

## Special Issue

# Transformation by stealth: the retargeting of home care services in Finland

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### What is known about this topic

- The Nordic welfare model is focused more on formal than on informal care.
- Coverage rates of home care services are high in the Nordic countries.
- Nordic home care services are traditionally in-house local authority provisions.

### What this paper adds

- Home care has recently undergone a radical transformation in Finland.
- This transformation has brought lower coverage rates, higher intensity, integration of health and social care, emerging privatisation and increasing reliance on informal carers.
- The implications of these changes for users and carers are twofold: those with highest needs receive increased amounts of support while others have become excluded from public home care provisions.

### Introduction

During the last two decades, home-based care services for older people have undergone a radical change in Finland, following a rather surprising path. During the 1990s and early 2000s, many other European countries expanded their home care service provisions; however, in Finland, the coverage rate of home-based social care services dropped radically during the same period. This

### Abstract

This paper analyses the trends and changes that home care services for older people have undergone during the last two decades in Finland. The data used come from national social care statistics, covering the time period from 1990–2010. The results show that, in contrast to many other European nations that have expanded their home care provisions, the coverage levels in Finland have dropped dramatically during this period. Those with the highest needs do receive increased amounts of support, but others have become excluded from publicly funded home care provisions and often need to rely on family members. In most localities, public service provision is focused on personal care, and no longer covers household tasks. This major change of the character of the service is connected to three other recent trends that structure current provisions: the amalgamation of home-based social and healthcare services, the marketisation and emerging privatisation of care and the integration of informal family care into the formal care system. Overall, the changes represent weakening defamilisation, that is, decreasing public responsibility for the needs of many older people and, correspondingly, an increasing reliance on family carers. This full-scale transformation of home care has taken place without any real policy debate or major modification of legislation. No actual decision was ever made to thoroughly alter the character of home care in Finland: the transformation happened by stealth.

**Keywords:** Finland, home care, informal care, Nordic welfare model, privatisation, targeting

change has taken place even though official national care policy continuously places an emphasis on home-based services. Moreover, it is not just the coverage rate but also the whole concept of home care that has undergone a profound change in Finland. Home-based care has become more medicalised and integrated with home nursing. As well, the provision of service of an intensity that was previously only available within institutional care has been initiated. What is striking is that such a

full-scale transformation of an essential welfare service has taken place without any real policy debate. The legislation governing the service has remained the same from 1982–2011. No one ever made the decision to thoroughly alter the character of home care in Finland; the transformation has thus happened ‘by stealth’.

The aim of this paper is to describe and analyse the transformation of home-based care in Finland. How and when did the transformation of Finnish home care services take place? How could such a dramatic shift be possible without any major alterations in health and social care legislation? At the same time as the intensification of home care, at least three parallel processes occurred: privatisation of care service provisions emerged, home-based health and social care services were to a large degree amalgamated and informal family care became integrated into the formal care system. How have these changes structured the metamorphosis of home care in Finland? Finally, what have the implications of this transformation been for users, informal carers and home care workers?

### Transformation of home help into ‘regular home care’

As a Nordic welfare state, Finland developed its home care comparatively early. By the turn of the 1990s, local authority home-help services covered approximately 19% of the 65+ population and 31% of the 75+ population (Table 1), which was at that time internationally exceptional. According to some other statistical sources, the coverage rate was even higher by 1990, namely 21% of the 65+ age group (NOSOSCO 1995). These services were public provisions, organised and provided by local authorities and funded from local taxation and central grants as well as modest income-related user fees (unlike in Denmark or Norway, home care has never been free of charge in Finland). The services were broadly accessible and flexible as the users had a large degree of auton-

omy in determining the tasks that home care workers performed at their homes (Szebehely 2003).

However, things were soon to change. In 1991, Finland was hit by a major economic recession that led to severe cuts in public expenditure, and also in central grants for municipal health and social care. Furthermore, right in the middle of the recession in 1993, another major change took place: a radical decentralisation that made local authorities significantly more independent from central government. In practice, the reform delegated financial and overall responsibility for health and social care from the national to the local level (Kröger 2011).

