (Van Ark, 2020).

3. Method

This research describes the possible change in the perceived administrative burden among Dutch psychiatrists in the context of a legislative amendment. A descriptive survey research method is chosen because the large amount of psychiatrists and nationally spread (Salaria, 2012).

In response to critical feedback from respondents to the original questionnaire, the survey from previous studies has been improved. To measure the administrative burden in an unbiased way, eight questions related to the general concept of 'administrative burden' are added. Based on the dimensions of van Loon et al. (2016) three questions are about usefulness and necessity and three questions about time pressure. The other two questions concern the degree of support of the ICT systems in which the registrations are entered. As in the original questionnaire, all individual registrations relating to the SAAPH as well as the CMHA were also requested in this survey. This time not only was attention paid on the ‘spent time’, but also the usefulness and necessity was taken into account. Subsequently, the questionnaire was linguistically updated in collaboration with an advisory committee consisting of three medical directors and a linguistical expert, also a psychiatrist. This improved the readability of the questionnaire and the unambiguity of the questions as well improved the quality related to the subject. The final questionnaire starts with five general questions to determine whether the respondent really belongs to the target group. Subsequently, eight questions were formulated to determine the overall perception of the administration burden at the time of the legislation. In addition to the overall perception, the change in usability and time pressure of 14 individual administrative actions was measured. Five of these actions relate to the objectives of the amendment to the law, such as more control for the client and better collaboration with the judiciary and municipalities. The other nine questions were related to the daily treatment process. All questions related to the administrative burden are measured for the SAAPH (before the transition) and to the CMHA (after the transition) on a 5-point Likert scale. Finally, an open question is formulated about how the transition was experienced. The questionnaire is available in Dutch upon request by the authors.

The online questionnaire was distributed using Qualtrics. For the distribution of the survey, the privacy of the professionals has been taken into account in accordance with Dutch (AVG) and European (GDPR) legislation. For this study, the names and e-mail addresses of the respondents were kept in the vaults of the healthcare organizations. An unique link was created for each respondent by the researchers. This link was linked by the secretariat of the healthcare organizations to the data of the organizations (name and e-mail address of the respondents). This allowed the secretariat to send a personalized bulk email to the psychiatrists inviting them to complete the survey with their personal unique links. The bulk email content was also the invitation as well the informed consent for participation. If someone did not want to participate, he could throw the e-mail away. If someone was willing to participate, he could click on the link and answer the questions from the online survey. Because this method was complicated for the secretariats, a manual was made with a step-by-step plan including

a telephone number for support that could help the secretariat. With the help of department of the Medical Directors of The Netherland Psychiatric Association, the survey was successfully distributed through various secretariats nationwide. Successively, within two weeks, a reminder was also sent to the participants via the secretariats. In total, 158 responses were registered from 14 different institutions.

The results of the Likert scale questions were quantitatively analyzed using SPSS version 25. The data reliability was tested with a factor analysis and Cronbach's alpha score and the change in administrative burden was analyzed using a Paired sample T-test. The answers on the final open question were open coded (text labels are connected with text fragments) using Atlas.ti 9. The codes are visualized in a structured mind map using axial and selective coding.

4. Results

Ultimately, 158 respondents from 14 organizations, spread across the Netherlands, completed the survey. According to the Dutch Central Bureau of Statistics, there were 3,845 registered psychiatrists in 2020. 2,070 of these psychiatrists worked at a mental health institution (StatLine, 2022). These numbers have been fairly stable in recent years. Table 1 shows that 138 psychiatrists completed the survey. This means that almost 7% of the total number of registered psychiatrists participated.

Table 1: Sample details

Age	
Less than 29	0
30-39	35
40-49	41
50-59	49
older	33

Primary function	
Psychiatrist	122
Psychiatrist medical director	16
Psychiatrist in training	0
Other	20

Work experience within mental healthcare	
Less than 1 year	3
1-4 years	29
5-9 years	35
10-14 years	41
15-19 years	15
more than 19 years	35

A factor analysis and reliability test was conducted before the elements Usability, Time pressure and ICT support were merged. The factor analysis showed that both before and after the amendment of the law, the elements consist of the same items (Table 2).

