Engagement of medical professional associations in the distribution of specialist doctors to support universal health coverage in Indonesia, 2014

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Executive Summary

Disparities in the distribution of specialist doctors among the regions of Indonesia contribute to limiting access to referral services of rural and remote populations, and threaten achievement of the Millenium Development Goals (MDGs) and Indonesia’s introduction of universal health coverage.

Researchers at the Center for Health Service Management at Universitas Gadjah Mada (PMPK-UGM) identified the potential for medical professional associations (MPAs) of the various specialities to contribute to addressing this issue. They communicated the results of their research demonstrating the problem of mal-distribution of specialist doctors and the potential contribution of MPAs, to a range of relevant MPAs. The Indonesian Doctors Association (IDI), Association of Obstetricians and Gynaecologists (POGI), Association of Internal Medicine Specialists (PAPDI) and Association of Anaesthetists (IDSAAI) agreed to participate in a policy dialogue and communication study visit to the University of Melbourne in October 2011.

This case study followed up the action plans developed by the study visit participants, and interviewed the participants to identify any changes in attitudes, practices or policies resulting from the discussions, 15 months after the visit.

POGI demonstrated considerable progress in implementing its action plans, developing new guidelines on professional conduct, changing its attitude towards general doctors undertaking limited speciality services in under-served areas and developing a proposal for specialists in training to rotate through under-served areas. PAPDI has also been active, but with a focus more on concerns of members in ‘difficult areas’, including continuing medical education of members working in dual practice and incentives for ‘contract doctors’.

However, the Ministry of Health (MoH) has not been very receptive, limiting engagement to invitations to attend consultation seminars. There has been no liaison with POGI in regard to its proposal for speciality training rotations.

Constraints on more effective engagement include the lack of a clear role and procedure for engagement of external stakeholders at the MoH, and the reluctance of MoH policy makers to engage in potentially politically contentious dialogue. The capacity and governance of the MPAs have also been a constraint on their engagement. However, with the increasingly complex policy problems that confront the health sector, greater engagement is needed in order to achieve effective health system governance and better policy making.

Introduction

Indonesia faces a number of complex policy challenges in the health sector, particularly with the introduction of the national social security system and universal health coverage (UHC) in 2014. One particular challenge is the inequity in the distribution of the health workforce, which is concentrated in urban and wealthier areas and scarce in rural and remote areas. While overall average ratios of the health workforce to population are close to WHO guidelines, there is significant disparity in ratios between provinces.
Specialist doctors are essential for the provision of hospital services and achievement of the MDGs. Overall, in 2008, 12,295 doctors from 30 specialisations were reported as practising in Indonesia, with an average ratio of 5.38 specialists per 100,000 population. This compares to the Ministry of Health (MoH) target, outlined in Healthy Indonesia 2010, of six specialists per 100,000 (Ministry of Health, 2003). The highest ratio per 100,000 population was 30.95 in the capital Jakarta, and the lowest was 1.61 in East Nusa Tenggara province. More than half of Indonesia’s specialist obstetricians and 40 per cent of its anaesthesiologists work in Jakarta and other main cities (Meliala, Hort and Trisnantoro 2013).

The interests of the medical profession in Indonesia are represented by the Indonesian Doctors Association (IDI) and various specific medical speciality associations, which are all grouped under the umbrella of IDI. All doctors are required to be members of IDI and their respective specialist association, but the associations have tended to focus on issues related to the welfare and position of their members rather than broader public health policy.

In 2009, studies carried out by the Health Policy and Health Finance Knowledge Hub in partnership with the Center for Health Service Management, Universitas Gadjah Mada (PMPK-UGM), of the growth of non-state hospitals in Indonesia identified the key role played by doctors, especially specialist doctors, in the distribution and function of health facilities (Hort, Akhtar et al 2011).

Researchers at PMPK-UGM identified the growing private sector and commercialisation of the health sector as a key underlying issue. Issues related to this commercialisation included: low government salaries and increasing dependence on supplementary income from work in the private sector; lack of ethical standards controlling engagement in commercial activities; high tuition costs that need to be repaid on graduation; and an increasing income gap between general and specialist doctors.