By 1995, when the recession started coming to an end, it could be seen that a substantial transformation had occurred in Finnish home care. In only 5 years, the coverage rate had been almost halved (Table 1). The number of older people receiving home help had been radically cut, and what was surprising was that such a development had hit exactly the service that had for a long time been marketed as the bedrock of care policy and as the foundation of community care (Vaarama & Lehto 1996). It was the age group 65–74 that was most seriously affected but also many people between 75 and 84 became excluded from the service. Only in the oldest 85+ age group did the number of service users continue on an upward trend, but even there the provisions did not keep up with the pace of population ageing, causing a decline in the coverage rate.

The end of the recession did not result in a return to a coverage rate close to 20% of the 65+ population – nor to a level of central grants enjoyed by local authorities at the turn of the 1990s. On the contrary, the policy line that had been adopted during the early 1990s continued in the late 1990s and early 2000s. Overall, the coverage rate of home help for older people decreased by as much as 40% between 1990 and 2010. This is in sharp contrast to the developments in many other countries, which, during the same period, continued to expand their home-based service provisions (see Huber *et al.* 2009).

**Table 1** Users of home-help services in Finland 1990–2010, % of 65+ age groups

	65–74 (% of age group)	75–84 (% of age group)	85+ (% of age group)	75+ (% of age group)	65+ (% of age group)
1990	9.3	29.0	42.3	31.4	18.6
1995	4.6	18.2	35.7	22.1	11.8
2000	3.6	15.2	34.8	19.7	10.7
2005	3.1	13.6	34.4	18.3	10.2
2010	3.2	14.4	37.3	20.4	11.2
Change (% of age group)	–65.6	–50.3	–11.8	–35.0	–39.8
Change (% of number of households)	–55.4	–31.1	+93.8	+0.2	–16.2

Source: THL 2011 (SOTKANet Statistics and Indicator Bank <http://www.sotkanet.fi>).

Alongside the drop in coverage rates, a major change took place concerning the intensity of home-based provisions. In 1995, a new concept was introduced in Finnish welfare statistics: 'regular home care'. This was a brand new category that came to include users who receive home care 'as part of a valid care and service plan', that is, who are defined as permanent service users by the system, or who otherwise receive home care visits at least once a week (THL 2010, p. 12). The compilation of statistics reflects the interests of policy-makers and, whereas earlier the interest had covered all users without any discrimination, now attention is focused primarily on heavy users of home care. Since 1995, particular counts on 'regular home care users' were performed every other year and, from 2007, every year. The increased attention clearly shows the growing importance of this 'regular home care' in home care policy in Finland. Now, it is most often only 'regular home care' that is reported when indicators on home care services are presented in official documents. User fees for 'regular home care' are based on the number of visits and monthly income. For example, an older person living alone and receiving a pension of 1500 euro per month would pay 343 euro for her/his 40+ monthly home care visits in 2011 (JKL 2011).

Results from these counts show a very linear development: from count to count, there have been smaller and smaller proportions of users who receive <20 home care visits per month (Table 2). The median number of monthly visits has risen rapidly, having almost doubled since 1995. The share of those 'regular home care users' who receive more than 40 monthly care visits, that is, at least 10 visits per week, has more than doubled (see also Vaarama *et al.* 2004, p. 47). These users receive a very intensive service, and the latest report states that as many as 9% actually receive at least 90 visits per month, that is, three or more home care visits per day (THL 2010, appendix table 2). However, these visits can be extremely short. According to a recent study, the total work time of home care workers per client actually decreased

by half an hour on average from 2007–2009 (Heinola *et al.* 2010, p. 38).

Increasingly, home care in Finland is only serving the very oldest and frailest. Since the mid-1990s, the main focus in home care policy has been on those users who are using an intensive service, not just receiving home services occasionally (Vaarama 2009, Heinola *et al.* 2010). The other side of the coin is that younger groups of senior citizens and those whose care needs are not yet very extensive have less and less access to home care services. Home care has become primarily a method to limit the demand for institutional care. In practice, the overall coverage of residential care has nevertheless remained very stable since the early 1990s, so the retargeted home care has managed to prevent further expansion of institutional provision, but not to reduce it. At the same time, the costs of home care services have nevertheless increased as providing intensive home care does require considerable resources (Vaarama *et al.* 2002, Heinola *et al.* 2010).