Table 2: Factor analyses

Rotated Component Matrix SAAPH[a]			
	Use	Time	ICT
R3_1	0.853	-0.064	0.221
R3_2	0.924	-0.026	0.082
R3_3	0.788	-0.077	0.056
R3_4	-0.127	0.805	-0.018
R3_5	-0.011	0.875	-0.097
R3_6	-0.024	0.823	-0.165
R3_7	0.124	-0.060	0.928
R3_8	0.167	-0.186	0.896
Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser normalization.			
a. Rotation converged in 4 iterations.			

Rotated Component Matrix CMHA[a]			
	Use	Time	ICT
R2_1	0.895	-0.076	0.162
R2_2	0.906	-0.209	0.096
R2_3	0.853	-0.136	0.035
R2_4	-0.191	0.871	-0.060
R2_5	-0.078	0.935	-0.001
R2_6	-0.147	0.844	-0.178
R2_7	0.074	-0.088	0.921
R2_8	0.146	-0.087	0.913
Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser normalization.			
a. Rotation converged in 4 iterations.			

The reliability of the combined items is tested with the Cronbach's alpha score (table 3). These scores are all above 0.7, which is in this research context acceptable (Bland and Altman, 1997).

Table 3: Reliability analysis

	SAAPH			CMHA		
	Use	Time	ICT	Use	Time	ICT
Items	3	3	2	3	3	2
Cronbach's Alpha	0.828	0.795	0.853	0.885	0.876	0.841

Table 4 shows that the usability (1) has increased by 0.667 points (SD 0.998). This means that administrative tasks are seen as more of a necessity after the amendment of the law. The time pressure (2) has decreased by 0.848 points (SD 1.050) which means that administrative tasks take more time after the amendment of the law.

ICT support (3) has also deteriorated after the amendment of the law. This factor increased by 0.563 points (SD 1.178). All differences mentioned are significant ($p < 0.001$).

Table 4: Paired sample t-test overall perception

		Paired Differences		t	df	Sig. (2-tailed)
		Mean	Std. Dev.			
1	Use	0.667	0.998	8.395	157	0.000
2	Time	-0.848	1.050	-10.148	157	0.000
3	ICT	0.563	1.178	6.011	157	0.000

In more detail, the differences per individual administrative action have been mapped out (appendix 1). Pair 3, 9, 10, 11 and 12 are related to the objectives of the amendment to the law. The other pairs are related to the daily treatment. The pairs are combined in these two factors. All factors are reliable with a Cronbach's alpha score above 0.7 (table 5).

Table 5: Reliability analysis individual administrative actions

	SAAPH				CMHA			
	Use_1	Use_2	Time_1	Time_2	Use_1	Use_2	Time_1	Time_2
Items	9	5	9	5	9	5	9	5
Cronbach's Alpha	0.869	0.867	0.915	0.897	0.907	0.889	0.957	0.906

Table 6 shows that the usability of the administrative tasks related to the daily treatment has increased by 0.140 points (SD 0.590) and the tasks related to the amendment objectives increased by 0.665 points (SD 0.825). The time pressure of the daily treatment tasks has decreased by 0.204 points (SD 0.561) and the tasks related to the amendment objectives decreased by 0.615 points (SD 0.786). These differences are in line with the overall results (table 3) and also significant ($p < 0.05$).

Table 6: Paired sample t-test

	Paired Differences		t	df	Sig. (2-tailed)
	Mean	Std. Dev.			
Use - daily treatment	0.140	0.590	2.944	154	0.004
Use - amendment	0.665	0.825	9.935	151	0.000
Time - daily treatment	-0.204	0.561	-4.504	153	0.000
Time - amendment	-0.615	0.786	-9.561	148	0.000

The mindmap of the last open question (figure 4) shows that although some respondents were positive/neutral about the transition, most respondents experienced the transition as negative. Two respondents even thought about resigning because of the transition.