At the same time, the Indonesian government moved towards more active regulation of the medical profession with the establishment of the Medical Council of Indonesia and new requirements for licensing of doctors, including participation in continuing professional development.

In 2011, researchers from PMPK-UGM undertook a series of consultations with IDI and MPAs to provide them with information on these policy issues and to gauge their interest and capacity to engage in broader public policy discussions. As part of these activities, PMPK-UGM and the Nossal Institute for Global Health (NIGH) co-hosted a policy dialogue and communication study visit for a group of Indonesian MPA leaders to Melbourne over a week in October 2011.

The purpose of the visit was to provide leaders from the Indonesian medical associations, the Indonesian Medical Council and policy makers from the MoH an opportunity to examine how MPAs in Australia engage in policy debate and policy development, and consider whether and how Indonesian medical professional associations could engage more actively in health system policy issues.

Specific objectives were:

- to compare the current role and responsibility of MPAs in Indonesia with international experience, particularly Australia’s;
- to describe the strategic action of MPAs to address physician distribution, retention, dual practice and incentives in Indonesia, based on current international best practice and experience.

During the policy dialogue visit, the MPA representatives and the participants from the Indonesian Medical Council and Ministry of Health developed action plans to address the issues they identified. Over the ensuing 15 months, researchers from PMPK-UGM continued to meet regularly with the MPA groups and to provide technical support to the implementation of the action plans.

In early 2013 PMPK-UGM and the NIGH undertook a case study of the impact of the efforts to engage the Indonesian MPAs in public policy through a series of interviews with MPA and MoH representatives. The focus of the case study is the extent of engagement of the MPAs that participated in the policy dialogue with the policy issue of the distribution of specialist doctors and the impacts of that engagement on policy.

Background

Role of MPAs in Addressing Public Policy

Universal health coverage in 2014 is a prominent milestone in Indonesia’s health system. It is packed within the health care reform strategy. UHC in Indonesia means that everyone has access to adequate promotive, preventive, curative and rehabilitative health care when it is needed, at
an affordable cost. The government has taken an important step through UHC to protect the equity of access to care and to provide financial protection for all Indonesians.

UHC requires strong regulation, the availability of competent providers and credible payers. All three should operate with harmonious relations and mutual support. However, one issue that needs attention is the availability of specialist doctors in health care institutions, especially in remote, border, and small island areas. The availability of specialist doctors is a critical factor for the success of universal health coverage.

MPAs are key in addressing mal-distribution. However, their involvement in health system policy issues is still questionable. At a workshop on ‘Health Care Professional Associations (HCMPAs) and Their Role in Achieving MDGs 4 and 5’ held in Dhaka, Bangladesh, in 2008, it was stated that HCMPAs have not been involved and have made a minimum contribution to health system performance. This was due to lack of communication with the government, lack of involvement in policy making, and attention that focused at micro level (hospital and clinical services) (PMNCH 2008).

Lalonde and Perron (2006) showed that professional associations in Canada could contribute to the development of maternal and child health (MCH) programs. Professional associations demonstrated that they could lead the health system by collaborating with its various components. Several steps were necessary to enable this contribution, namely: good management in professional associations’ organisation; capacity building for members to understand the health system and its challenges; enhancing credibility by producing evidence-based recommendations; and creating networks with many stakeholders.

The MPAs’ role within the health system also requires particular capabilities - awareness raising, political lobbying and standard setting - which are very important to influence national or international policy development. The Society of Obstetricians and Gynaecologists of Canada’s capacity building is based on the premise that strong and vibrant professional associations can assume a leadership role in the promotion of improved maternal, newborn and child health and thus contribute to the attainment of global and national goals and objectives, including the MDGs (Lalonde and Perron 2006).

This case study describes the program developed by the MPAs in Indonesia to tackle doctor distribution and its relation to the implementation of UHC 2014. It is important for the MPAs to create a new strategy to distribute or redistribute their members. Equity must be the trigger to develop particular programs and should be built into the health system and aligned with current national regulation. The government has already attempted several programs to distribute doctors and other health workers, but they have not been effective and have not addressed the fundamental issues. The MPAs’ program has to be linked with the expectations of the community, but also backed up by the government providing sufficient resources to support health professionals working in the field.