### Amalgamation of home help and home nursing

Alongside the reallocation of resources to the oldest old with the highest needs, another important change in home-based care services in Finland has been the integration of home help and home nursing. Home nursing (*kotisairaanhoido*), referring to nursing services that are provided by healthcare authorities in the homes of people with diagnosed illnesses, was earlier administratively and professionally separate from home help provided by social welfare authorities. Home help (*kotipalvelu*) was offered by semi-professionals called home helpers with a couple of years of occupational education or by less well-trained home-help assistants. On the other hand, home nursing was performed by trained nurses or assistant nurses and included tasks like wound care, administration of medicines and giving injections (Kröger *et al.* 2009).

As a response to widespread criticism about the separateness of home-help services and home nursing, and as a method to increase cost-effectiveness, several local authorities have integrated these two services, creating a new service form under the title of 'home care' (*kotihoito*) (Henriksson & Wrede 2008). This development has in many municipalities been connected to administrative reforms that have integrated local health and social care administrations. There was criticism that home help and home nursing did not genuinely co-operate, which left their operations fragmented and forced users to mediate between the two systems (see Salonen & Haverinen 2004). The new integrated model promised to remove this fragmentation and provide a coherent service, offered by the same care worker.

**Table 2** Users of regular home care in Finland 1995–2009, visits per month, % and median

	1–8	9–16	17–20	21–40	41+	Total	Median
1995	49.7	18.1	4.1	15.6	12.5	100	8
1999	43.8	17.2	3.9	14.4	20.7	100	10
2005	43.8	13.0	2.9	15.2	25.1	100	11
2009	40.8	11.2	2.4	17.3	28.2	100	14
Change (%)	-17.9	-38.1	-41.5	+10.9	+125.6		

Sources: Vaarama *et al.* (2000, p. 84), Vaarama *et al.* (2004, p. 47), STAKES (2000, 2006), THL (2010).

A corresponding change occurred within occupational training for care workers. In 1993, training programmes for home helps and assistant nurses were merged, creating a new 3-year (for secondary school graduates: 2-year) programme and a new occupational role of 'practical nurse' (*lähihoitaja*), who was expected to function as the basic care worker in the newly integrated health and social care system (Vuorensyrjä 2006). Within residential care, the anticipated integration never occurred, but in home-based care, it did in large parts of the country and 'practical nurses' were soon to become its largest occupational group (Kröger *et al.* 2009).

### Towards marketisation and personalisation of care

Publicly provided home-based service tasks have also undergone a change. Originally, in the late 1960s, these services were primarily focused on household tasks (called *kodinhoitoapu*, that is, help in home-making), but gradually personal care became the most central task and, during the 1990s, a large number of Finnish local authorities stopped offering household services like cleaning. A distinctive shift within home care from taking care of the home to taking care of the body has been identified in several studies (e.g. Andersson *et al.* 2004, Voutilainen *et al.* 2007a).

On the other hand, there are also a growing number of for-profit private home-help services that people may purchase directly. Cleaning services in particular are increasingly purchased by older people from for-profit providers. Since 2001, direct purchase has been supported by a new 'tax deduction for household work' (*kotitalousvähennys*). Currently, it is possible to receive a tax deduction of up to 3000 euro per year per person to cover 60% of the costs of using home care services from a registered for-profit provider. In addition to the taxpayer's own home, services provided at the homes of parents, and grandparents are also supported by tax credit. Service fees for ordinary municipal home care are income-related, which means that those with higher incomes pay a higher fee for their services. As a consequence, being supported by tax credit, private alternatives may be less expensive than public care services for wealthier people. There are thus underlying pressures for an increasing erosion of the principle of Nordic universalism, according to which people of all income levels should be served by one and the same service system (Kröger 2003).

Finland does not yet offer direct payments or personal budgets although some proposals for their introduction have been made. Personalisation of care provisions has advanced via another route. Encouraged by the *Act of Service Vouchers* that came into force in 2004, several municipi-

palities have started to offer vouchers to home care users and informal carers. These vouchers can usually be used to purchase a service from a for-profit home care provider that the user can select from a list of providers approved by the municipality. Users need to pay part of the total fee, which can be high as the value of vouchers is often rather low. Vouchers were introduced to promote choice for users and carers, but they are also a method of encouraging the emergence of care markets and, thus, privatisation of home care (Timonen *et al.* 2006). Local authorities are free to decide whether they wish to use vouchers, and, furthermore, entitlements for users and carers depend fully on the local policy. However, their implementation has been slower than anticipated, and effects on the growth of care markets have remained very limited. In a survey carried out among 91 local authorities in 2007, it was found that 31 municipalities had used vouchers for temporary home care, 25 for daily home-based services and 16 for 24-h provision. The total number of users remained at 1300 (Volk & Laukkanen 2007).

