Transformations in Canadian Health Systems Leadership: An Analytical Perspective

Graham Dickson

Royal Roads University - Centre for Health Leadership and Research, Canada

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Introduction

In recent years—as witnessed by a number of articles in this journal—there has been a growing interest in the contribution the knowledge of, and the practice of leadership can make to the unique challenges of the health sector in Canada. Whereas the functions of management and administration have always been components of the organized Canadian health sector mosaic, it is only in the last ten years or so that the construct of leadership has emerged as an emerging force in that sector (Leeb et al, 2005; Leatt, 2004; Leaders for Life, 2007). Yet leadership remains for many a fuzzy concept; for others it is a 'catch-all word: that is, a word that stands for what is needed when something is not working well, or as in the case of the Canadian health system, what is needed when struggling with the implementation of major system reforms. The questions are often asked, for example, by lamenting media types or frustrated health managers and CEO's in Canada: 'Why can't I make the changes that I need to make to improve service delivery? Why does the health system seem to be impervious to change, even after numerous Royal Commissions, or provincial studies, that clearly tell us that major change is needed (Ward, 2007)? And someone within earshot then answers, inevitably: "Because we (the collective we) lack real leadership…that's what is needed". Ironically, leadership is the savior, but is always seen as somehow lacking, even by those who inhabit formal positions of power, and who by virtue of their position, are (or at least should be) the experts in the field.

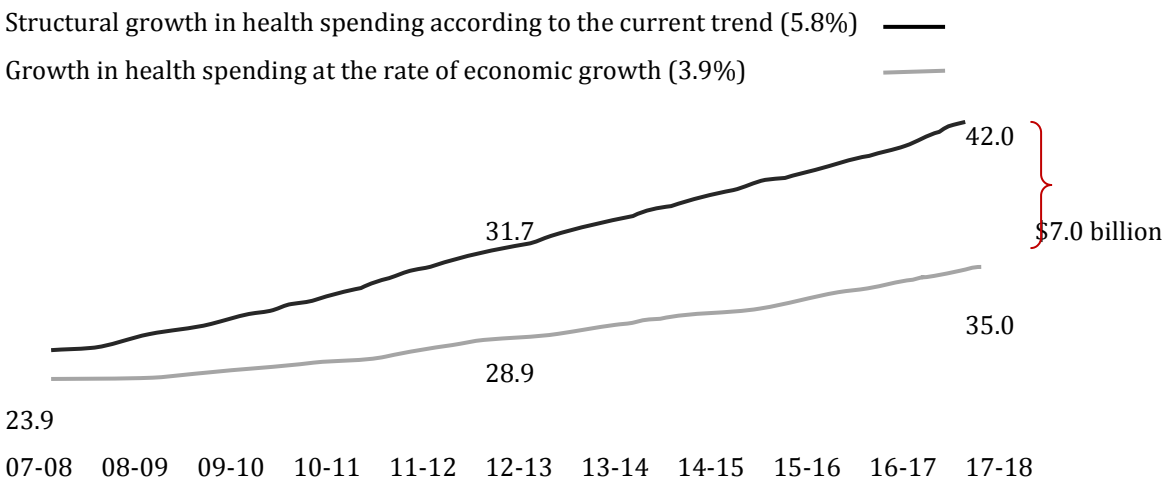
But what is this leadership? Why has this word emerged as the key to effective health reform? Does it have to be as 'fuzzy' as some people think, or can it be defined so as to be improved, or grown? And if it is indeed the 'silver bullet' for meaningful health system transformation (Degeling & Carr, 2004, White & Nanan, 2008), can we give it enough shape and substance in the modern context such that efforts can be mounted to improve the quality of leadership in the country?