This study focuses on the awareness and contribution of MPAs to the implementation of UHC in 2014. UHC is a revolutionary way to finance the health service for every Indonesian citizen and changes the payment mechanism drastically, from retrospective to prospective. It would affect the physician’s way of practising and serving patients. Evidence shows that practice behaviour will be changed if the payment mechanism is changed. This is the first issue that should be identified within MPAs.

UHC demands the equitable distribution of doctors in all regions. According to the Ministry of Health and other sources, Indonesia has 93,000 general practitioners and 24,000 specialist doctors. However, they are not equally distributed and mainly work in Java. Every region in Indonesia must be able to receive an equal service, in terms of human resource qualifications and other resources. Inequity issues arise whenever the standard varies from region to region. Around 40 per cent of primary health centres have no doctors, and most of the remote district hospitals have insufficient specialist doctors. This is the second issue that is explored in this study: whether MPA executives have a good awareness of how the distribution of their members could support UHC.

Policy Dialogue and Discussion Visit to Melbourne, October 2011

Participants in the policy dialogue included leaders from the Indonesian Doctors Association, Indonesian Midwives Association (IBI), Association of Obstetricians and Gynaecologists, Association of Internal Medicine Specialists (PAPDI), Association of Anaesthetists (IDSAAl), Indonesian Medical Council and two staff from the Ministry.
of Health (Bureau of Personnel, and the workforce planning section of the MoH Health Workforce Development Board).

During the visit they consulted with representatives from the Australian medical professional regulatory agencies (Medical Board of Australia, Australian Health Practitioner Regulation Agency), the Commonwealth Department of Health and Ageing, medical professional associations (Australian Medical Association, Rural Doctors Association of Australia, Royal Australasian College of Physicians, Royal Australasian College of Surgeons), and with Australian health workforce researchers.

PMPK-UGM researchers also presented on the issues of the medical workforce in Indonesia and facilitated discussions on the role and function of medical professional associations and the policy challenges of Indonesia, including medical workforce distribution and professional practice.

The visit itself resulted in a number of changes of attitude among the participants, and in the development of action plans for their institutions. Changes noted included:

• improved recognition of common interest in health system problems and of the roles the different groups (MoH and MPAs) can play;
• increased understanding of the constraints and complexities involved in addressing issues such as mal-distribution of doctors;
• confirmation of the legitimacy of doctors’ engagement in policy from the experience of associations and colleges in Australia;
• new ideas on the role and function of medical professional associations, and on strategies to address workforce distributional problems.

Action Plans

The Indonesian Medical Association developed plans to continue to advocate for progress on the national social health insurance system, and for an increased budget allocation for health, while strengthening its organisational capacity through the appointment of a non-clinical executive officer, clarifying the role of the board in governance, and improving services for members.

POGi proposed to increase the focus on professional ethics, define standard competencies for specialists, undertake institutional reforms and incorporate rotations of trainees to under-served regions as part of the specialist training program.

The Ministry of Health planned to improve coordination and communication with MPAs in workforce planning and in developing policy on workforce distribution. It was also proposed to develop a regulation to support a new workforce distribution strategy.

The Indonesian Medical Council planned to support an assessment of the current distribution of general and specialist doctors, and to engage with the MoH in a needs assessment of doctors and specialists.

Methods

Follow-up Implementation of Action Plans By MoH And MPAs: Observational Research

Researchers from PMPK-UGM maintained regular contact with the MoH and MPA representatives who participated in the policy dialogue visit over the next 18 months, to March 2013. Through this contact they provided technical support and advice, and participated in some of the activities when requested. At the same time, the researchers recorded and documented the activities undertaken by the stakeholders.

Perceptions and Views of the Stakeholders: Interviews and Focus Group Discussions

Semi-structured interviews, framed by a question guide but with scope to explore items of import in depth were undertaken by two researchers: BA (NIGH) and AM (PMPK-UGM). The interviews were conducted in Jakarta over two weeks in March 2013, in Indonesian or through an interpreter.

The respondents were 10 key members or executives of the MPAs (Associations of Obstetricians and Gynaecologists, Internal Medicine, Cardiology and Anaesthesiology), and the executives of the Ministry of Health (Bureau of Personnel; Bureau of Planning, Health Workforce Development and Empowerment Board; Maternal & Child Health; Health Service).