The reasons for being positive relate to the main goals of the new law, such as placing the patient in the center by giving him more control over his own treatment, intensifying cooperation between organizations around the patient and the possibilities to support the patient in their own environment.

The reasons for being negative are mainly related to negative experiences, such as

1. Unnecessary paperwork - patients who cannot fill in all the required paperwork because of their well-being and an increased registration pressure (also for the patient) that the psychiatrists perceive more like a control mechanism.
2. An increase in work pressure – complying with the rules within the CMHA is time-consuming and labor-intensive.
3. A lack of ICT-support – systems were/are not ready to comply with the CMHA and cause duplicate registrations.

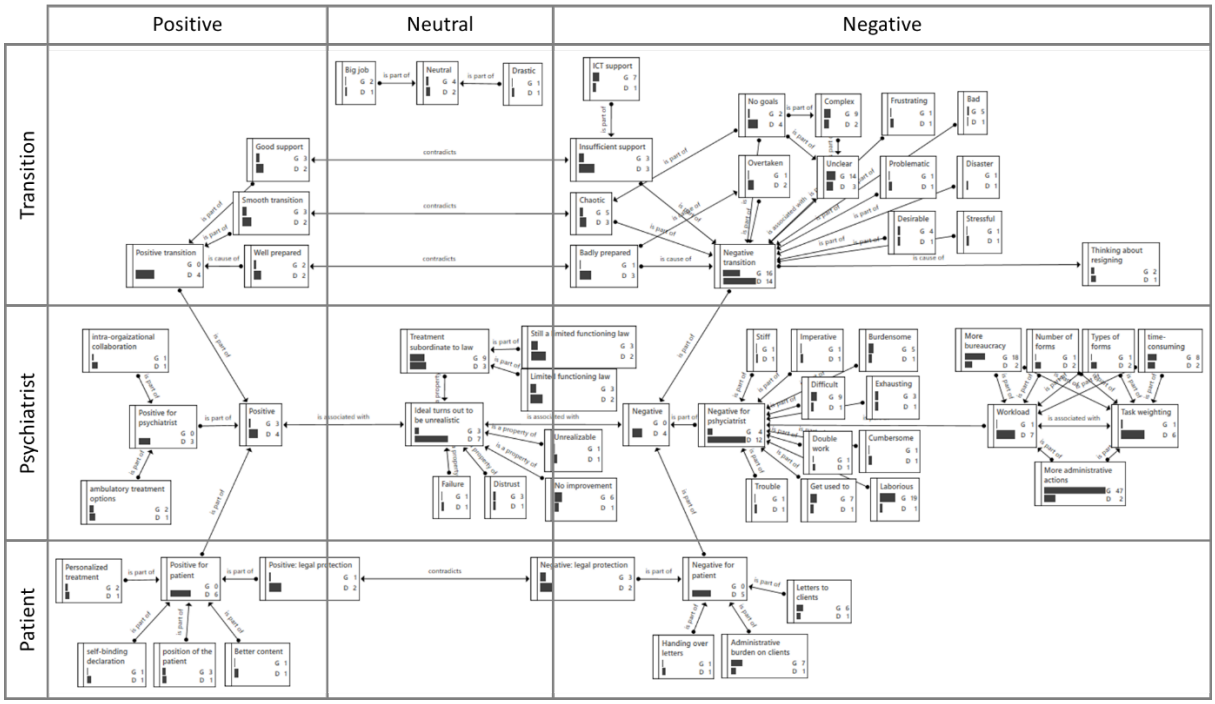

Figure 4: Experience with legislative amendment

5. Conclusion and discussion

Due to the amendment of the law from the SPAAH to the CMHA, the intake process of mental healthcare in the Netherlands had to be reorganized. Essential roles, conditions and deadlines are laid down by law. For example, the client has been given a prominent role in determining the 'desired' care. In order to comply with this, the healthcare authority must contact the client within a certain period of time to determine the treatment together (Maris et al., 2021). In many cases, however, the client is unreachable and unable to determine what care they need. In addition, they are unmotivated to be treated because they do not understand their problem. As a result, the start of treatment is expected to be delayed, the amount of paperwork will increase, as will the waiting lists, the workload and thus the (perceived) administrative burden.

