

Uncovering misalignments in the health- and elderly care system

Navigating
system change
in an aging
society

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Abstract

Purpose – The increasing size of the elderly population is emerging as a primary catalyst for the escalation of healthcare expenditure, and a sense of urgency is manifest. However, the complexity of the health- and elderly care systems provides challenges in improving system efficiency. Hence, the system-level understanding of the main obstacles to integration care needs further exploration. In order to better integrate health- and elderly care, the study needs to identify the actual misalignments underpinning the issue. This study provides the theoretical foundations for resource misalignments and provides empirical examples of these.

Design/methodology/approach – Semi-structured interviews with multiple stakeholders on various hierarchical levels were carried out to create a more complete view of the system and resources deployed in health- and elderly care. The application of user-centered design methods and co-creation with employees have also been crucial to the outcomes of the study.

Findings – Results show that health- and elderly care is a large-scale complex system. The overlapping and mutually reinforcing misalignments are: (1) regulation and policy differences, (2) stakeholder quantity and variation, (3) external control of health- and elderly care, (3) decreasing collaboration and (4) communication channels and IT development.

Originality/value – This qualitative study builds on institutional theory and resource integration theory and contributes with empirical descriptions of misalignments in the health- and elderly care system. These descriptions will serve as points of departure for systems design to improve the efficiency and effectiveness of health- and elderly care.

Keywords Institutional theory, Complexity, Systems design, Health- and elderly care, Misalignments, Resource integration theory

Paper type Research paper

Received 3 July 2023
Revised 15 September 2023
Accepted 15 September 2023

Introduction

The increasing proportion of the elderly population is emerging as a primary catalyst for the escalation of healthcare expenditure in OECD countries (Mayhew, 2000). Global initiatives are taken to meet the situations. In 2020, the United Nations general assembly adopted a resolution called Decade of Healthy Aging (2021–2030), (UN, 2002). Global collaboration involving governments, civil society, international organizations professional and academia are also initiated to improve the lives of older people, their families and the communities in which they live (UN, 2002). One key aspect to improve healthcare system performance is through integration, and previous research has increased our knowledge of the potential of integration. For instance, previous research has indicated that inter-professional teams consisting of both healthcare and social care personnel have the potential to improve the quality of life among elderly and an early identification of medical problems (Kodner, 2002). However, the complexity of the health- and elderly care systems provides challenges for coordinated care services

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This work has been performed with support from Vinnova – Swedish Governmental Agency for Innovation Systems - under grant number 2019-03029.



Journal of Integrated Care
Vol. 31 No. 5, 2023
pp. 117-128
Emerald Publishing Limited
1476-9018
DOI 10.1108/JICA-07-2023-0042

(Drennan *et al.*, 2005), suggesting that the system-level understanding of the main obstacles to integration care needs further exploration. Specifically, the underlying issue of misalignments in resource use in health- and elderly care has received scant empirical and theoretical attention. In order to integrate health- and elderly care, we need to identify the actual misalignments underpinning the issue. Hence, the purpose of this study is to present findings regarding misalignments that obstruct the integration of health- and elderly care in Sweden. Further, this research also has the secondary purpose to provide the theoretical underpinnings of these misalignments and to provide empirical examples from the health- and elderly care system. These theoretical foundations are laid out further.

A system focus has gained increased importance for practicing designers. The focus rests on the understanding that expanding the system boundaries is beneficial to enable improvements in the value creation of the service eco-system in question. There is a growing need to identify emerging change patterns, contexts, how actors are interrelated and institutional mechanisms (Field *et al.*, 2021).

Practicing designers are starting to apply methods and tools from the system thinking field (Jones, 2014), and have identified a need to integrate design methods and processes with system thinking to manage complex system challenges. A term that is used to describe the integration of design thinking and system thinking is systemic design (Ryan, 2014). The need to adopt a systemic perspective has also resulted in an increasing interest in theories such as institutional theory (Koskela-Huotari *et al.*, 2020), structuration and practice theory (Edvardsson *et al.*, 2013) and mental models (Vink *et al.*, 2018). These are not necessarily viewed in separation and can be integrated into broader perspectives. The theories emphasize the interdependencies between different resources in organizations, such as physical, human and organizational resources. This perspective is particularly relevant to design, as service systems often involve multiple actors and resources that must be integrated effectively to create value.

