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COMMENTARY

The Australian Government's 'Social Inclusion Agenda': the intersection between public health and social policy

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Social exclusion and social inclusion have been popular policy themes in the UK and Europe, and made more modest appearances in countries such as Canada and New Zealand, for over a decade. In 2007, the Australian Government became the latest country in this trend of structuring social policy around issues of exclusion, launching its 'Social Inclusion Agenda' (SIA). The SIA aims to increase social and economic participation through a reorientation of social services and increased attention to issues of equity. At the same time, there has been international consensus on the importance of the social determinants of health (such as education, income and gender) for individuals and populations. The SIA has the potential to make a substantive contribution to the social determinants of health and hence the health and wellbeing of the population. However, much will depend on the extent to which international discourses of inclusion, exclusion, structural inequality and third way politics are taken up, adapted or discarded in the Australian context. At this formative stage of the SIA's development, the public health community is in a unique position to contribute to the development and direction of the SIA to secure the potential health gains it offers. This article outlines the formulation of social inclusion policy in Australia, and discusses the potential promises and pitfalls of a social inclusion approach. Our examination of the Australian experience of social inclusion policy provides an opportunity to reflect on the relationship between social inclusion and health internationally.

Keywords: marginalisation; participation; social policy

Introduction

After coming to power in 2007, the Australian Prime Minister announced the arrival of the new social democracy in Australia, and the end of neoliberalism (Rudd 2009b). The Australian Government's social democracy explicitly recognises its roots in the policies and ideologies of the Blair Government in the UK and the politics of the 'third way'. The centrepiece of the Labor Government's reform has been the Social Inclusion Agenda (SIA). This agenda has the potential to have a direct impact on the social determinants of health, operating in areas such as housing, education,

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employment, social security and income distribution. Currently, the SIA is still taking shape and we do not yet know what shape the full agenda will take. The time is ripe for the public health community to contribute to the broad policy agenda and the social inclusion strategies and initiatives that are yet to be determined.

This article provides the foundation for such engagement. We begin by placing the SIA in its broader international policy context. We go on to describe the current state of the SIA and its relationship to health. We finish by discussing the promises and pitfalls of the SIA. In doing so, we hope to engender interest and engagement from the public health community on the international trend towards policies based on social inclusion, and (more specifically) what may be one of Australia's most significant broad scale public health policies of recent times.

Social exclusion as a policy theme

Social exclusion has been a policy theme in Europe, and made more modest appearances in countries such as Canada and New Zealand, for over a decade. For example, during the early 1990s, the European Union declared a commitment to reducing social exclusion. This was followed shortly by the Blair Government's social exclusion strategy. Social inclusion has also formed the basis of other important social policy strategies in the UK, such as Scotland's 2008 poverty agenda (Silver 1994, Scottish Government 2008). While not always characterised by national (or international in the case of the EU) policy commitments, social inclusion has been an influential concept in other Western countries. New Zealand's 2002 e-Government strategy targeted exclusion from the digital economy, while the Canadian Council for Social Development and the Canadian Policy Research Network have advocated for a social inclusion approach to be adopted in Canada (Crump 2004, Galabuzi 2004). Despite debate over the successes of these initiatives, the European Union's declaration of '2010 the year for Combating Poverty and Social Exclusion' reinforces the on-going centrality of this concept to policy internationally.

The term social exclusion stems from conceptualisations of the disadvantaged as being 'socially excluded'. It developed in France in the 1970s, partially in response to the crisis of the welfare state. Exclusion came to describe those experiencing social disadvantage. It drew attention to, and described, the difficulty of creating solidarity between individuals, groups and society (Silver 1994). Consequently, early political ideas of exclusion were based on notions of social solidarity and the role of the state in preventing the 'rupture of social fabric' and nourishing social cohesion (Silver 1994, De Haan 1998, p. 10).

In the 1990s, social exclusion gained new prominence as a cornerstone of third way politics, and became a social policy framework under New Labour in the UK (Giddens 1998, Bevir 2005). In crafting the third way, New Labour sought to adapt social democracy to the current political, economic and social environment. The third way looks for a new relationship between the individual and the community: one where government has responsibilities to address poverty and disadvantage, but also holds certain expectations of individuals (e.g. to undertake paid employment and build the democratic state by participating in civil society) (Giddens 1998). In doing so, the third way is claimed to take a middle road between the collectivist sentiments of the left, and the individualistic, market-based logic of the right (Giddens 1998). However, critics argue that it has a tendency to lapse into

conservatism and is an amorphous political project: 'difficult to pin down and lacking direction' (Giddens 2000, p. 22).