This paper attempts to answer these questions by looking at the concept of leadership from three perspectives: (1) as a unique concept and function distinct from administration or leadership; (2) what recent qualitative studies in Canada suggest health leadership is, and what its defining elements are within the Canadian health sector as described by senior executives and presenters in recent conferences, as they discuss and debate the challenges of health system change in Canada; and (3) the implications of the above discussion on the health system. The result is to see leadership as a function within the health system, that as the system changes, is changing itself both in response to those system reforms; but is also expected to be a force that does not just respond to change, but actually accelerates and shapes it. Indeed, if health services delivery in Canada is to transform, then so too must our conceptions of leadership transform, and our practices of leadership development.

The demand for leadership in health in Canada

In Canada, the health-care system is constantly being bombarded by pundits who complain about public about lengthy wait lists, broadcast regular anecdotes about how a senior's care was botched or neglected, and foment constant political turmoil about where the money is going to come from as a population ages and demands for services outstrips the capacity of the government to pay for them (see Figure 1: Gouvernement du Québec, 2008).

Figure 1: Projected public spending on health 2007-2008 to 2017-2018 (Billions of dollars)



Source: Ministère des Finances du Québec.

However, it is not public and the media who are calling for change. Stephen Lewis (2007) and Roy Romanow (2007)[1], two well-known health experts, have stated that improved leadership is key to making the changes that are necessary (e.g., waitlist management, fiscal sustainability, primary care reform, end-of-life care [Ward, 2007]). It seems that many health Chief Executive Officers agree with them: in April, 2008, 150 CEO's from across Canada's health system attended an executive forum focused on the topic of *transformational leadership in health care* – a session devoted to learning strategies for, and examples of how to lead meaningful change in service delivery at the unit, organization or provincial level (Canadian College of Health Service Executives [CCHSE], 2008).

A year later, in April, 2009, a second group of executives attended a session entitled, *System Sustainability through Innovation* (Canadian College of Health Service Executives , 2009). Participants suggested that the Canadian health system has to make major changes, and that the 'old' models of leadership will not create the changes needed. For example, Anne McGuire and Sharon King (2009) outlined the challenges of leading the implementation of a strategic plan for the Izaak Walton Killam (IWK) Children and Women's hospital in Halifax, Nova Scotia. They indicated that old models of implementation were not working, and new models of leading change, emphasizing momentum, execution, perseverance, and collaborative engagement were required. In their view, the IWK leaders had to unlearn that delegation as a strategy did not work; that linear approaches to change did not work; that old models of executive teamwork did not work. The IWK executive needed to adopt a more fluid, organic approach to change with a commitment to learning about how to engage people in order for them to make sense of the change in the context of their own work (Dickson & Tholl, 2009).

These changes portend a transformation of the Canadian health system—in the truest sense of the word, i.e., "A qualitative change" leading to improvements in health service delivery (http://www.websters-online-dictionary.org/definition/transformation). For many providers and patients, it represents a second meaning of the term, 'transformation': a "change in form, appearance, nature, or character" of their role, their function, and their identity within the health

[1] [1] Roy Romanow is a former Premier of Saskatchewan who was commissioned in 2002 to conduct a Royal Commission on the state of the health care system in Canada. See Government of Canada (2002).

sector (http://dictionary.reference.com/browse/transformation). In the coming decade, health leaders envisage stewarding significant changes in healthcare delivery, including quality improvement and safety initiatives, clinical and operational re-design, privatization, and funding redesign (Porter, 2009); and stewardship of regions that have moved from 'corner stores to conglomerates' (Rowlands, 2009). These changes will collectively create a system very different to what we know today. Canada is not alone of course in that many other jurisdictions are contemplating and to some degree executing major change: e.g., Sweden, the United States, and of course the United Kingdom[2].