Furthermore, a growing number of Finnish municipalities have outsourced at least a part of their own service provisions (especially the so-called auxiliary services, i.e. meals on wheels, transportation, safety alarms) so that publicly funded home-based services are in practice provided more and more often by non-profit or for-profit providers. In some municipalities, some specific forms of services, for example, home-based respite care, are provided entirely by non-profit organisations. On the other hand, for-profit provision, which was until the mid-1990s practically non-existent within home care in Finland, has been growing very rapidly. In 2004, a quarter of home care recipients received their home care services from for-profit providers, which surpassed the number of non-profit service users (Kähkönen & Volk 2008). According to the *Delivery Act*, municipalities are expected to put all purchases that surpass 100 000 euro up for competitive tendering, and this also applies to home care. However, the variety of both non-profit and for-profit services is more extensive in larger municipalities, whereas in many rural municipalities, in-house provision is still the only source of home care (Kröger 2009).

### Integration of informal care into home care

There is one more major change in the Finnish care system that is clearly connected to the transformation of home care. Informal family carers have become closely integrated within the formal care system, and this development has occurred simultaneously with the transition into 'integrated regular home care'. There has been a statutory home care allowance scheme for older people in Finland since the early 1980s, being originally included in the *Social Welfare Act* of 1982 (Sipilä 1994).

However, for a decade, it remained small-scale. Since the early 1990s, the difficulties of family carers have nevertheless become much more widely highlighted in public discussion and, at the same time, the support system for carers has become extended and established more firmly. In 1993, the carers' support scheme received a piece of legislation of its own, reflecting the firmer institutionalisation of the programme as an essential part of care policies for older people. The act was further reformed in 2005 and is now titled the *Act on Support for Informal Care*. In fact, the concept of a carer (*omaishoitaja*, 'kin carer' or 'kin nurse') did not exist earlier in the Finnish language; it was created only by the 1993 act. Consequently, the term has in Finland come to mean primarily those family carers who are receiving formal support (see e.g. Vaarama *et al.* 2006).

Recent surveys have shown that family members are the most usual and, more and more often, the only source of help for older people; they have also shown that a substantial number of adult children regularly provide help with domestic tasks, transportation and errands for their parents (Vaarama 2009, Vaarama & Moisio 2009). Even among older people who receive home care services, the amount of informal care received is on average twice the amount of care (time) received from formal sources (Heinola *et al.* 2010, p. 38). Only a small proportion (10–15%, according to estimates) of carers receive formal support as its coverage depends on the policies and economic conditions of the municipalities (Kröger 2009). On the other hand, there are also many care-giving family members who do not wish to apply for the support and become formally labelled as carers (Mikkola 2009).

It is the task of the municipal home care service to decide upon the formal support offered to informal carers. The Informal Care Support Act and national guidelines define the sums to be paid to carers as well as respite care and other services that should be on offer. In 2011, the national minimum amount of home care allowance before taxation is 353 euro per month. Since 2007, supported carers have also had a right to 3 days off from

caring per month. However, the implementation of these targets has been left to the discretion of local authorities and, as a result, large variations between individual municipalities do exist (Voutilainen *et al.* 2007b, Kröger 2009). For example, respite care is mainly offered only within residential settings, which is unacceptable for many older people and their carers (Voutilainen *et al.* 2007a, Mikkola 2009).

Nonetheless, support for carers has been one of the very few forms of social support that has expanded recently: in absolute terms, the number of carers of older people who received an informal care allowance increased by 87% between 1990 and 2010 (Table 3). In relative age group terms, the share of those 65+ backed by informal care support (received by their carers) has grown 30%. There is also an increase of this provision within the 65–74 and 75–84 age groups (see also Heinola *et al.* 2010).