Under the third way and New Labour, discourses of exclusion began to fracture. Levitas (1998) identifies three forms of social inclusion discourse used by New Labour: a redistributionist discourse (RED), a social integrationist discourse (SID) and a moral underclass discourse (MUD). In Britain social exclusion first emerged as RED, signalling an extension of citizen rights and greater redistribution of resources to address inequality. However, RED was soon joined by SID and MUD: SID depicted exclusion as a problem of poverty and emphasised paid employment as the solution, while MUD centred on the moral and behavioural delinquency of the excluded (Levitas 2004). In short, Levitas (2004) argues that under RED exclusion is caused by a lack of material resources, SID a lack of paid work and MUD a lack of values. Under the latter two discourses exclusion began to move away from the ideals of social solidarity and state responsibility to place greater emphasis on principles of individualism (Giddens 1998, Levitas 2004). This ethos was particularly evident in New Labour's policies based on rights and responsibilities, such as the New Deal or Welfare to Work, where individuals were viewed to have certain responsibilities to the state, particularly to promote their own welfare (Drakeford 2008).

Within this fracturing of social exclusion discourse under New Labour, language and policy rhetoric also began to shift from addressing problems of exclusion to creating social inclusion (Spandler 2007). The shift towards treating exclusion and inclusion as binary opposites occurred under Blair's Social Exclusion Unit (Spandler 2007) and, as the SIA demonstrates, has since permeated policy discourses internationally. Spandler (2007) argues that this is no mere slippage of rhetoric, but rather a significant conceptual shift. As noted above, social exclusion focuses attention on the structures and processes in society that create unequal access to resources, generate differential quality of membership in society and produce unequal outcomes (Galabuzi 2004). In social policy terms, it draws attention to both process and outcome. Social inclusion, in contrast, can, as Labonte (2004, p. 118) argues, 'blind us to the use, abuse and distribution of power'. It draws attention away from structural change, and shifts policy efforts towards adapting people to the needs of society and the market (rather than vice versa). Social inclusion therefore promotes a softer programme of social reform, or as Labonte (2004) puts it – inclusion is about reform, exclusion is about revolution.

The Australian Social Inclusion Agenda

Prior to the change in government in late 2007, the conservative Howard Government held power for over a decade. Australia's history of conservative social and economic policy arguably stretches back further still. The Labor Governments of the 1980s and early 1990s introduced macroeconomic and industrial reforms based on neoliberal principles of privatisation, deregulation and free market policies (Mendes 2008). When the conservative Howard Government took office in 1996, they expanded the reforms of the previous government, placing a yet greater emphasis on the principles of the free market and individualism (Bessant *et al.* 2006).

With respect to social policy, the Howard Government was deeply concerned with the 'economic and moral dangers of welfare dependency' (Bessant *et al.* 2006,

p. 111). This saw the rise of the ‘rights and obligations’ paradigm in Australia, or ‘mutual obligation’. Mutual obligation policies were based on principles of individualism and emphasised self-reliance; this tightening of government welfare was found in work-for-the-dole (or welfare) policies (Bessant *et al.* 2006, Mendes 2008). Such concerns with welfare dependency were also evident in the United States during the same period (Daguerre 2008).

The Howard years and the rise of neoliberalism in Australia have been referred to as ‘the years of neglect’, where economic rationalism failed to allow for policy agendas that sought to address inequity, exclusion and disadvantage (Reddel 2002). Under the Howard Government, the state no longer based policies on principles of equity to ensure that socially responsive programmes targeted the realities of people’s lives (Reynolds 2000). Consequently, the legacy of this period has been greater poverty and increased inequality among Australian communities (Vinson 1999, Mendes 2008).