However, Canada is remarkably resistant to large-scale change (Lewis, 2007; Ward, 2007). One of the reasons might well be the collective conception of leadership in Canada, the lack of focus it receives, and therefore, a paucity of leadership action. "The challenge in achieving better performance necessarily must lie in improving leadership, priority setting, decision making, and management at all levels" (White & Nanan, 2009, p.148). But how can we improve leadership, if we don't have a collective understanding as to what it is? Indeed, William Drath (2008) makes the point that "Only thoughts, words and actions that are recognized as leadership can constitute leadership" (p. 6). Therefore, dialogue and discussion aimed at collective understandings about what leadership looks like, feels, like, and acts like, is fundamentally important to making leadership meaningful to people. This paper is dedicated to both sharing examples of those dialogues and the collective understandings shared by senior leaders in the Canadian health sector, an understanding that is important for a 'system' in transformation (Dickson et al, 2007),

At the core of the transformation challenge anticipated in health care in Canada is a similar expectation for transformation in leadership: a demand for new and modern conceptions, commensurate with changing societal dynamics and values (Leatt & Porter, 2004; Leeb et al. 2005, Dickson et al 2007). The question then needs to be asked: If a 'qualitative change' is needed in the health system, what kind of 'qualitative change' in leadership is needed to take on these challenges? What are the distinguishing features of new approaches to leadership, that define it differently from old conceptions, and from administration and management, and that conceptualize it in a modern health context (Braithewaite, 2009; Dunoon, 2008; Dickson et al, 2007; Bennis, 2003; Kotter, 2000)? A number of initiatives have begun to explore this issue. The rest of the paper is devoted to that topic.

The qualitative gap: Evidence for a felt need to 'transform' conceptions and practice of leadership

There are three key sources of evidence for a 'felt need' to transform conceptions and practices of leadership for the Canadian health system. The first derives less from evidence than logic: it pertains to an understanding the word *leadership* as distinct from other words sometimes loosely used in its place: i.e., management and administration. The second derives from specific studies associated with investigating, through extensive literature reviews and qualitative methods (e.g., interviews, focus groups, etc.) aimed at defining 'modern' health leadership (Cikaliuk 2008, Dickson, 2007; Dickson, 2006). The third is how leadership is discussed and used in discourse by leaders at national conferences in Canada (Dickson and Tholl, 2009; Ford, 2008; Murray, 2009). The contribution of each of these will be discussed in this section of the paper.

[2] Sweden has implemented system-wide changes in service delivery through contracting out, challenge, and coherent policies for innovation across the state, county, and municipal governance systems (see Dickson, 2009). Similarly, the IHI National Forum in the USA (2008) has numerous programs on leadership that have shaped national activities such as the 100,000 Lives campaign; and the UK has established the Institute for Innovation and Improvement, that is stimulating leadership development within the National Health System (Clark 2008).

Leadership as Distinct from Management and Administration

Simpson and Jackson (1984) argue that the very existence of a word, distinct, from other words, is evidence that it has a meaning unique to itself. So what qualities distinguish leadership from other words--i.e., management, administration—and that give it a unique conceptualization? By definition, leaders go "first". A leader takes on the responsibility of acting to shape the future. Therefore, leaders are explorers who break new ground and set direction in a confusing and unclear landscape (Kouzes and Posner, 2002; Dickson, 1998). Managers and administrators are the engineers who build the paths that follow in the footsteps of the leader. Given this function leaders are always caught halfway between the known and the unknown, between reality and creativity, and between safety and risk: like the Roman god Janus[3] they sit at the cusp of the past and the future (Lindemans, 2008). Leaders use their wisdom to determine what actions need to be taken to create the future that they seek. Leaders are comfortable (or at least accepting) of the ambiguity and confusion that inhabiting the space between the known and unknown requires of them (Kaye 2003). After all, research and evidence cannot provide certainty as to the future as by definition it is knowledge of the past. When research fails them, or appears to lead them in a direction that appears contradictory to the best interests of the populace, leaders then need to turn to another source of knowledge for guidance: values and ethics. "Leaders are people who do the right thing; managers are people who do things right" (Bennis, 2003). Leaders often have to 'satisfice': i.e., be satisfied with the best knowledge and results available to them while knowing it is incomplete (Simon, 1947). Managers or administrators can choose to focus on the known world and control, organize, and plan it to be delivered with some degree of certainty (Bennis, 2003). Leaders cannot. It is precisely the futuristic and uncertain space in which leaders find themselves that sometimes frightens many people from taking on the role of leadership and often "self-selects" those who become leaders from those who do not (Dickson, 1998).