The question guide is attached as Annex 1.

Focus group discussions (FGD) were also held with two executive members of each professional association (batch 1) and two heads of section in each bureau or directorate general (batch 2). Information from the FGD was used to triangulate the information collected in the interviews.

Where appropriate, documentary evidence of policy changes and plans was reviewed to confirm information provided from the other sources.
Results

Activities Undertaken by MPAs and MoH Following Policy Dialogue

Medical professional associations

Follow-up meetings with the executive of POGI found that the association had been active in adopting the learning from the policy dialogue. POGI discussed the proposed actions at its annual conference and developed and adopted new guidelines on professional ethical standards. POGI undertook developing a proposal to link training for obstetricians and gynaecologist (O&G) specialists through residency placements in under-served areas and has approached the MoH about support for this strategy. POGI also changed its policy from opposition to agreeing with the training of general practitioners (GPs) to undertake some O&G procedures for hospitals where no O&G specialist is available.

PAPDI invited PMPK researchers to present at an internal meeting and revised its strategic plan based on this input. PAPDI has also participated in seminars organised by PMPK on workforce issues and presented the issues faced by its members.

The Association of Anaesthetists has continued to participate in the follow-up seminars and discussions but has yet to make any internal changes to its organisation or policies.

Ministry of Health

The Health Workforce Development Board invited MPAs to participate in planning discussions for the first time in November 2011. The lack of doctors and particularly specialist doctors in remote areas was given new priority by the commitment of the government to introduce UHC by January 2014.

The Planning Department of the Health Workforce Development Board engaged with UGM researchers to develop a new workforce policy specifically for the problems of remote, under-served and border areas. Additional research was commissioned by the Planning Department to support the policy development.

PMPK-UGM

PMPK-UGM convened a series of seminars and meetings with individual MPAs and with the MoH to discuss retention of doctors and specialist doctors in under-served and ‘difficult’ areas and to consider the establishment of a specific association for doctors working in difficult areas. Representatives from the Rural Doctors Association of Australia were invited to share their experience.

PMPK-UGM has further developed distance training and communication modalities, particularly through its website, to keep doctors in remote areas informed on current policy issues and new research.

Perceptions and Views of Stakeholders

Awareness of professional associations on health system development

Interviews with professional associations identified that all were aware that the distribution of specialist doctors was an issue for both the MoH and their members. The perceived importance of this issue varied considerably, and therefore engagement with the MoH (or MPA members) also varied.

MPAs that had participated in the 2011 policy dialogue were more focused on engaging distribution issues with their members, but few appeared to have rigorously progressed or developed work plans to address this. POGI was the most focused MPA and had progressed its ‘distribution work plan’ developed from the workshop held in Melbourne in 2011. PAPDI has also been active, but with a focus more on concerns of members in ‘difficult areas’, including support of continuing medical education of members working in dual practice and incentives for ‘contract doctors’. IBI was aware of distribution issues, but identified this as the concern or role of provincial health offices, rather than an issue for IBI to be directly involved in.

MPAs were aware that the Bureau of Personnel (BoP) was responsible for the development of regulations relating to distribution, but few (except for a recent example from POGI) were proactive in approaching the BoP with concerns or recommendations. The usual way of engaging was to attend a discussion meeting at the BoP’s invitation.

UGM researchers identified that they originally raised the issue of distribution with MPAs in an attempt to move MPAs from a ‘self-interest’ motive to one more aligned with strengthening the broader health system.

MoH departments interviewed agreed that MPAs were aware of national issues relating to distribution, but overall still did not engage in a meaningful way with MPAs.
Management Capacity and Capacity Building of Professional Associations

The management capacity of MPAs varied, as did their desire to engage politically. POGI and PAPDI were identified by UGM researchers (and MoH) as the most proactive MPAs.

POGI has recently conducted an internal consolidation of its branches and increased communication between branches (through a website). It was also stated that the directorship had become much more proactive, and was now ‘ready to talk’ with the MoH because of its more consistent and ‘centralised’ approach.