In 2007, the Australian Labor Party ran on a platform of social inclusion and greater equality. In contrast to the UK, Australia has tended to use the framework of inclusion rather than exclusion. After their election, the Labor Government announced a commitment to addressing disadvantage through the SIA (Gillard and Wong 2007). They anticipate that the SIA will combat complex and intractable problems of exclusion and disadvantage through an emphasis on promoting social, economic, political and civic participation (Stephens 2008). The SIA reflects the government’s goal that all Australians will have the opportunity to participate fully in society. Under their vision of a socially inclusive Australia, all citizens will have resources and opportunities to: participate in education and training; work in employed, voluntary, family or caring capacities; become engaged in their local communities; and have a voice to effect decisions which influence their lives. Social inclusion therefore acts as a ‘policy current’: a guiding, fluid policy that moves across departmental boundaries (Bills 2001). As such, it serves as a framework for a broad set of policy initiatives spanning housing and homelessness, education, early childhood development, employment and training (Gillard and Wong 2007).

In early 2008, the Australian Government established the Social Inclusion Board, which acts as the main advisory body to the government on disadvantage and social inclusion. The Board provides advice and information to the Minister for Social Inclusion. The Social Inclusion Board plays a purely advisory role to government. It exists external to government, and is comprised of professionals drawn from a range of sectors, including government. A Social Inclusion Unit (SIU) was also established in the Department of Prime Minister and Cabinet. In contrast to the Board, the SIU plays a more active role – coordinating government action across departments. Here, the Australian Government is following closely in the steps of the Blair Government in the UK: Blair established a Social Exclusion Unit (that was later turned into the Social Exclusion Taskforce). Both the SIU and the taskforce encourage cross-departmental, or joined-up, approaches to addressing disadvantage and exclusion.

Social Inclusion Board members were appointed by the Prime Minister and Deputy Prime Minister. Currently the Board is chaired by Patricia Faulkner, former Head of the Victorian Department of Human Services and a partner with KPMG National Healthcare practice, and Monsignor David Cappo, who established the South Australian Social Inclusion Board in 2002. Other members represent the areas of community engagement, indigenous health and affairs, health care and medical professionals, social services organisations, media and academia. The broad selection

of individuals, and the decision to appoint Faulkner from private industry to head the Board, is indicative of the government's aim to integrate social and economic policy. As indicated by the (then) Minister for Social Inclusion: the Social Inclusion Board 'will be made up of serious economic and social thinkers, not just welfare representatives. This will not be a memorial to good intentions – it will be about action and hard headed economics' (Gillard 2008). Gillard's emphasis on economic solutions to social policy issues is part of a broader re-imagining of welfare in Australia, whereby government and key welfare organisations are pushing for a shift from charity to economic and social innovation for community development.

The board has established a number of priority areas under the umbrella of the SIA. To date, these include: homelessness, closing the gap for Indigenous Australians, employment for people living with a disability or mental illness, addressing the incidence and needs of jobless families with children, place-based disadvantage, and support to 'at risk' families and children (Social Inclusion Board 2009).

In the UK, not-for-profit organisations were identified as the social infrastructure through which social exclusion policy should be implemented. The Australian Government has taken this same approach to the implementation of the SIA. Drawing on the experiences of Canada and the UK, the Australian Government has established a National Third Sector Compact and an office for the Third Sector to deliver the SIA. The National Compact sets out the broad terms for a new era of partnership and consultation between the not-for-profit sector and the Federal Government.

While the development of the National Compact is a positive step, the government could do more to support the sector. For example, a recent Productivity Commission review of the not-for-profit sector identified barriers to social inclusion and effective partnerships that are not dealt with within the Compact (Australian Productivity Commission 2009). These include onerous reporting requirements, high administration and compliance costs, and inappropriate models of engagement by government that emphasise competitive tendering rather than client-directed services (Australian Productivity Commission 2009). The Commission's recommendations would see a more active and independent not-for-profit sector, able to deliver more innovated client-centred services that would better address social exclusion. While the government has not yet taken up these recommendations, a Not-for-profit Sector Reform Council was established in late 2010, which may take this agenda forward.