Efforts to Develop Conceptions of Health Leadership in Canada

In the US, the Institute for Health Improvement (IHI) has become a powerful tool for shaping new conceptions of leadership (IHI National Conference, 2008). In the UK, the former Blair government championed health leadership as a tool to support major change and created the former National Health Modernization agency (and subsequently, the Institute for Innovation and Improvement) to stimulate modern leadership development across the country (Clark, 2008). No such energy behind leadership development existed in Canada until very recently. In particular, two initiatives have embraced the conviction that more attention to leadership is vital to success (Leaders for Life, 2008; Canadian Health Leadership Network, 2009). Yet, equally, there appears to be an understanding that the kind of leadership that created the health system of today is not the leadership that will take us into the future (Penney, 2007; Philippon, 2007) and some effort is being made to overcome this deficit.

But what does leadership look like? For many people the qualities and actions that define quality leadership is elusive. As one senior executive stated recently: "To me, leadership is like fog: you can see it, it's all around you, but you can't grab on to it." But if we cannot then how can we develop it? It might be appropriate at this time to turn to the research on leadership for some assistance here.

[3] The Roman God Janus is the God of beginnings and endings; of openings and exits. His visage on Roman coins shows two conjoined faces, one facing forward and one facing backwards. The month of January is named after Janus (Lindemans, 2008).

Avolio, Walumba, and Weber (2009) examine recent theoretical and empirical developments in the leadership literature. Topics receiving attention are authentic leadership; cognitive psychology and leadership; what they call 'new-genre leadership' (leadership explaining charismatic leadership behavior, visionary, inspiring, ideological and moral values, as well as transformational leadership [p. 428]); complexity leadership; shared, collective, or distributed leadership; leader-member exchange; followership and leadership; cross-cultural leadership; substitutes for leadership; servant leadership; spirituality and leadership; and e-leadership. They conclude their article by stating that the field of leadership is taking "a more holistic view"; that they see "much more attention paid to the area of strategic leadership," and that "the time has never been better to examine the genuine development of leadership (p. 441-2)." They also quote Avolio et al (2009),and Reichard & Avolio (2005) who conducted a meta-analysis of pertinent research and concluded that "regardless of the theory being investigated, results showed that leadership interventions had a positive impact on work outcomes" (p. 425).

It is important to note that at no point do Avolio, Walumba and Weber (2009) actually define the term 'leadership' in their article. Indeed, the article suggests—as does the list of topics described above—that concepts of leadership take many forms (e.g., authentic, transformational, transactional, complexity, etc.). At one point they do state that "...there has been a growing sense of tension in the leadership literature that models of leadership that were designed for the past century may not fully capture the leadership dynamic of organizations operating in today's knowledge-driven economy" (p. 430). This has given rise to what they call complexity leadership, in which "leadership is an emergent phenomenon within complex systems." If one takes the view that health is a complex adaptive system, as does Glouberman & Zimmerman, (2004) and Plsek & Greenhalgh, (2001), then one is led to the conclusion that leadership can be defined only in time-specific contexts and in terms of the qualities and attributes that fit that context. In this view, leadership is constantly transforming in its ideal expression, and studies undertaken at a particular point of time simply reveal a snapshot of ideal leadership at that moment in its transformation.

