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Health-care providers' perspectives on health-insurance access, waiving procedures, and hospital detention practices in Kenya

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Abstract

Background: Patients at Kenyan public hospitals are detained if their families cannot pay their medical bills. Access to health insurance and waiving procedures to prevent detention may be limited. This study explores the perspectives of health-care providers (HCP) on health-insurance access, waiving procedures, and hospital detention practices.

Procedure: A self-administered structured questionnaire was completed by 104 HCP (response rate 78%) involved in childhood cancer care.

Results: The perspectives of respondents were as follows: all children with cancer should have health insurance according to 96% of HCP. After parents apply for health insurance, it takes too long before treatment costs are covered (67% agree). Patients with childhood cancer without health insurance have a higher chance of abandoning treatment (82% agree). Hospitals should waive bills of all children with cancer when parents have payment difficulties (69% agree). Waiving procedures take too long (75%). Parents are scared by waiving procedures and may decide never to return to the hospital again (68%). Poor families delay visiting the hospital because they fear hospital detention and first seek alternative treatment (92%). When poor families finally come to the hospital, the disease is in advanced stage already (94%). Parents sometimes have to abandon their detained child at the hospital if they cannot pay hospital bills (68%). Detention of children at the hospital if parents cannot pay their medical bills is not approved by 84% of HCP.

Conclusions: HCP acknowledge that access to health insurance needs improvement and that waiving procedures contribute to treatment abandonment. By far, most HCP disapprove of hospital detention practices. These factors warrant urgent attention and adjustment.

KEYWORDS

health-care providers, health insurance, hospital detention practices, waiving procedures

1 | INTRODUCTION

Hospital detention practices (HDP) are defined as "refusal to release living patients after medical discharge is clinically indicated or bodies of deceased patients, when families are unable to pay hospital bills."[1] Every extra day in detention adds to the cost of patients' hospital bills. This increasingly hampers families' capacity to secure the release of their loved ones.[1–3] Some patients or their bodies are imprisoned for months in hospitals or mortuaries.[4,5] Sometimes, detained patients are entirely deserted by their families.[2–4] The Global Taskforce of the International Society of Paediatric Oncology has asked for attention to this insufficiently addressed problem. HDP take place in low- and middle-income countries in Africa, Asia, Latin America, and Europe.[1,6–10]

Most children with cancer live in low- and middle-income countries where chances of survival are low.[11] A prime ground for treatment failure in these countries is the abandonment of conventional cancer

Abbreviations: HCP, health-care providers; HDP, hospital detention practices; MTRH, Moi Teaching and Referral Hospital; NHIF, National Hospital Insurance Fund

treatment, which is defined as the failure to start or continue curative treatment during four or more successive weeks.[12–15] In Kenya, childhood cancer treatment outcomes at the Moi Teaching and Referral Hospital (MTRH) clearly illustrate this arduous situation where 54% of children with cancer abandon conventional treatment.[2]

Two previous studies conducted at MTRH found that national HDP may contribute to high abandonment rates.[2,3] The average imprisonment period for children with cancer at MTRH is 5 weeks (results from an unpublished study). Parents of detained children reported feelings of desperation and powerlessness because their child was imprisoned. Hospital detention was a traumatizing experience that encouraged the abandonment of conventional treatment and stimulated traditional alternative medicine usage, according to parents.[2,3] The vast majority of parents felt that hospital detention of children must cease.[3] In another study, we found that 40% of parents, who were aware of HDP, delayed coming to MTRH because they feared that their child would be detained.[16] We concluded that HDP are highly distressing for families and contribute to delays in health-seeking behavior and treatment abandonment.[2–5,16]