To date, the SIA has had some early successes. Largely, these have related to establishing important infrastructure to enable 'joined-up' solutions. For example, the National Affordable Housing Agreement (NAHA) demonstrates a more integrated approach to addressing housing shortages through Commonwealth and State partnerships. The NAHA means levels of government will be working together to improve housing affordability, and promote social inclusion by reviewing taxes, urban planning and the regulatory environment (FACSIA 2009). In employment, a National Innovation Fund allows for more innovative and experimental delivery of employment services. In addition to providing employment, it's anticipated that this fund will help promote other forms of participation (e.g. social) and address skill shortages. To date, funded projects include social enterprises and market gardens for skill development and social interaction (DEEWR 2010).

However, the SIA (and social inclusion as a concept) has been met with scepticism by social policy analysts (Smyth 2010).

The SIA and public health

We suggest that the SIA has the potential to contribute to public health in three broad ways: (1) by delivering more effective and efficient goods and services to citizens, particularly those who are marginalised or disadvantaged, (2) through promoting social participation and social cohesion and (3) through addressing structural inequality. As SIA initiatives and strategies are developed, there are likely to be many more ways that the agenda will contribute to health. We argue that the ideological basis of the SIA is not a naturally 'health promoting' one, with an emphasis on individualism via choice or aspiration. However, if approached from an egalitarian or social justice perspective, the SIA may indeed make a substantive contribution to the health and wellbeing of populations. As the CSDH (2008, p. 1) reminds us, '[s]ocial justice is a matter of life and death'.

The improved provision of goods and services to disadvantaged populations

Under the directive of the SIA, the government hopes to deliver more effective, efficient and inclusive public services to citizens, particularly those who are disadvantaged or marginalised (Australian Productivity Commission 2009). This is to be achieved through new partnerships with the not-for-profit sector (ACOSS 2008).

Australia's not-for-profit sector is very broad and made up of a diverse range of small and large institutions and organisations. These include charities, advocacy organisations, voluntary affiliations and services. While the sector as a whole can be said to be centrally concerned with social justice, the mission, values, role and purpose of individual organisations vary considerably (Lyons 2001). The sector is understood to be an important facilitator of social and civic participation, it also builds social capital and promotes social cohesion (Lyons 2001). Over the past two decades, the sector has become increasingly involved in the provision of social and public services, which support the health and welfare of the population (Lyons 2001, Mendes 2008). This has resulted in some (particularly Christian) welfare agencies developing into large 'corporatised' providers of government-funded programmes and services. Some organisations, such as Mission Australia and the Salvation Army, now rely on government for up to 70% of their funding (Mendes 2008).

Under new partnerships with the not-for-profit sector, the government aims to better support the sector in delivering important goods and services to citizens (Australian Federal Government Discussion Paper 2008). A renewed commitment to disease prevention will see an even stronger emphasis placed on the not-for-profit sector. As highlighted by the National Preventative Health Taskforce (2009, p. 51), 'NGOs, at all levels, are partners and often leaders in prevention, providing research and development advocacy, social marketing, public information and primary care'. Several recent government inquiries into the role and function of the sector suggest a current rethinking and revaluing of the not-for-profit sector (see, for example, ACOSS 2008, Australian Productivity Commission 2009). These inquiries have highlighted the role of the sector in addressing the needs of disadvantaged and

marginalised groups and individuals. They have also foreshadowed an enhanced policy role for not-for-profit organisations. The advocacy functions of the sector mean that it is ideally placed to contribute to more robust public policy debate (Melville 2008).

This dimension of the SIA has the potential to achieve real gains in areas such as education, healthcare and welfare by better supporting not-for-profits. These organisations are at the frontline of service delivery addressing the social determinants of health.

Promoting social participation and social cohesion

Through an enhanced relationship with the not-for-profit sector, the government also hopes to facilitate social, civic and political participation and promote social cohesion and inclusion. It is hoped that initiatives like the aforementioned National Innovation Fund will revitalise the not-for-profit sector and encourage social participation and cohesion through socially innovative service delivery, increased volunteering and a proliferation of social enterprise initiatives. Here, the government is largely relying on the natural capacity of the not-for-profit sector to 'do good' (Lyons 2001). Government reliance on the not-for-profit sector is part of a growing international trend. Fyfe (2005) argues that internationally governments have increasingly looked to the sector to remedy the ills of modern welfare states.