Yet this does not suggest that one should abandon efforts to define health systems leadership. Indeed, if such efforts are conducted as part of the process of health systems transformation itself, then leaders can become aware of their own leadership actions and how they are contributing (or not) to effective change. In this context, in the past two years, two major qualitative 'applied research' projects were conducted, in which quality leadership in health systems in British Columbia and Canada was investigated through a process of triangulating data from interviews, focus groups, and literature reviews (Dickson, 2008; Dickson et al, 2007). One product of this work (outside of the productive dialogue itself generated in the doing of the work) is the LEADS framework. It defines exceptional health leadership in terms of five capabilities: i.e., an exceptional health leader *Leads self, Engages others, Achieves results, Develops coalitions, and transforms Systems* (Leaders for Life, 2009). The BC Leaders for Life program have adopted the LEADS framework in BC, as a guide to curriculum development, succession-planning, selection of leaders, and as a guide to creating meaningful change.

The Canadian Health Leadership Network (CHLNet) initiated a second project. CHLNet is a coalition of individuals and organizations formed to stimulate the development of an enriched community of leaders and managers in Canada (Canadian Health Leadership Network, 2008). CHLNet is encouraging health organizations and agencies in Canada to collaborate on succession planning, coalesce resources for leadership development and recruitment, and attract greater resources and energy to leadership development and leadership research across the country. To focus its energy, it collaborated with the Canadian Health Services Research Foundation to sponsor a study aimed at defining 'exceptional health leadership' (Dickson et al, 2007). This project built on the data generated in the BC Leaders for Life project and bolstered it with a new literature review

(to capture developments since the first project) and a series of focus groups with senior leaders across the country. The result was the Pan-Canadian Health Systems Leadership Capabilities Framework, which states that exceptional health system leaders *Champion caring*, *Cultivate self and others*, *Create Results*, *Connect with others*, and *Change systems*. CHLNet as a guide to the development of leadership endorsed this framework across organizations, across systems in Canada (Canadian Health Leadership Network, 2008). Recently, a working group put together by the Leaders for Life program in BC and CHLNet have been examining the conflation of the two frameworks into one. This is informed by an 'action learning' phase, in which both frameworks have been used to guide leadership development in BC and Canada, and a subsequent desire to evolve the frameworks into a new form that would unite the work of the two entities into one stronger framework (Fenwick, 2009).

The Ongoing Transformation of Understanding of Canadian Health Leadership

As the above-mentioned projects are proceeding on one plane, the ongoing dialogue amongst senior leaders in Canada about what comprises effective health systems leadership continues. This is as it should be - ongoing transformation of the health system itself also continues apace. The CEO Executive forum hosted by the CCHSE is an ideal opportunity to gauge, year to year, the evolution of thinking of senior leaders in the Canadian health system as it pertains to their understanding and conceptualization of effective health leadership. Earlier reference was made in this paper to a CEO Executive Forum in April 2008 and a subsequent forum in April 2009. The latter event provided an excellent opportunity to investigate health systems leadership as perceived by both practitioners from the sector itself (about 50 senior executives from across Canada), and presenters who provide perspectives on leadership from their point of view, and who stimulate dialogue about leadership amongst the participants. This section of the paper reviews some salient learning about health systems leadership gained from that forum.

Jeremy Gutsche, (2009), in his session on 'adaptive innovation', conducted an exercise with the participants to determine their view as to desired changes in the Canadian health system. The participants suggested that the Canadian health system should:

- Create a cultural connection with society (the public taxpayer) and focus on the value benefits of good health.
- Stimulate a wholesale attitudinal shift of Canadians towards health through social marketing campaigns.
- Encourage, enable and empower the acute care system to understand the power of investments in population health.
- Pursue changes in governance and service delivery models so as to 'sort out' constantly shifting dynamics between provinces, the federal government, and regional mechanisms of organizing service delivery.
- Create national, provincial and local policy frameworks that support innovation.
- Undertake a national activity for the population and government to identify the *needs* (which should be funded in a universal health system) versus the *wants* that continue to grow.
- Accelerate the implementation of technology—e.g., e-health. electronic health records, improved information systems, and new technologies for diagnosing and treating health conditions.