Institutional theory explains how organizations and social structures are shaped by broader institutional pressures and norms (DiMaggio and Powell, 1983). Accordingly, organizations conform to these external pressures and gain legitimacy and increased sustainability in their environment. These pressures can come from a variety of sources, such as laws and regulations, cultural values, norms and beliefs. Institutions could be formal such as laws or policies, or informal in unwritten rules and social norms, where the parts are interconnected and codependent on each other in institutional arrangements (Vink *et al.*, 2021; Vargo Stephen and Lusch Robert, 2016). They are constantly reproduced by actors in the system, often without the actors being aware of it, for example, by routinized behavior.

Institutional theory rests on the understanding that behavior and mental models are to a large extent inert and resistant to change (DiMaggio and Powell, 1983; Edvardsson *et al.*, 2013; Koskela-Huotari *et al.*, 2020). Characteristically, the ability to change norms and institutionalized behavior is beyond the agency of one actor, that is, individual or organization. Institutional pressures can also limit the ability of organizations to innovate and adapt to changing circumstances, which can be a challenge in dynamic and complex environments (Dimaggio, 1988). Hence, to change institutionalized behavior requires considerable reflection and efforts involving a multitude of actors.

Resource integration theory explains how organizations combine and coordinate resources to achieve their goals (Edvardsson *et al.*, 2012). It emphasizes the importance of understanding the interdependencies between different resources, including physical, human and organizational resources, and how they are combined and utilized to create value. Resource integration theory suggests that effective resource integration requires alignment between the goals and objectives of the organization and the resources available, as well as coordination and communication among individuals and teams responsible for managing these resources. According to resource integration theory, the actors or subsystems need to integrate their various resources in order to contribute to the value co-creation of this system as a whole (Caridà *et al.*, 2019).

Suboptimal resource integration results in a level of misalignment in resource deployment (Banerjee, 2014). Due to the interconnectedness of the actors in the healthcare system, a change in the system necessitates the reintegration of resources (Berg *et al.*, 2018; Patrício *et al.*, 2020). The embedded actors' knowledge of existing institutional arrangements and their interrelatedness are beneficial for the value creation of the system and increase the possibility to improve it. Furthermore, an actor does have less agency outside its system boundaries. These two aspects relate to extending the systemic conceptualization of service design and conducting more holistic empirical investigations called for by Vink *et al.* (2021).

The delivery of efficient and effective health- and elderly care is dependent on enabling the whole system to harmoniously apply their resources. To generate knowledge of fruitful areas for system design improvement, this study will identify, describe misalignments and discuss the consequences of these misalignments in joint recourse deployment or integrated care (Goodwin, 2016). In essence, this research effort extends the understanding of integration as synonymous with collaboration and presents the theoretical foundations of integration and illuminates these with empirical data. Hence, this study uncovers the general underlying aspects – the misalignments – that underpin suboptimal care for the elderly in Sweden. Knowledge of these misalignments will create a more informed basis for subsequent improvement efforts including, but not exclusively related to, collaboration issues.

Method

To identify misalignments in elderly care, the research group conducted in-depth semi-structured interviews with 17 respondents, each lasting approximately one hour. The aim was to uncover both structural and cultural aspects, as well as specific temporal and situational contexts.

Respondents were chosen with the aim to gather insights from a multitude of actors in both private and public sectors, covering different hierarchical levels within the health- and elderly care system (see interviewees' roles and their organizational setting in Table 1). The topics addressed included the organization, the respondent's role, other stakeholders involved, their daily work, interconnections, work processes, organization, IT-systems,

	Role	Organisational setting (public/private)
1	Director of Innovation	Stockholm City Council (public)
2	Manager	Stockholm Elderly Administration (public)
3	Strategist	Stockholm Elderly Administration (public)
4	Care administrator	District of Farsta (public)
5	Manager Elderly Care	District of Farsta (public)
6	Coordinator homecare	District of Farsta (public)
7	Manager homecare	District of Farsta (public)
8	Homecare employee	District of Farsta (public)
9	Innovation strategist	Region of Stockholm (public)
10	Strategist	Region of Stockholm (public)
11	Entrepreneur	Health Care Digitalisation Start Up (private)
12	Physiotherapist Manager	Healthcare provider (private)
13	Physiotherapist	Healthcare provider (private)
14	Health Centre Manager	Healthcare provider (private)
15	Assistant nurse Home Healthcare	Healthcare provider (private)
16	Manager Home Healthcare	Healthcare provider (private)
17	Nurse Home Healthcare	Healthcare provider (private)