The objective of this research was to investigate to what extent the perceived administrative burden of Dutch psychiatrists differs from the situation before and after the implementation of the CMHA. The psychiatrists were asked by means of a national survey what their experience was before the amendment of the law and what it is now after the amendment. The quantitative results show that the administrative burden has increased and in more detail it appears that the registrations concerning the CMHA in particular cause the greatest burden. The qualitative analysis shows that there are positive voices about the intentions of the law, but that these are undermined by negative experiences with the legislation, such as an increased workload in terms of time, reduced usability of the law and associated rules and poorer ICT support.

These results show that none of the participating institutions has succeeded in adopting the legislation and thereby reducing the administrative burden. We therefore conclude that a legislative amendment has direct consequences for the administrative burden within an organization.

As mentioned in the introduction, the subject of reducing administrative burdens has already been researched, but these studies were mainly aimed at reducing the costs of administrations, e.g. on time, and at the level of healthcare institutions (Nielsen et al., 2017; Larjow, 2018). This study focuses on the administrative burden experienced by individuals. The insights gained are relevant for the way in which (national) government and healthcare management at a strategic level should also pay attention to this 'softer side' of the burden.

This study indicates that the government can limit the burden by taking much more into account the possible consequences on the administrative burden, especially the perceived burden by the individual, when formulating new laws and regulations or reformulating them.

This study is the apotheosis in a series of four pilots in order to understand the complex Dutch psychiatric system. The psychiatric system has been studied in detail and its complexity made visible to the community in collaboration with students who generally had no experience in the sector. The study was conducted under the supervision of a medical director-psychiatrist and two senior researchers (authors) and funded by the various organizations they work for. The main results are based on a questionnaire that has been thoroughly developed from the literature, reviewed by a committee of three medical director psychiatrists and reviewed by a group of psychiatrists. A Likert scale gave the psychiatrists the opportunity to answer the questions nuanced. Also the pathway of the law from start to end was drawn up.

The final results and insights are described by the participants as breathtaking. For example, the mind map gave a clear picture of the different things that color the system. This visual insight made the complex world a lot clearer, such as the similarities between the administrative burden that each individual psychiatrist experiences and the reasons for this.

The system has been under heavy pressure for years and this pressure has only increased due to the transition. The psychiatrists and other healthcare professionals indicate that they are not being heard by politicians. It took more than a decade to conceive the CMHA and replace the SAAPH. The most important aim of the psychiatrists was to enhance the quality of life of the patients and to enhance the centeredness of their well-being. The politicians changed over time the aim of the law and wanted psychiatry to take care of the more aggressive human being. Several other laws further complicated the situation. Even a cry for help and a halt to the implementation of the CMHA was not heeded by the politicians. This has greatly diminished confidence in politicians.

That is why psychiatrists need to regain trust and not mistrust the current society and need to go away from paranoia. They are aware of the internet and social media framing in the wrong way and need to urn that in the opposite way. Politicians, on the other hand, should not make fundamental changes in a complex professional environment and burden the professionals in a way the mental health environment will be disrupted totally and ensures that the entire mental health system implodes with all its consequences for patients and professionals. When damage is done and professionals and patients are exhausted, the politicians must take responsibility for their actions.

6. Limitations and next steps

This study is the fourth exercise to understand the real impact of a legislative amendment on the administrative burden among healthcare professionals, especially psychiatrists. The collaboration among psychiatrists and researchers has been improved during this research period and is now within the system. The aim was to provide insight into the difficulties psychiatry faces nowadays and to convey their concerns to the responsible parties.

As mentioned before, the advantage of this law should be that the patient is at the center of the universe. The question remains, however, whether this goal has been achieved. This investigation and the questionnaires were addressed to the psychiatrists, the profession responsible for those most complex and vulnerable people in society. No other profession was asked and no patients were consulted about their views on the transition from SPAAH to CHMA and whether they thought it would improve their quality of personal life.