- Create policy and service delivery models that encourage and enable patient responsibility for own health care, particularly in primary care and in dealing with multiple chronic disease conditions (particularly as it pertains to care of the elderly).
- Invest in staff safety and wellness; and into employee accountability and empowerment.
- Invest and support information technology in support of health and work redesign: e.g., such as the LEAN initiatives in BC and Quebec (CCHSE, 2009, p.)

In subsequent sessions presenters identified key issues and concerns in the Canadian health system from a national and provincial perspective (i.e., reports from each province), explored the influence of technology on leadership (Gutsche, 2009; Bontis, 2009) and provided perspectives on needed changes to the Canadian system (Porter, 2009). Other presenters (MacGuire & King, 2009) provided a case study on change (discussed earlier in this paper). A final dialogue was held with all participants to explore the implications of all of the above for the practice of leadership in the health system, at both a macro-systems level (e.g., province), a meso-systems level (e.g., health authority), and a micro-systems level (e.g., individual unit or area of responsibility). A summary report for the session was written (Dickson & Tholl, 2009).

Analysis of the contents of that report suggests three major findings, or themes pertinent to this paper. The first is that there is a frustration amongst Canadian health leaders about their own perceived leadership inaction: i.e., they feel constrained and fettered from acting as they know they should; but also recognize that it is their own responsibility to take the initiative needed to convert leadership inaction to 'leadership in action'. A second key theme was that a key component that will enable them to take initiative is to learn and unlearn (Argyris, 1999) what 'leadership in action' looks like in a modern, knowledge and technology-driven, society. And a third theme was the articulation of some of the key differences between how leadership has been practiced and how it will need to be practiced in the future; i.e., how it will transform to adapt to a knowledge and technology driven society. A summary of key ideas pertaining to that transformation is presented in Table 1 below:

Table 1: Transformation of Leadership Attributes from Past State to Future State: e.g., a Knowledge and Technology Driven society

From	To
• A competitive mindset	• A collaborative mindset
• A focus on improving internal organizational processes as siloed improvements	• A focus on external as well as internal processes: e.g., more systems thinking, coalition-building, and 'system-wide' process redesign
• A focus on structure to maintain order	• A focus on culture to stimulate change
• A 'redesign' of service delivery models to meet needs of professional groups	• A 'redesign' of service delivery models with the patient experience as the focus of change
• Information protection and hoarding	• Information sharing and transparency
• Seeking information in a 'scarce' evidence-environment to inform decisions	• Analyzing information in a 'abundant' evidence-environment to inform decisions

• 'Long term' tenures for CEO's and political masters; some independence from the political process	• 'Short term' tenures for CEO's and political masters; less independence from the political process
• No standards for effective leadership and management other than those determined by an employer	• Agreed upon standards for effective leadership and management as defined by the professional bodies representing them
• A reliance on management skills (e.g., planning, organizing) in a somewhat predictable environment	• A reliance on leadership skills (e.g., inspiration, visioning, change facilitation) in a turbulent, complex environment
• A reliance on external professional standards, rules, regulations to guide behavior	• A reliance on internal character, ethics, and creativity to respond to constantly changing circumstances
• A reliance on logistics, stable clinical practice standards, and consistent process to guide service delivery	• A reliance on knowledge absorption and technological innovation to constantly improve processes for service delivery
• The ability to engage a stable, uni-dimensional (from a demographic and ethnic point of view) workforce	• The ability to engage an unstable, multi-dimensional workforce with sophisticated information technology skills
• Employees who accept 'top down' decision making	• Employees who demand input into decisions and horizontal engagement
• Linear, traditional models of strategic planning	• Organic, transformative change approaches, with a focus on collaborative approaches to execution

A review of the above table in the context of this article suggests three main conclusions. The first is that when one compares the attributes of leadership on the right hand side of the table to both the Pan-Canadian Health Systems Leadership Capabilities Framework and the LEADS framework, there is significant resonance of expectations. All three (Pan-Canadian, LEADS, and the chart) represent a more 'holistic' view of leadership as anticipated by Avolio, Walumba, and Weber, (2009). Leadership is not perceived solely as the dynamic between individual leader and follower, but as a force operative on an interpersonal, unit, organizational and systems level. It takes expression as a function of complexity of context (i.e., number of interdependent variables influencing its action), individual and group psychology, individual cognition, tools available to it (e.g., technology), and culture (ethnicity; unit of analysis [e.g., province, organization, country]; and customs, traditions and precedents implicit in context).