Similar to other countries where HDP take place, Kenya has both a national health-insurance scheme, as well as a waiver system aimed to be availed by the poverty stricken to fulfill medical disbursements, but both operate suboptimally.[2–4] Despite health-insurance affordability, less than 10% of Kenyans are insured.[17,18] In addition, the waiver procedures are not made easily accessible.[2,3,19] A previous study illustrated that 53% of all families without health insurance had their children detained at the hospital. In total, 37% of these families were not informed by medical staff that a waiver could be applied for.[2] Consequently, numerous poor patients lose their liberty and security over inadequate access to health insurance and waiving procedures.[2–4]

But what are the perspectives of government officials, hospital administrators, and health-care providers (HCP) on HDP? Reports and protests against these practices seem to derive mainly from journalists and human rights organizations.[4,5,19]

A Human Rights Watch report[4] about HDP in Burundi unequivocally mentions the following: "Official responses to hospital detentions have been confused and contradictory, vacillating between denial, justification, and misrepresentation. Hospital managers and government officials often minimize the problem, claiming that those who cannot pay their bills are released after a few days. Most refuse to use the term 'detention' to describe the practice. At the same time they justify the detentions as necessary, saying hospitals would be forced to close their doors if they could not use such means to oblige patients to pay their bills. Because government officials do not consider detention of patients to be a human rights violation, they take no measures to make hospital staff halt the practice, nor do they punish them for continuing it."[4]

However, HDP do violate numerous basic principles of international law.[4,19] In 1948, the United Nations Universal Declaration of Human Rights was created in response to the Second World War.[20] It consists of nine core international human rights treaties. Each treaty has a committee of experts to monitor its implementation. Of all 192 member states, 80% ratified at least four of nine core international human rights treaties.[21] Kenya joined the organization in 1963 and ratified seven treaties.[21] HDP violate, for instance, the International Covenant on Civil and Political Rights (ratified by Kenya in 1972); arbitrary detention of any kind disrespects its Article 9, which states that everybody has the right to liberty and security. Detention for nonpayment of a debt violates Article 11. Detention in crowded conditions with scarce food violates Article 10, which recognizes the right to not be imprisoned under unworthy inhumane conditions.[4,21,22] The International Covenant on Economic, Social and Cultural Rights (ratified by Kenya in 1972) is also violated; Article 9 acknowledges the right to social security, including social insurance, to protect people who cannot afford health care against sickness. Article 12 recognizes the right to the highest attainable physical and mental health standard.[4,21,23] In addition, detention of children violates various articles in the Convention of the Rights of the Child (ratified by Kenya in 1990); Article 9 recognizes that a child shall not be separated from their parents against their will. Article 24 affirms that no child can be deprived of their right of access to health-care services, particularly to diminish infant and child mortality. Measures must be taken to abolish traditional practices detrimental to children's health.[21,24]

Insights into perspectives of HCP on access to health insurance, waiving procedures, and HDP is lacking. Our study explores these perspectives of HCP involved in the care of children with cancer at a Kenyan academic hospital.

2 | METHODS

2.1 | Setting

Kenya is a lower middle-income country where half of the population lives below the poverty line.[25] Our study was carried out at MTRH, an academic hospital in Western Kenya. MTRH is one of the only two hospitals in Kenya capable of delivering comprehensive curative childhood cancer treatment. In spite of an expected 700 children with cancer below 15 years of age in the catchment area of MTRH, only 110 children are annually diagnosed with cancer, indicating that most families are not presenting with their children for diagnosis and treatment.[26] At MTRH, pediatric wards contain 72 beds, of which 12 are assigned to the pediatric oncology unit.