Source(s): Author's work

Table 1.
Interviewees' roles and
organizational setting

communication, responsibilities, objectives, laws, rules, guidelines, digitalization, incentives, as well as challenges and opportunities in delivering health- and elderly care. The interviews aimed to allow rich and detailed responses aimed to get insight into the actors' work, and perception of the health- and elderly care system.

A visual approach was employed during the interviews. This involved using a large blank sheet of paper at the beginning of each interview. Throughout the interview, prepared cutouts representing stakeholders, rules and communication systems were used to visually illustrate the discussed issues. Pen markings and text were used to connect these elements, creating a graphic representation or map of the health- and elderly care system. This contributed to identifying and making practices and mental models visible, as well as creating a better understanding of the patterns related to misalignments.

Further, user-centered design methods and the active participation of employees in co-creating activities have been applied. Project participants engaged in activities such as:

- (1) Training on user-centered service design methods,
- (2) Conducting observations and in-depth interviews within each other's organizations,
- (3) Joint analysis workshops where data from interviews and observations were discussed and thematized,
- (4) Idea-generation and prototyping workshops involving a larger group of employees, focusing on co-creating visions for a future state and identifying barriers and enablers for innovation.

Interorganizational co-creation enabled the analysis to validate and further discuss misalignments. This contributed to the credibility of the results by facilitating a joint scrutiny and interpretation of data gathered from observations and interviews.

The interviews were audio-recorded and transcribed. The analysis followed a bottom-up coding approach (Attride-Stirling, 2001), with the findings categorized into themes. The final coding was a collaborative effort by the two authors, involving both separate and joint work. To ensure code consistency, the researchers collectively reviewed all the coded material for a final coding (Knutsson and Linell, 2010). Subsequently, the participating researchers employed an activity theoretical model (Engeström *et al.*, 1999) to further analyze the empirical data, ultimately leading to the identification of misalignments in the health- and elderly care system.

Results

With institutional theory and resource integration theory as theoretical lenses, the present study identifies the actual misalignments underpinning suboptimal resource use in the health- and elderly care system. The analysis resulted in the uncovered misalignments presented in this section. These are to be regarded as overlapping and not mutually exclusive.

Regulation and policy differences

Results from the study suggest that the concept of a reasonable standard of living is not solely about basic needs but also about having the opportunity to live a meaningful life, including social interaction aspects. Decisions regarding the support provided to each person can be appealed to the Administrative Court or a higher instance.

Many guidelines issued by the municipal council are created to avoid cases going to court. Hence, vague formulations in laws such as the Social Services Act (SFS, 2001) lead to an ever-increasing number of guidelines from municipality. However, detailed guidelines also make it difficult to tailor care to individual needs.

I believe it is important to highlight examples from here [home care] of how laws and regulations affect the quality of this encounter [with the elderly person] to demonstrate that this is too detailed.
– Quote, employee working with public sector innovations management

Another legal issue mentioned was that current legislation does not account for the possibilities offered by modern technology, and the development and procurement of welfare technology are often hindered by a restrictive interpretation of laws.

But that's the challenge, that the laws and regulations we have are interpreted in different ways (. . .) we have a wide range of interpretations of the laws and regulations, including a very restrictive approach. – Quote, employee in MedTech company

Laws concerning the dissemination of personal data protect individuals. However, respondents argued that restrictions to access in different support systems can prevent certain professions from accessing important information. One example is the access to information of what drugs have been subscribed by other stakeholders. Another example are patients who had been admitted to in-patient care without home care being informed, leading to increased workload when the staff member must call various stakeholders to seek information.

Stakeholder quantity and variation

The group of elderly receiving care and support in their homes is not homogeneous, and there are different expectations regarding the assistance they can expect. It may be the case that relatives have many requests, or the patient themselves may have specific preferences. However, it is not always feasible or even necessary to fulfill all these requests.