A second major conclusion is that leadership is, as the paper states earlier, a much more complex and unique concept than is management or administration. It is what Manfred Max-Neef, (2005) describes as the ultimate trans-discipline; that is, it operates at the intersection of science, values and beliefs, functioning in unique contexts, and faced with the responsibility of often reconciling irreconcilables (Martin, 2007). Another way of putting it is as Hodgkinson, (1983) does, stating that 'leadership is philosophy in action". As societal values and beliefs change, as science changes, and as our system and global consciousness expands, so does our conceptions and practices of leadership. This might well explain why so many Canadian leaders feel inactive, as leadership truly demands a skill set and a character set that is very difficult to achieve. If indeed

leadership is 'going first', and going first demands a level of wisdom and courage not commonly held, then leadership is going to be a commodity not easily found.

A third conclusion is that if one accepts the premise that leadership is transforming in resonance with changes in the context in which it is operating (in this case the Canadian health system), then ongoing leadership development (learning and unlearning) is both a precursor to, and an enabler of, effective change. Concomitantly, it follows that the design of leadership development interventions must, ensure that they enable development of the unique attributes of leadership itself: such as, the attribute of 'going first'? Or, of the attributes of: 'Organic, transformative change approaches, with a focus on collaborative approaches to execution'; or 'A reliance on internal character, ethics, and creativity to respond to constantly changing circumstances' (reference is Table 1). Clearly, traditional models of management development, or training models, will not suffice[4]. Other models need to be investigated further[5]. This is a potentially rich area for experimentation and development, for as Avolio, Walumba, and Weber, (2009) state: "The field of leadership has done surprisingly little to focus its energies on what contributes to or detracts from genuine leadership development…we expect that over the next 10 years, research and theory in this area will explode as organizations increasingly ask for ways to accelerate positive leadership development as they enter the front lines of the war for leadership talent" (p. 441). CHLNet and Leaders for Life and indications that this interest is emerging within the health care system in Canada.

Conclusion

Health service delivery in Canada is under significant pressure to change. Budget cuts, escalating costs resulting from demographic shifts, and dramatic technological advances are all driving health toward a major transformation. This circumstance has created a demand for more and higher quality leadership. From a 'health services systems' perspective, change is facilitated and change fatigue minimized when leaders in the health system conceptualize and operate from a common understanding of what effective leadership is. The creation of this common understanding is facilitated by opportunities for dialogue and discussion amongst senior leaders in which leadership is examined in the context of the desired changes in health services delivery. This paper examines three recent opportunities for dialogue in which senior leaders in Canada have collectively generated shared meanings for health services leadership. A typology of those shared meanings for effective leadership in which key elements are identified and examined, and expressed as transforming from old expressions to new is outlined. This phenomenon has implications for a leader's expectations of, and ability to practice leadership; and for developmental approaches to growing leadership. One key implication is that more research should be done into how to develop leadership that is constantly evolving into new forms and the health system itself evolves. It also suggests that coalitions dedicated to leadership development such as CHLNet, Leaders for Life; and professional organizations such as CCHSE have a vital role to play in stimulating, and developing the leadership needed to steward successful health transformation in the Canadian health system.

[4] Indeed, such models are antithetical to effective leadership development, as they provide environments for learning that are predictable, organized, and finite.

[5] Programs such as pilot programs developed for the BC Leaders for Life program; the Royal Roads Master of Arts in Leadership program, the Dorothy Wylie Leadership program in Ontario, and the Canadian Medical Association's Physician Management Institute program might be looked at in this regard.

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