2.2 | Health insurance

Kenya's Health Ministry erected the National Hospital Insurance Fund (NHIF) in 1966. NHIF membership can be obtained by all Kenyans above 17 years of age. Nonemployed or self-employed NHIF members pay only 1.4 Euro per month for inpatient care of the contributor, their spouse, and their children. Employed NHIF members pay a monetary amount dependent on their wages.[27]

2.3 | Hospital detention practices

After clinical discharge by a doctor, children are detained at the hospital till their medical bills are paid or waived. Each supplementary hospital detention day is levied. Armed security guards are stationed at an iron gate at the entrance of pediatric wards to enforce these HDP. When parents do successfully flee with their child, their medical bills

must be covered by the security guard, social worker, and sometimes the nurse caring for the child.[2,3]

2.4 | Waiving procedures

Medical bills of destitute families can be partially or completely dismissed through waiving procedures. Social workers assemble information on families' financial circumstances and compose a report that is rendered to a waiver committee chaired by the principal administrator entrusted with hospital finance and governance. Waiving procedures have no written guidelines for social workers, patients, and their families. Criteria and regulations are absent. Access to waiving procedures is lacking and not all families are informed about this possibility.[2,3]

2.5 | Study design

This cross-sectional study consisted of a self-administered structured questionnaire. All 133 HCP working at the pediatric department of MTRH were contacted individually and asked to complete the questionnaire.

The questionnaire focused on HCP's perspectives on health-insurance access, waiving procedures, and HDP. Statements were evaluated on a three-point rating scale (agree/uncertain/disagree).

A panel of Kenyan, Indonesian, American, and Dutch doctors compiled and assured clear and appropriate statements. The questionnaire was pilot-tested for its content, linguistic clarity, and cultural sensitivities on five Kenyan HCP. Minor revisions were made based on the pilot test. The questionnaire was anonymous. Respondents self-identified their professional title. By definition, "doctors" were pediatricians, medical officers, and clinical officers. "Other HCP" were nurses, social workers, physiotherapists, occupational therapists, nutritionists, psychological counselors, or child-life health workers. This was the only demographic variable assembled. Respondents were guaranteed that their answers would remain confidential. The study was approved by the Institutional Research Ethics Committee.

2.6 | Data analysis

Frequency distributions were calculated. The Mann–Whitney test compared differences in perspectives on health-insurance access, waiving procedures, and HDP between doctors and other HCP. Data management and analysis were performed with SPSS for Windows version 20.0. A two-sided *P*-value less than 0.05 was considered statistically significant.

3 | RESULTS

Questionnaires were distributed to all 133 HCP of the pediatric department in January and February 2013. Table 1 shows that 104 HCP (response rate 78%) participated.

3.1 | Health-insurance access

The treatment of childhood cancer should be given a higher priority by the Kenyan government, according to 99% of HCP (Table 2). All children with cancer should have health insurance (96% agree). After parents apply for NHIF, it takes too long before health insurance starts to cover treatment costs (67%). Significantly more doctors (35%) than other HCP (17%) state that children with NHIF receive better care ($P = 0.004$). Patients with childhood cancer without NHIF have a higher chance of abandoning cancer treatment (82%). Significantly more doctors (62%) than other HCP (30%) state that children with NHIF have better survival chances than patients without NHIF ($P = 0.003$).

TABLE 1 Health-care providers participating in questionnaire study

Health-care providers	N	Response rate (%)
Pediatricians	9	69
Medical officers	4	80
Clinical officers	13	81
Nurses	41	71
Social workers	4	100
Physiotherapists	4	100
Occupational therapists	3	100
Nutritionists	2	100
Psychological counselor	3	100
Child life health workers	21	88
Total	104	78

3.2 | Waiving procedures

The hospital should waive bills of all children with cancer when parents have payment difficulties, according to 69% of HCP (Table 3). Waiving procedures take too long (75% agree). The approach of social workers toward waiving procedures, consisting of pressuring parents to pay, is too aggressive according to 44% of HCP, while 19% are uncertain and 37% disagree. Parents' experiences with waiving procedures contribute to high treatment abandonment rates (64%). Criteria of waiving are unclear according to 45% of HCP, while 15% are uncertain and 41% disagree. Parents are scared by waiving procedures and may decide never to return to the hospital again (68%). No significant differences in perspectives on waiving procedures were found between doctors and other HCP.