It could be the patient themselves or their relatives who want certain things. But it's not always possible or even necessary. – Quote, employee in home care

At the same time, some express reluctance to burden the system or believe they cannot afford these services. The high quantity of home care providers and health centers in Stockholm also lead to an increased pressure on the individual provider to meet the demands of the user/patient that has the ability appeal. This can, according to respondents, lead to an uneven distribution of available healthcare and support services.

Respondents also argued that the sickest patients are cared for in their homes since they cannot travel to health centers. At the same time, they argued that working in the patient's home environment is perceived as low status within their profession.

External control of health- and elderly care

Follow-up of healthcare encompasses various aspects such as financial monitoring, use of NFC tags, oversight by authorities such as IVO, the National Board of Health and Welfare and the Swedish Association of Local Authorities and Regions, as well as test calls from the region.

In the operations, the notion of trust-based governance and management is not perceived to have made an impact.

Trust-based governance as it was intended (. . .) but now it can be a shift, but it didn't happen. It still involves a lot of control. I think there is a tendency to add more controls rather than remove any.
– Quote, employee in home healthcare

One employee highlighted that there is a tendency for politicians to become nervous due to the pressure from mass media, which leads to increased monitoring, while resources needed to meet the monitoring requirements are reduced. During the interviews, the word “fear” came up repeatedly, highlighting how fear among employees, management and politicians hinders the development of welfare services.

It was also highlighted during the pandemic. The media asks, 'how could this happen?' Well, we need more controls so that we can respond to the media when they ask. - Quote, employee in home health care

Additionally, the possibility of appealing decisions to administrative courts or higher authorities contributes to the fear of making mistakes or making decisions that could be perceived as unfair, which limits the ability to offer individualized care and support. One respondent highlighted that fear is also a significant factor, hindering innovation within public services.

Measurable factors such as the number of care occasions or time spent with each individual can be perceived by respondents as surveillance and micromanagement. Respondents emphasized that the monitoring parameters used should be more clearly linked to the quality work of the organization to support a more proactive approach.

I would rather see more control of quality parameters (. .) do more interviews with customers. (. .) It would be much more effective because it also provides higher quality for customers (. .) then it wouldn't matter if you spent an extra 10 hours this month because she had a stomach bug. - Quote, employee in home care

The capturing of the value of health improvements is problematic, as one organization may incur the costs to create the value for another organization, or the performance-based reimbursement may lead in the wrong direction.

The economic models (. .) do not replace health but rather illness. - Quote, employee working with public sector innovation management

Service providers see a potential conflict between individualized care and related performance-based reimbursement based on expected measurable factors rather than considering the variation in the elderly person's daily condition. For example, a toilet visit that is expected to take 5 min according to the standard, may take up to 20 min depending on the elderly person's condition, and may require assistance from two caregivers.

They don't take into account the individual's daily condition when making a decision (. .) So it becomes this standard to adhere to. - Quote, employee in home care

They also believe that the standards do not take into account daily challenges and logistical problems such as traffic conditions, parking possibilities or if the elderly person is aggressive. Many of these challenges and logistical issues are since care takes place in the elder's home, as opposed to care provided in hospitals or nursing homes, which makes it difficult for service providers to balance their budget. Many employees are driven by ethical and moral motives and often carry out activities that are not covered by the reimbursement scheme to ensure individualized care, high-quality care and a sense of professionalism. While this is seen as positive, it is also seen as problematic because it makes it difficult to meet the requirement of a balanced budget and increased stress among employees.

Decreasing collaboration

The joint areas of cooperation are a constant issue. There are notable areas that respondents raise as causing disturbances in carrying out the daily operations. Respondents argued that there is a need for laws and guidelines that support collaboration between the authorities within the welfare sector since insufficient collaboration also hinders the effective development of welfare technology and care for the elderly. Several employees argued that collaboration across organizational boundaries tends to decrease rather than increase. Some delegations from home healthcare to home care have been removed, such as dispensing medications from pre-packaged units of prescribed dosages.

This organizational boundary between healthcare and home care has a real consequence, that it is now being clearly divided. Previously, there was more collaboration. - Quote, employee in home healthcare

The consequence for the patient/user is that they may receive assistance from elderly care personnel to go to bed for the night, only to be awakened by home healthcare when they are supposed to take their evening medication or change their ostomy bag. Respondents emphasized the need for increased opportunities for interdisciplinary collaboration and the opportunity to jointly develop routines for collaboration concerning the elderly. Physical meetings were highlighted as important.