POGI appears to be the most active of the MPAs, with an understanding of the role of a MPA similar to that of an Australian professional college. Similar to PAPDI, it has a proactive directorship and a relatively vocal membership. POGI also appears to be the most politically astute. An example is advocating internally that members treat Jampersal (publicly insured) clients, even though the Jampersal remuneration is much lower than they would receive privately. This was described as an altruistic measure by POGI members, but also recognised as a strategic move to provide POGI with greater leverage with MoH on other issues.

Programs of Professional Associations to Support Social Health Insurance

Of those interviewed, only POGI and PAPDI have progressed plans based on discussions at the Melbourne workshop. PAPDI established an internal committee to identify problems or areas of concern for the association. One of these was lack of awareness of where its members were working, so PAPDI has since mapped the distribution of members and used this in subsequent discussions with MoH on distribution regulations.

Interviews with POGI identified that it chose to be involved in specialist distribution because of the recognised high maternal mortality rate (MMR) throughout the country and with Indonesia not achieving the MDG goal in this regard. It felt there was insufficient attention given to this by the government. POGI recognises that one reason for the high MMR is the mal-distribution of specialists, and the altruistic motive is to ensure that members respond to this appropriately. One reflection is that the directors understand that achieving the MDG (MCH/MMR) goals is a focus of the government, and thus a trigger for greater political involvement by the association.

A direct outcome of the Melbourne workshop was the action plan developed by POGI to create a ‘bonding’ program between specialist training providers (universities) within three geographical zones. Each candidate entering an O&G specialist training program agrees to be ‘distributed’ for one year post-graduation and sent to a hospital in need, based on distribution data of that region collected by POGI. This program was developed and agreed to by POGI, relevant provincial and district governments and universities; however, it was done without awareness of a central regulation (Regulation 36, 2009) which states that it is the government’s responsibility to regulate distribution of health workers. POGI is therefore now unable to enact its plan.

Communication and Involvement of Professional Associations in Policy Development

Communication and involvement of professional associations in policy development was limited. Most MPAs, as well as MoH departments, stated that MPAs were involved in developing regulations or policies, mostly at the request of the convening department. However, this involvement was generally as a ‘discussion’ at the start of the development period, with limited or no follow-up as the process developed. The information requested by MoH departments appeared to be relatively superficial and based on reports, basic data or the personal experience of the MPA representative. There were few descriptions of the use of validated evidence or research to inform policy, with only the Bureau of Personnel identifying that it used surveys from the MoH Research Division (Litbankes) in preparation for the new distribution regulation.

The head of the Infant Health section of the MoH stated that she felt communication between associations and MoH has improved over the past four years. This was perceived to be the outcome of joint fieldwork and more active communication and linking, all of which have been supported by other actors, including research teams from UGM.

PAPDI reported that direct requests from MoH for data were now occurring due to personal and professional relationships between MoH officials and PAPDI (the vice-
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Impact of Associations’ Recommendations on National Health Policy

Overall, the impact of MPA recommendations in development of national policy appears to be limited. As one respondent stated, ‘There is limited impact because there is limited engagement’. All associations described their willingness to be more involved, but of those interviewed, only POGI and PAPDI were taking proactive approaches with MoH.

MoH departments indicated that they did not yet see a strong rationale for including MPAs in policy development, and they therefore had limited impact. They were invited for discussion at the start of developing regulations or policy, but this was more procedural than ‘useful’. One department indicated that MPAs should have only a limited role in developing national health policy because there were many associations, all with different agendas, and these agendas were focused on their membership rather than altruistic or patient/community focused. The clear identified role for MPAs was to provide data (such as mapping of doctors’ distribution), with a possible role in operational research; however, it was also noted that this was not currently being done.

The role of researchers appears to be a strong driver in enabling MPAs to engage in the development of regulations or policy. UGM researchers advocate directly with MoH and with MPAs on the potential benefits of engagement, and are also often used by departments to ‘informally discuss’ policy and research issues.

Discussion

The aim of the research communication and policy dialogue efforts with the Indonesian MPAs was to facilitate and encourage their engagement in relevant public policy development. This involved researchers in providing information not only on the specific issue, but also on the potential role that could be played by MPAs, the benefits of that role and building their capacity to undertake that role. Communication and policy dialogue needed to involve both the MPAs and the policy makers within the MoH.