3.3 | Hospital detention practices

Due to HDP, poor families postpone coming to the hospital and first seek alternative treatment, according to 92% of HCP (Table 4). When poor families finally come to the hospital, the disease is in advanced stage already (94% agree). It is unfair to detain children at the hospital if parents cannot pay hospital bills (75%). Parents sometimes have to abandon their detained child at the hospital if they cannot pay hospital bills (68%). Children should not be left alone at the hospital, if their parents cannot pay hospital bills (84%). It is unfair that security guards and social workers must pay hospital bills if parents escape from the hospital with their child before bills are paid (74%). Detention of children at the hospital if parents cannot pay hospital bills is not approved by 84% of HCP. No significant differences in perspectives on HDP were found between doctors and other HCP.

TABLE 2 Health-care providers' perspectives on health-insurance access (n = 104)

Statements		All HCP Total, count (%)	Doctors Total, count (%)	Other HCP Total, count (%)	*P*
Treatment of childhood cancer should be given higher priority by Kenyan government	Agree	103, 102 (99)	26, 26 (100)	77, 76 (99)	ns
	Uncertain	1 (1)	0 (0)	1 (1)	
	Disagree	0 (0)	0 (0)	0 (0)	
All children with cancer should have health insurance	Agree	103, 99 (96)	26, 25 (96)	77, 74 (96)	ns
	Uncertain	2 (2)	0 (0)	2 (3)	
	Disagree	2 (2)	1 (4)	1 (1)	
NHIF covers cancer treatment completely	Agree	103, 39 (38)	26, 5 (19)	77, 34 (44)	ns
	Uncertain	27 (26)	10 (38)	17 (22)	
	Disagree	37 (36)	11 (42)	26 (34)	
It is unclear what is covered by NHIF	Agree	104, 32 (31)	26, 14 (54)	78, 18 (23)	0.003
	Uncertain	16 (15)	4 (15)	12 (15)	
	Disagree	56 (54)	8 (31)	48 (62)	
Patients and parents are not always informed about NHIF at diagnosis	Agree	103, 28 (27)	26, 9 (35)	77, 19 (25)	ns
	Uncertain	14 (14)	4 (15)	10 (13)	
	Disagree	61 (59)	13 (50)	48 (62)	
NHIF is affordable for the poor	Agree	104, 70 (67)	26, 18 (69)	78, 52 (67)	ns
	Uncertain	10 (10)	2 (8)	8 (10)	
	Disagree	24 (23)	6 (23)	18 (23)	
After parents apply for NHIF, it takes too long before NHIF starts to cover treatment costs	Agree	104, 70 (67)	26, 21 (81)	78, 49 (63)	ns
	Uncertain	4 (4)	1 (4)	3 (4)	
	Disagree	30 (29)	4 (15)	26 (33)	
Children with NHIF receive better care in hospital than children without NHIF	Agree	104, 22 (21)	26, 9 (35)	78, 13 (17)	0.004
	Uncertain	6 (6)	4 (15)	2 (3)	
	Disagree	76 (73)	13 (50)	63 (81)	
Families with NHIF have better relationships with hospital staff than families without NHIF	Agree	102, 24 (24)	25, 9 (36)	77, 15 (19)	0.020
	Uncertain	5 (5)	3 (12)	2 (3)	
	Disagree	73 (72)	13 (52)	60 (78)	
Patients with childhood cancer without NHIF have higher chance to abandon cancer treatment	Agree	101, 83 (82)	25, 23 (92)	76, 60 (79)	ns
	Uncertain	5 (5)	1 (4)	4 (5)	
	Disagree	13 (13)	1 (4)	12 (16)	
Patients with childhood cancer with NHIF have better chance of survival than patients without NHIF	Agree	102, 39 (37)	26, 16 (62)	76, 23 (30)	0.003
	Uncertain	18 (16)	8 (31)	10 (13)	
	Disagree	45 (48)	2 (8)	43 (57)	

HCP, health-care providers; NHIF, National Hospital Insurance Fund; ns, not significant.