Approximately 3,500 psychiatrists work in the Netherlands and 1,500 psychiatrists in private practices. This research did not reach out to private practitioners. Also residents in psychiatry are not taken into account.

Of the approximately 2,000 institutional psychiatrists, 305 started filling out the questionnaire, 147 did not finalized the fill-out. There may be a bias by those that are confronted with the new law daily. Those who have not filled out the questionnaire or have had already too much administration.

Psychiatrists are scarce and it is unwise to burden them too much with a law harness. If this harness gets too tight, more psychiatrists will leave the job, harming mental healthcare in general and decreases the quality of care for patients. That cannot be the intent of the law and therefore a review of the law is a necessity.

For the future, we therefore recommend that a committee of politicians and psychiatrists work closely together to review current laws and to prepare new ones as much as possible so as not to chase away more psychiatrists,

but to improve the quality of life of patients. This committee must ensure that systemic problems in psychiatry are solved, so that all psychiatry will work for the most vulnerable in society. Achieve less administrative burden and greater life satisfaction for the benefit of the patient.

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Appendix A

Paired Samples Test (Usability)								
	Paired Differences					t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Pair 1	0.105	0.776	0.065	-0.023	0.233	1.617	142	0.108
Pair 2	0.055	0.743	0.071	-0.086	0.196	0.773	108	0.441
Pair 3	0.692	0.986	0.097	0.501	0.884	7.160	103	0.000
Pair 4	0.174	0.780	0.075	0.026	0.322	2.334	108	0.021
Pair 5	0.328	0.962	0.126	0.075	0.581	2.593	57	0.012
Pair 6	0.134	0.818	0.069	-0.002	0.270	1.948	141	0.053
Pair 7	0.118	1.018	0.101	-0.082	0.318	1.168	101	0.246
Pair 8	0.200	0.973	0.109	-0.017	0.417	1.838	79	0.070
Pair 9	0.843	1.231	0.109	0.626	1.059	7.715	126	0.000
Pair 10	0.629	1.197	0.100	0.432	0.827	6.289	142	0.000
Pair 11	0.548	1.102	0.103	0.344	0.751	5.330	114	0.000
Pair 12	0.575	1.058	0.091	0.394	0.755	6.290	133	0.000
Pair 13	0.338	0.979	0.080	0.180	0.495	4.239	150	0.000
Pair 14	0.099	1.191	0.113	-0.125	0.323	0.877	110	0.382

Paired Samples Test (Time)								
	Paired Differences					t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Pair 1	-0.130	0.818	0.070	-0.268	0.007	-1.873	137	0.063
Pair 2	-0.071	0.803	0.081	-0.232	0.090	-0.881	97	0.381
Pair 3	-0.620	0.919	0.092	-0.802	-0.438	-6.749	99	0.000
Pair 4	-0.222	0.708	0.071	-0.363	-0.081	-3.123	98	0.002
Pair 5	-0.462	0.917	0.127	-0.717	-0.206	-3.628	51	0.001
Pair 6	-0.217	0.712	0.061	-0.337	-0.098	-3.586	137	0.000
Pair 7	-0.120	0.715	0.071	-0.262	0.022	-1.679	99	0.096
Pair 8	-0.239	0.746	0.089	-0.416	-0.063	-2.705	70	0.009
Pair 9	-0.689	0.954	0.086	-0.860	-0.517	-7.970	121	0.000
Pair 10	-0.691	1.145	0.098	-0.885	-0.497	-7.039	135	0.000
Pair 11	-0.543	1.047	0.102	-0.746	-0.340	-5.312	104	0.000
Pair 12	-0.680	1.049	0.093	-0.863	-0.496	-7.328	127	0.000
Pair 13	-0.250	0.724	0.060	-0.369	-0.131	-4.142	143	0.000
Pair 14	-0.373	1.052	0.097	-0.565	-0.181	-3.849	117	0.000