A significant volume and diversity of empirical evidence demonstrates that social participation and social cohesion are likely to be significant determinants of health outcomes (Blazer 1982, House *et al.* 1982, Orth-Gomer and Johnson 1987, Kawachi *et al.* 1996, Glass *et al.* 1999, Rose 2000). This evidence suggests that a policy that facilitates diverse forms of participation and inclusion is likely to be health promoting. However, the extent to which the health benefits or harms of participation initiatives are differentially distributed within populations must also be investigated (Macintyre and Petticrew 2000). The social conditions in which people live their lives do indeed influence their capacity to participate, and these conditions are shaped by social policies (CSDH 2008) such as the SIA. The health benefits, or possible harms, will depend on the nature of the social participation initiatives, the context in which they are implemented and the populations within which they operate.

Addressing structural inequality

Structural inequalities are those inequalities which result from the operation of underlying social structures, such as the distribution of income, and access to educational and employment opportunities. Structural inequalities are typically difficult to combat: as they form the status quo there is typically strong resistance to the population-level policies which are required to move them (Nussbaum 2000). These disparities are also reflected in inequalities in the social determinants of health, such as education, employment and housing (Marmot 2006). The relationship between structural inequality and health is now widely accepted (Lynch 2000, Marmot 2006, Wilkinson and Pickett 2006). People located higher on the social gradient are likely to have better health outcomes than those below them (Marmot 2006). Policies that focus on addressing disadvantage (particularly those like the SIA,

which prioritise education, employment, homelessness and place-based disadvantage) are likely to go some way towards addressing structural inequality. As previously discussed, there has been government action in the areas of employment, housing and education to date. However, the ability for initiatives in these areas to achieve good outcomes may be limited by the government's broader conceptualisation of equality. To date, the government's emphasis has been on 'equality of opportunity', as highlighted by the following quotation:

The new Australian Government is also implementing a fairness agenda aimed at maximising equality of opportunity for every individual to pursue their life opportunities to the fullest.

(Rudd 2008)

In other words, the government provides a range of public resources to everyone but is not necessarily held responsible for the outcomes of individual decision-making. This emphasis is akin to a 'starting-gate' theory whereby every person is offered the same basic opportunities (e.g. some level of education, no formal barriers to employment) and expected to make the best of them (Anderson 1999). This treatment of equality has implications for the scope of inclusion encouraged by the state, and the degree of inequality we seek to mitigate. Many would argue that the real-life experience of disadvantage is more complicated than this (Warr 2005), although the provision of opportunity is a positive step forward. The degree to which these policies address structural inequality will depend upon what kinds of opportunities are made available to all citizens. For example, will it be *high quality* education and *adequately* remunerated employment?

'Equality of opportunity' is only one way of thinking about equality. It is possible to choose other versions which are more in keeping with the overall aims of social inclusion. An account of equality which focuses on outcomes, for example whether the result of employment and training programmes actually improves inclusion, is preferable to one that assumes that the beneficiaries of government programmes will be less excluded from society (Anderson 1999).

Early promise and possible pitfalls of the SIA

The above section highlights the real promise of the SIA for public health: a supported, engaged and empowered not-for-profit sector and a resourced, connected and cohesive citizenry. However, our discussion of equality reveals that social inclusion policies are not always as 'health promoting' as they could be.

As previously discussed, the UK experience demonstrated that social inclusion policies that draw on third way thinking have a tendency to become focused on individual choices and aspirations, as highlighted in the emphasis on 'equality of opportunity' (Levitas 1998). This is evident even at the broadest level. Social inclusion can set up a division in society between an included majority and an excluded minority. In doing so, it presents a homogenous and consensual image of society that masks social divides, such as those based upon culture, gender or class (Levitas 1998). It also carries normative assumptions regarding a common ideal of life: it assumes that a 'mainstream' of society exists, and that being part of this mainstream is both desirable and likely to promote wellbeing. Within this view of society, state intervention becomes narrow and minimalist: it focuses on precipitating individuals' passive transition across the boundary from excluded to

included (Levitas 1998). To date, key Australian welfare agencies have argued that we need to focus on a discourse of social inclusion that promotes the ability of people to lead lives they have reason to value, rather than create policies that push people over the line from excluded to included (Smyth 2010).