4 | DISCUSSION

This study showed that most HCP think that all children with cancer should have health insurance and that it currently takes too long after applying for insurance before treatment costs are covered. A previous study found that it takes 2–3 months before NHIF becomes active and during these first uncovered months, the highest treatment costs are incurred.[3] HCP also acknowledged that children without NHIF have a higher chance of abandoning cancer treatment, which has indeed proven to be correct.[2] Half of all HCP denied that children with NHIF have better chances of survival, yet in reality insured children do have better survival rates.[2] Most HCP stated that the hospital should waive bills of all children with cancer when parents have payment difficulties. The majority

TABLE 3 Health-care providers' perspectives on the waiving procedure (n = 104)

Statements		All HCP Total	Count, n (%)
The hospital should waive bills of all children with cancer when parents have difficulties with payment	Agree	103	71 (69)
	Uncertain		20 (19)
	Disagree		12 (12)
Waiving procedure takes too long	Agree	102	76 (75)
	Uncertain		8 (8)
	Disagree		18 (18)
The approach of social workers in the waiving procedure toward pressuring parents to pay is too aggressive	Agree	103	45 (44)
	Uncertain		20 (19)
	Disagree		38 (37)
The experiences of parents with waiving procedure contribute to high rates of treatment abandonment	Agree	103	66 (64)
	Uncertain		16 (16)
	Disagree		21 (20)
Waiving procedure is a good procedure	Agree	102	51 (50)
	Uncertain		20 (20)
	Disagree		31 (30)
The criteria of waiving are unclear to me	Agree	103	46 (45)
	Uncertain		15 (15)
	Disagree		42 (41)
Waiving procedure positively influences the relationship parents have with hospital staff	Agree	103	42 (41)
	Uncertain		17 (17)
	Disagree		44 (43)
Parents are scared by waiving procedure and may decide never to return to hospital again	Agree	102	69 (68)
	Uncertain		13 (13)
	Disagree		19 (20)

HCP, health-care providers.

TABLE 4 Health-care providers' perspectives on hospital detention practices (n = 104)

Statements		All HCP Total	Count, n (%)
Due to hospital detention practices, poor families postpone coming to hospital, and first seek alternative sources of treatment	Agree	102	94 (92)
	Uncertain		2 (2)
	Disagree		6 (6)
Due to hospital detention practices, poor families postpone coming to hospital, and finally come with advanced disease stages	Agree	103	97 (94)
	Uncertain		2 (2)
	Disagree		4 (4)
It is unfair to detain children at hospital if parents cannot pay hospital bills	Agree	103	77 (75)
	Uncertain		18 (17)
	Disagree		8 (8)
Due to hospital detention practices, parents sometimes have to abandon their child in hospital if they cannot pay hospital bills	Agree	101	69 (68)
	Uncertain		11 (11)
	Disagree		21 (21)
Children should not be left alone in hospital if their parents cannot pay hospital bills	Agree	102	86 (84)
	Uncertain		4 (4)
	Disagree		12 (12)
It is unfair that security guard and social worker must pay hospital bills if parents escape hospital with their child before hospital bills are paid	Agree	103	76 (74)
	Uncertain		16 (16)
	Disagree		11 (11)
If parents have financial difficulties, relatives may force parents to abandon cancer treatment, because relatives are afraid that they also need to pay for hospital bills	Agree	103	77 (75)
	Uncertain		14 (14)
	Disagree		12 (12)
I approve of detaining children at hospital, if parents cannot pay hospital bills	Agree	101	8 (8)
	Uncertain		8 (8)
	Disagree		85 (84)

HCP, health-care providers.

of HCP thought that parents are scared by waiving procedures and may decide never to return to the hospital again. Almost all HCP stated that poor families postpone coming to the hospital due to HDP and first try to seek alternative treatment. Once poor families do finally come to the hospital, the disease stage is advanced already. HCP acknowledge that destitute parents sometimes have to abandon their detained child at the hospital and that this is not good for children's wellbeing. A crucial finding is that most HCP disapprove of detaining children at the hospital if parents cannot pay hospital bills.