Overall, formal support for carers of older people has in Finland become significantly broadened at the same time as formal care services have become very strictly targeted. One part of the transformation of the home care system in Finland has been a growing reliance on informal family care. Many more older people only receive care nowadays from their families, whereas the model of 'shared care', where both the state and the family provide help for the same people and which has been understood as a particular characteristic of the Nordic care regime, has become less common (see Kröger 2005). At the same time, support for carers has been on the increase, but it needs to be remembered that this support still covers only a small minority of all carers. Using Saraceno's (2010) concepts, it could be claimed that 'familialism by default' has become the prevailing model in Finland concerning those older people who do not yet need intensive help; for those with high needs, 'supported familialism' is emphasised. In other words, defamilialisation, the earlier hallmark of the Nordic care model (see, Rauch 2007), nowadays covers only the oldest old with the highest needs in Finland.

**Table 3** Older people whose carers received informal care allowance in Finland 1990–2010, % of 65+ age groups

	65–74 (% of age group)	75–84 (% of age group)	85+ (% of age group)	75+ (% of age group)	65+ (% of age group)
1990	1.0	2.5	6.6	3.3	2.0
1995	0.8	2.0	5.0	2.7	1.5
2000	0.9	2.3	5.3	3.0	1.8
2005	1.2	3.0	6.0	3.7	2.4
2010	1.2	3.6	6.0	4.2	2.6
Change (% of age group)	+20.0	+44.0	–9.1	+27.2	+30.0
Change (% of number of households)	+62.2	+97.0	+97.5	+97.2	+86.9

Source: THL 2011 (SOTKANet Statistics and Indicator Bank <http://www.sotkanet.fi>).

### Outcomes for older people, their families and home care workers

As an outcome of the stricter targeting of home care in Finland, older people have in recent nationwide surveys been reported to experience shortages in municipal care service provisions, and these shortages have grown wider during the 2000s. According to a survey undertaken in 2006, a third of people aged 70–74 stated that they did not receive enough help and support. Furthermore, in 2009, almost 50% of those who did receive home care services stated that the help that they received was not adequate, especially concerning household tasks. The number of unsatisfied users doubled from 2004–2009 (Vaarama *et al.* 2006, 2010, Voutilainen *et al.* 2007a, Vaarama 2009).

It is true that the intensification of home care has made it possible for many older people to avoid moving into an institution, even at a stage when their care needs are already high. It has even been claimed that the intensification of municipal services increases equality among older people by cutting support from those who do not have intensive care needs and from those who have enough resources to purchase services for themselves releasing resources for those who are the most vulnerable (National Audit Office, 2010). However, older people whose needs are not met by municipal services, and particularly those older people who do not have informal resources or financial means to pay for services, end up in a difficult situation. For example, many of them stay indoors at home alone without the possibility of going out and meeting other people (see Tedre 2006, Heinola *et al.* 2010). Practices that enhance participation in social life and bring everyday joy have become marginalised within the home care system; such as preventive social care practices considered essential to break the emotional and social isolation of older people.

Furthermore, information has emerged from some local authorities that public home care services are offered primarily to less well-off people, while those with good economic resources are advised to purchase private home care themselves (see also Vaarama 2009); a policy of ‘creeping selectivisation’, which sharply contrasts with the principle of universalism that is often seen as the cornerstone of the Nordic welfare model. There has been plenty of media coverage concerning problems in access and quality of publicly organised home care services. General trust in public home help has consequently decreased in Finland (Muuri 2010). As a consequence of these problems, we can see growing inequalities between low-income older people who need to depend on their families and high-income older people who are purchasing more and more private home care services from the market.

Family members of older people face continuous concern over the well-being of their kin. In particular, as more and more adult children are forced to take responsibility over the daily or weekly care of their parents, because of the extension of ‘familialism by default’, this may affect their ability to participate in paid work, and it also limits the time available for their hobbies, friends, partner and own children, which will at least in the long run have negative effects on their well-being (Leinonen 2011). From the point of view of family carers, the extension of ‘supported familialism’ is a mostly positive development. More carers than before now receive formal support in Finland. However, the support system for carers is far from complete. The coverage of the allowance is very limited, the amount of the benefit is low and many carers have found it difficult to organise appropriate respite care during their statutory free days (Salanko-Vuorela *et al.* 2006).