Contact is facilitated when you get to see the face behind the email address, which allows you to solve small practical problems that could otherwise lead to misunderstandings. - Quote, employee in home care

Regular and preferably physical meetings were also argued to provide employees with a better overall understanding of the health- and elderly care system and how their own contributions contribute to the bigger picture.

Communication channels and IT development

Today, much of the contact between different healthcare providers occurs via telephone. Respondents claimed that the elderly usually only have notes with phone numbers or, at best, a folder with contact information. The respondents argue that the problem of quickly and efficiently reaching the right person when needed not only affects the elderly and their relatives but also hampers communication between the different service providers responsible for care around-the-clock.

Another challenge highlighted in the results is that development projects often have a focus on technology rather than an understanding of the context and real needs.

They start with the technology but miss the context. More knowledge is needed about the user's needs and involving the user in the development process. - Quote, employee home healthcare

Involving employees in the development of digital technologies for welfare services could have other positive effects, such as facilitating recruitment and retaining staff. It could also increase the motivation of healthcare professionals if they were compensated for developing work methods rather than being driven solely by quantitative goals.

If you want to keep employees in a workplace, they must find it interesting and want to work here. I have the opportunity to do things like developing digital aspects. It's something that makes people want to stay as well. It's not just about salary. - Quote, physiotherapist

Analysis and discussion

A general argument suggested by the results of the study is that the health- and elderly care ecosystem is a large-scale complex dynamic system (Berg *et al.*, 2018; McDaniel *et al.*, 2013; Patricio *et al.*, 2020). The study highlighted how suboptimal resource integration results in a level of misalignment in resource deployment.

Regulation and policy differences

The regulation and policies for health- and elderly care actors vary. They are different for various professions, and they are interpreted in different ways depending on regional or municipality level, and between individuals in the same workplace. When healthcare providers have separate goals and incentives, it leads to a challenge of coordination and

collaboration in patient care ([Field et al., 2021](#)). The misalignment of incentives among various medical providers can also contribute to an inefficient allocation of resources, resulting in less-efficient medical care ([Enthoven, 2009](#)). The healthcare system in Sweden has been described as fragmented due to the complex and decentralized nature of healthcare delivery ([Byrkjeflot and Neby, 2008](#); [Nilsson et al., 2016](#)). Fragmentation can also lead to variability in quality and outcomes of care ([Lyngsø et al., 2016](#)).

Partly, fragmentation is by design ([Hall, 2021](#)), as the deregulation of previous monopoly structures to create market-like conditions has been considered an important underlying principle of a well-functioning health- and elderly care ecosystem. The current system has enabled citizens to choose their service provider more freely and for the service providers to choose the support structure, such as IT-systems, where external control of these have been deemed interfering with the notion of free markets. This has also created more fragmentation and resulted in increasing system complexity.

Stakeholder quantity and variation

In extension to regulations creating diversity and heterogeneity, the varied contextual settings of the stakeholders and citizens also increase fragmentation. The contingencies and nature of the work needed and carried out are inherently varied from several aspects, for example, uncertainty, plannability, variability and locality. This is also reflected in the status differences between roles and workplaces noted in the results. The sheer number of actors, the various types of actors, such as public and private, and their interdependence contribute to make this system inherently ambiguous ([Chuang and Howley, 2019](#); [McDaniel et al., 2013](#)) and add to the complexity in the system ([Ljung and Ivarsson Westerberg, 2017](#); [Ivarsson Westerberg, 2021](#)).

External control of health- and elderly care

The health- and elderly care actors are subject to extensive external control. A suggested cause of increasing bureaucracy is the complexity of the system ([Ljung and Ivarsson Westerberg, 2017](#); [Hall, 2021](#)). As [Hall \(2021\)](#) argues, the increase in external control creates a pressure to deliver information, and then necessitates an increase in administration for actors. Previous literature suggests that this is driven by increased enforcement of political objectives, which creates bureaucracy in the entire system ([Hall, 2021](#)). These tendencies are in line with the findings of the present study.