Although we find in our study that most HCP disapprove of HDP, in daily reality HCP seem to accept and comply with enforced national policies. Yet, the instant when doctors discharge their patients and render medical invoices can denote transition from hospital therapy to hospital imprisonment for those unable to pay.[4] Doctors allow this to happen and thereby become accomplices to a human rights abuse.[4,20–24] It does not only create distrust in the relationship with their patients but also violates the oath they took which forms the foundation of medical ethics.[4] The Geneva Declaration, the present

enactment of the Hippocratic Oath, is very clear as it states the following: "The health of my patients will be my first consideration; I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient; I will not use my medical knowledge to violate human rights and civil liberties, even under threat."[28]

The question remains as to why there is so little protest from HCP in low- and middle-income countries against practices that unequivocally conflict with their core professional ethics? Similar to government officials and hospital administrators, some HCP may argue that hospitals simply need money to keep functioning and that the alternative would be that hospitals go bankrupt and no one receives medical care. Others may argue that the alternative would be to refuse treatment to the poor, which is considered to be worse.[4,29] Doctors may contend that this concerns politics beyond their professional expertise and influence. They may not feel empowered to act or do not know how to participate in campaigning against HDP. The lack of resistance, sense of responsibility, and remorse may also be cultural in nature; many low- and middle-income countries are based on collectivism.[30] In collectivist societies, the conservation of social harmony and showing respect to persons in higher positions in society have utmost importance. To fight injustice and help detained patients implies that social harmony is disturbed and leaders are criticized. This is considered to be worse, morally, than refraining from helping those in need.[30] Many low- and middle-income countries are deeply affected by corruption.[30–33] On a large scale, doctors, who receive full-time salaries to work in public hospitals, attend private practices during office hours. Patients in public hospitals are subsequently taken care of by inexperienced staff without supervision. This illustrates that taking care of the poor is not prioritized.[30,34] Those in power, including politicians, hospital managers, and doctors, may seem indifferent toward the fate and suffering of the poor.[30–34] Belonging to a higher socio-economic stratum themselves, they do not have to fear that their loved ones will ever be locked behind hospital bars. Without a direct threat to themselves, the need to stand up for the human rights of the vast majority of their countrymen and patients diminishes, particularly because this may jeopardize their own position and income.[30,31] Or maybe HCP are afraid to raise their voices in insecure countries that violate human rights. Most likely, the underlying reasons for this silent acceptance of the status quo among HCP are a combination of the accounts above.

Root causes of HDP need to be addressed. Health ministries in many low- and middle-income countries do not allocate their health budgets fairly and consistently to public hospitals due to financial mismanagement and corruption. Consequently, public hospitals do not accredit enough earnings from government subsidy, international and national donors, and patient amends to function well.[30–35] HDP may be installed to increase revenues.[4] International organizations and donor countries fund the health sector in these nations to a large extent, and hereby could enforce reforms. Notwithstanding this contingent control, the international community does not respond to the cry for help from detained patients and does not apply its power to stop hospital detention.[2–4,19,30,34]

Our study has various limitations. As this investigation has been conducted at a single institution, the restricted scope of the study population needs to be taken into account. In addition, participants' educational backgrounds and experiences with childhood cancer varied. Participants may have given socially desirable responses, as in Kenyan culture it is not acceptable to criticize.[30]

Mediation and endorsement by international organizations and donor countries is required to end HDP. International financial institutions (e.g. World Bank, IMF), health organizations (e.g. WHO), and donor countries should mandate that governments both end HDP, as well as mandate health-insurance coverage, through diplomatic pressure and stipulations for aid assignment. The United Nations need to concede that HDP violate the core international human rights treaties. Their committees of experts, that monitor its implementation, must investigate and report on hospital detention.[4,20–24] National governments in low- and middle-income countries must be counseled and equipped with tools to stop these offences. Legislation must be installed and executed to make HDP punishable.[1,4,7] Kenya already has an affordable health-insurance scheme. Mandatory health-insurance coverage must now be adopted and applied to improve access to health care for all its citizens.[30,35]

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CONFLICT OF INTEREST

The authors have no conflicts of interest to declare.