This case study has identified the extent to which this aim was achieved, and some of the constraints to achieving it. Of the 15-20 specialist MPAs in Indonesia, only three (POGI, PAPDI and IDSAAI), together with IDI, agreed to participate in the activity. Of these, POGI and PAPDI went on to demonstrate changes in attitude and efforts to engage productively in public policy issues, particularly the distribution of the specialist workforce.

However, the effectiveness of their engagement has been limited. While the MoH has been willing to consult more with MPAs and consider their viewpoints in policy discussions, this has not translated into engagement in substantive or technical policy issues. This appears largely due to the policy making process within the MoH and the lack of a clear role and procedure for engagement of external stakeholders. The MoH policy makers involved in communication and policy making have continued to engage with PMPK-UGM researchers on policy issues, but have consulted only superficially with the MPAs.

The capacity and governance of the MPAs has been a constraint on their engagement, and those MPAs that have responded have also needed to make internal organisational changes.

Another constraint arises from the perspectives and capacity of policy makers in the MoH. The policy making ‘space’ is contested and open to political influence. MoH policy makers have indicated their preference to engage with ‘neutral’ and ‘academically reliable’ partners and their concerns about engaging with groups with political influence. They appear to lack skills and understanding of how to deal with stakeholders with their own agendas and
find it easier to attempt to exclude them from the policy process.

However, the increasingly complex policy problems that confront the health sector, and the progressive shift towards a mixed public-private health system, will require greater engagement of stakeholders in the health sector in order to achieve effective health system governance and performance. Researchers may still need to play a role not just in providing research evidence but also in providing models and support for effective policy making processes.

References


Annex 1. Question Guide

a. Interview

i. Professional association
   1. Awareness on national issues
   2. Management capacity
   3. Program development
   4. Communication and involvement
   5. Impact of recommendation

ii. MoH
   1. The professional association and its role within the health system
   2. Contribution of professional association’s program to the performance of health system
   3. Communication and involvement
   4. Contribution of professional association’s recommendation to the policy making process

b. FGD

i. Batch 1 (professional association)
   1. Identification of national issues that have been discussed in 2012
   2. The change of management system of professional organisation
   3. Identification of program developed to support national health policy
   4. Description of strategy to communicate and to involve in the policy making process
   5. Identification of delivered recommendation to the policy makers

ii. Batch 2 (MoH)
   1. Identification of professional association’s awareness in national health policy issue (specialist doctor distribution and social health insurance)
   2. Identification of professional association’s program contributed to the MoH
   3. Description of strategy by the MoH to enhance the involvement of professional association in the health system strengthening program
   4. Identification of recommendation of professional association that has been discussed with the MoH

c. Document review

i. Meeting notes
ii. Presentations
iii. Policy papers

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<th>Date</th>
<th>Institution</th>
<th>Activity</th>
<th>Result</th>
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<tbody>
<tr>
<td>November 2011</td>
<td>Planning Dept MoH workforce division</td>
<td>Planning seminar included MPAs</td>
<td>MPAs attended and provided input into workforce planning</td>
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<tr>
<td>January 2012</td>
<td>Planning Dept MoH workforce division; researchers from PMPK</td>
<td>Development of workforce policy proposal</td>
<td>Proposal includes reference to role of MPAs</td>
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<td>February 2012</td>
<td>PMPK</td>
<td>Seminar with MPAs on health system reform</td>
<td>Role for MPAs identified and constraints on fulfilling role</td>
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<tr>
<td>April 2012</td>
<td>Planning Dept MoH workforce division; researchers from PMPK</td>
<td>ToR for new guidelines for workforce distribution in under-served areas developed to address needs of UHC</td>
<td>MPAs included in guidelines; new strategy included in policies to address UHC</td>
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<td>April 2012</td>
<td>POGI and PMPK</td>
<td>Strategic leadership workshop for POGI</td>
<td>Dissemination of new approaches arising from policy dialogue visit</td>
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<td>May 2012</td>
<td>MPA and PMPK</td>
<td>Follow-up meeting to discuss action plans</td>
<td>Renewed commitment</td>
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<td>August 2012</td>
<td>Annual conference of PAPDI</td>
<td>Expanded meeting on role of MPAs in relation to UHC</td>
<td>Working group formed to create PAPDI policy on UHC</td>
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