The dangers of generating policies that are focused on ‘thresholds’ of inclusion are well-illustrated by studies into labour force participation. In Australia, labour market participation has been central to the government’s action on social exclusion. Much like under New Labour, employment is considered the most effective means to inclusion: as stated by the former Minister for Employment ‘a job, and the means to obtain one, is the first and most important plank towards economic participation and social inclusion’ (O’Connor 2009). Under the SIA, the government aims to provide opportunities for education and work to all citizens. The idea of employment as the central, and first step, towards inclusion negates the inequality and exclusion that can be found amongst the employed, and in some instances as a result of employment (Levitas 1998). In Australia, one out of four workers is classified as ‘low-paid’ (Masterman-Smith 2009). These workers have been found to experience significant, and compounded, exclusion: their wages are insufficient to enable them to participate fully in society; yet, their classification as ‘in-work’ prohibits them from accessing many government services (Masterman-Smith and Pocock 2008). Findings in this area challenge the idea that increasing employment is the best means to promote inclusion: long hours in low-paid positions have been found to limit access to social networks and participation gained through voluntary roles (Masterman-Smith and Pocock 2008). Policies that emphasise the plight of the jobless, without considering the implications of low-paid work, can therefore be counterproductive in terms of policy outcomes such as inclusion and equality (Masterman-Smith 2009).

Thus, we must be careful to ensure that inclusion does not become a measurable outcome, rather than a process that highlights the structures of society that generate disadvantage (Levitas 1998). Levitas (1998) draws attention to the long-term implications of this type of policy oversight. In the UK, New Labour’s emphasis on employment created lower employment, but increased health inequalities (Levitas 1998, Shaw 1999, Seeleib-Kaiser 2008). Thus, without a clear elucidation of the complexity of structural disadvantage, solutions may be misplaced and less effective. In part, this is because social inclusion carries an inherent tension between an individualistic concern for success and a need to build collective responsibility for social cohesion. The public health community generally, and the not-for-profit sector more specifically, is well-positioned to provide insight for bridging this gap.

Smyth (2010) argues that social inclusion could amount to little more than an umbrella term for ad hoc policies and initiatives directed at disadvantaged populations and places: it could miss the opportunity to ‘[bring] the social back in and giv[e] all citizens a stake in their society’ (Smyth 2010, p. 9). This concern resonates with current debate surrounding the Review of Health Inequalities in England (Marmot 2010). The Marmot (2010, p. 15) review found that strategies and policies that focused ‘solely on the most disadvantaged will not reduce health inequalities sufficiently’. Rather, a social gradient approach is more likely to deliver greater outcomes at a population level (Marmot 2010, Whitehead and Popay 2010). The challenge is to act universally ‘but with a scale and intensity that is proportionate to the level of disadvantage’ (Marmot 2010, p. 15). Moreover, the focus on individuals rather than the structural conditions that constrain choice will

continue to thwart real progress in reducing health inequalities (Whitehead and Popay 2010).

Finally, the SIA, like its UK counterpart, may fall into the trap of focusing too heavily on the characteristics and behaviours of the socially excluded at the expense of societal change. Arguably, in Australia, this has already begun with a strong rights and responsibility paradigm emerging in welfare reform. Compulsory welfare quarantining or 'income management', where a proportion of welfare payments are withheld by government, has recently been adopted. It's argued that this policy merely punishes welfare recipients (ACOSS 2008). This hints at the formation of a MUD. Spandler (2007) argues that the switch from social exclusion to social inclusion leaves Australian social policy particularly susceptible to co-option by MUD discourses, because social inclusion does not illuminate the social structures and divisions that generate and sustain exclusion.

Conclusion

At this formative stage, the SIA suggests that disadvantaged and marginalised Australians will receive more inclusive and effective social welfare in the future. However, the question remains: to what degree is the SIA likely to move beyond the delivery of goods and services to promote a more inclusive, or 'fairer' (Rudd 2009a), Australia? In order to maximise the capacity of social inclusion approaches to 'improve the conditions of daily life' (CSDH 2008, p. 10), the public health community and those researching the social determinants of health must contribute to the debate surrounding the development of policies such as the SIA. As Raphael (2003) argues, social exclusion may be viewed as a (significant) social determinant of health. Knowledge of how to address processes of exclusion can therefore draw upon what we already know about the successes and failures of policy responses to other social determinants of health.

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