The health- and social care system is highly vulnerable to scrutiny from the media and social scrutiny from patients/clients and their families. It can also be politically advantageous to act in the short term in order to appear decisive as a government or to cater to a political opinion and unspoken expectations, or employees who want to defend their positions or expert roles which all contribute to a lack of trust [1].

On an operational level, the results suggest that the financing of healthcare actors does not contribute to actors avoiding fulfilling their commitments to enhance their profit. Although this may occur, it is noted as rare, and the control system captures this. On a higher level, the performance-based reimbursement of social- and healthcare organizations does not necessarily benefit from better health, something also noted by [Hazarika and Dutta \(2012\)](#). Further, one actor may incur costs to create the value for another actor.

The importance of collaboration between actors is manifest; however, and in line with extant research ([Wadmann et al., 2009](#)), direct economic incentives for collaboration are weak or lacking. Further, and in relation to the variation in context between actors, lower levels of plannability in work tasks have been noted as a challenge for current performance-based reimbursement. To enable the requirements of flexibility while also retaining financial accountability for unallocated time in social care, tasks have also been noted by, for example, [Kraus \(2012\)](#).

Decreasing collaboration

System fragmentation and resulting complexity present a clear challenge for the collaboration between actors. At the same time, the study showed that the collaboration tends to decrease. This type of collaboration is going down due to more adherence to quality control and division of professional responsibility areas. According to [Craftman *et al.* \(2013\)](#) and [Gransjön Craftman *et al.* \(2015, 2016\)](#), district nurses could not manage their workload without delegating the administration of medication; however, the delegation of administration of medicine to unlicensed personnel in residential care homes was also problematic, as patient safety could be threatened.

Results also suggest that getting to know one another is an important issue. This is in line with [Karlsson *et al.* \(2020\)](#), who state that personal knowledge of actors and knowing what they can do have been found to be important for sustainable interorganizational collaboration. Actors need to continuously learn about the changing system and their role in this.

Communication channels and IT development

A general finding is that IT systems and general phone communication are central in enabling the function of the system. The main issue with the former is that they are old and maladapted for current use, and they are difficult and costly to develop. The phones have clear benefits, although it is also challenging for staff to know who to contact, find their number and then get through to this person.

Systems have been developed in a patchwork manner, where one has been built on top of another and the purpose of systems change over time. An additional challenge is also that laws, regulations and interpretations thereof change during development and use of systems. Present results complement those challenges in IT-related collaboration between different healthcare organizations, identified by [Svensson \(2019\)](#), including insufficient information exchange, inconsistencies in communication, differences in the use of IT systems and deficient coordination.

The study shows that innovation and procurement are hindered by institutional pressures due to policies, laws and regulations ([Hollmark *et al.*, 2015](#)). The study also indicates that involvement of staff in the development and implementation of technology is marginal. This risks developers to miss important contextual factors since staff is not involved, even though it could create increased motivation among staff and potentially more effective systems in the health- and elderly care sector.

Conclusions

Healthcare is an example of a large-scale, complex socio-technical system embedded in the interconnected institutional arrangements of multiple actors. Any change in this system, such as implementation of new work methods, technology or services, will depend on the successful change of institutional arrangements and mental models.

This study contributes to institutional theory, resource integration theory and the field of systemic design and can support a development of new routines, digital or organizational solutions. In this study, misalignments in the health- and elderly care system can be found on several levels. The regulation and policy differences and stakeholder quantity and variation in elderly need are contributing to the fragmentation and complexity of the health- and elderly care system. Decreasing collaboration is also in part a consequence of stronger adherence of regulation and connected external control. External control fragments the health- and elderly care system, in a similar manner as the regulations, as collaboration is not supported by current reimbursement schemes. Further, communication channels, such as IT-systems and general handhelds like mobile phones, are general conduits for collaboration, although they all have substantial issues that needs to be addressed. These identified misalignments serve as focus areas for future improvement for the health- and elderly care system.

Although these misalignments are to be found in extant research, they are mainly treated in separate studies. The present study gives an integrated account of aspects previously described more in isolation. To understand the interrelatedness of these is important for the improvement of current elderly health- and care operations. Theories used were fruitful for application in this setting given the size and complexity of the studied system.

Note

1. SOU 2019:43 Med tillit följer bättre resultat – tillitsbaserad styrning och ledning i staten.

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