There are some studies on integrated home care that show that the earlier fragmentation between home-based health and social care services has become reduced as it is now most often the same personnel that perform both the home-help and the home nursing tasks (e.g. Andersson *et al.* 2004). On the other hand, professional groups from both health and social care have been critical of the reform (Wrede & Henriksson 2004). Healthcare professionals comment that the current staff (who are for the most part no longer trained nurses) do not have adequate medical expertise to perform home nursing tasks. For their part, social care professionals argue that the integrated home care resembles rather closely earlier home nursing and is focused on medical treatments. According to this criticism, an approach that aims more broadly to promote the quality of life of older people has become marginalised within the new integrated home care (see e.g. Wrede & Henriksson 2004, Henriksson & Wrede 2008).

Intensification of home care has clearly changed the work of care workers. Visits have become more numerous but also shorter. Care work at home is nowadays perceived as hectic, and many workers feel that they are no longer able to fulfil users’ needs and wishes. Consequently, many home care workers do not feel happy in their work and are dissatisfied with their work conditions. This anxiety of home care workers is indicated in reports produced by trade unions (e.g. SUPER 2010) and in academic research (e.g. Kröger *et al.* 2009). For example, according to the NORDCARE study, a quarter (24.9%) of Finnish home care workers think that they ‘usually have too much to do’ and almost as many (21.9%) say that they are ‘unable to respond to the needs of the users’. In addition, over a fifth (21.6%) have ‘seriously considered leaving their job’ (Kröger *et al.* 2009). When home care workers were asked to report their

hopes for change, many wished for 'more helping hands' and 'more individualised care', as well as for 'work without time pressure' and 'the ability to focus not only on basic needs' (Leinonen 2009).

## Conclusions

The transformation from a service that covered a large part of the older population and a large range of tasks to a service that focuses strictly on the oldest old and the frailest frail and only on personal care dates from the early 1990s. As a result, home care in Finland has become significantly more selective and targeted. Large proportions of people under 85 have become excluded from the service. A brand new concept of 'regular home care' was launched to reflect this new orientation of home care services in Finland. Intensified home care has become a method of keeping institutional provisions as low as possible as its services are now focused on the traditional user group of residential care, namely those older people who need substantial amounts of daily care.

It is not only the coverage levels and the targeting of services that have undergone profound changes during the last two decades in Finland. The whole concept of home-based care has gone through a radical transformation, changing from separate systems (home help from social welfare and home nursing from health-care) to an integrated service provided by a brand new occupation. This process of integration has not been easy; however, integrated home care has become the main approach, especially in the larger cities. Furthermore, home care has moved away from a focus on household tasks to a concentration on personal bodily care. At the same time, local authorities are also outsourcing more and more of their care service provisions to for-profit providers, and direct purchase of for-profit services is increasingly supported by tax deductions and vouchers.

Despite this thorough transformation, the basic legislative framework regulating home care has remained almost completely unchanged since the early 1980s. The integration of home help and home nursing did require small additions to both the Social Welfare Act and the Primary Health Care Act, but no major revisions of either law have been made. There has been no real policy debate concerning the retargeting of home care services, and none of the governments that have been in power since the early 1990s has made a distinctive decision to radically reform the nature of home care in Finland. This means that the changes have not been driven by national policy-making but more by reactions of local authorities to recent and anticipated pressures from service demands and expenditures. As there are no national eligibility thresholds, access to care services depends on

local discretion. Overall, this transformation is a testimony to the vital role of local autonomy within the Finnish care system (see Kröger 2011).

There is one major exception to the lack of national policy-making: the expansion of support for family carers has been widely addressed among the public and also written into a new piece of special legislation. Overall, the emphasis given to both 'familialism by default' and 'supported familialism' has been one characteristic of the transformation of care policy in Finland (see Saraceno 2010). This development is based on the retargeting of care: those frail individuals who receive home care services today receive a lot of personal care, and those whose needs pertain to household help have to depend on informal care and private purchase of services. This represents a major shift of responsibility towards families and away from the welfare state. In addition, the ongoing marketisation and emerging personalisation of care can be seen as a route to promote a kind of familialism: when users and their families are offered service vouchers and tax deductions, they need to take on more responsibility as customers within the care market. This usually also brings a growing financial responsibility: users and carers easily end up paying a larger proportion of the total costs of home care than they did before.

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