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REFERENCES

1. Mostert S, Lam C, Njuguna F, et al. HDP: statement of a global taskforce. *Lancet*. 2015;386:649.
2. Mostert S, Njuguna F, van de Ven PM, et al. Influence of health-insurance access and hospital retention policies on childhood cancer treatment in Kenya. *Pediatr Blood Cancer*. 2014;61:913–918.
3. Mostert S, Njuguna F, Langat SC, et al. Two overlooked contributors to abandonment of childhood cancer treatment in Kenya: parents' social network and experiences with hospital retention policies. *Psychooncology*. 2014;23:700–707.
4. Human Rights Watch and the Association for the Promotion of Human Rights and Detained Persons. A high price to pay: detention of poor patients in Burundian hospitals. 2006. http://hrw.org/reports/2006/burundi0906.
5. Sanders E. In Kenya, patients held hostage to medical bills. Los Angeles Times. June 27, 2009.
6. Hadjimatheou C. Greek hospitals tighten payment rules. BBC World Service, Athens. 2012. http://www.bbc.com/news/magazine-18073793.

7. Lythe R. Thought you'd get free care if you fell sick in Spain? Britons held hostage by foreign hospitals. Daily Mail. May 8, 2013. http://www.thisismoney.co.uk/money/holidays/article-2320851/Getting-hospital-treatment-holiday.html.
8. Sager J. Hospital refuses to give baby to mom until she pays for C-section. Parenting News. May 24, 2012. http://thestir.cafemom.com/baby/138084/hospital_threatens_to_hold_baby.
9. Abdikeeva A. Roma Health Rights in Macedonia, Romania, and Serbia. A Baseline for Legal Advocacy. The Open Society Public Health Program. 2013. https://www.opensocietyfoundations.org/sites/default/files/roma-health-rights-macedonia-romania-serbia-20130628.pdf.
10. Baby held hostage. February 12, 2007. http://fixcas.com/cgi-bin/go.py?2007a.Feb12a.
11. Kellie SJ, Howard SC. Global child health priorities: what role for paediatric oncologists?. *Eur J Cancer*. 2008;44:2388–2396.
12. Arora RS, Eden T, Pizer B. The problem of treatment abandonment in children from developing countries with cancer. *Pediatr Blood Cancer*. 2007;49:941–946.
13. Sitaresmi MN, Mostert S, Schook RM, et al. Treatment refusal and abandonment in childhood acute lymphoblastic leukemia in Indonesia: an analysis of causes and consequences. *Psychooncology*. 2010;19:361–367.
14. Arora RS, Pizer B, Eden T. Understanding refusal and abandonment in the treatment of childhood cancer. *Indian Ped*. 2010;475:1005–1010.
15. Mostert S, Arora RS, Arreola M, et al. Abandonment of treatment for childhood cancer: position statement of a SIOP PODC Working Group. *Lancet Oncol*. 2011;12:719–720.
16. Njuguna F, Martijn H, Langat S, et al. Factors influencing time to diagnosis and treatment among pediatric oncology patients in Kenya. *Pediatr Hematol Oncol*. 2016;33:186–199.
17. Joint Learning Network for Universal Health Coverage. Compare: population covered. www.jointlearning.org/program/compare/population.
18. Registration-NHIF: National Hospital Insurance Fund. www.nhif.or.ke/healthinsurance/customers. Accessed April 26, 2018.
19. Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities. Center for Reproductive Rights and Federation of Women Lawyers Kenya. 2007. https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bo_failuretodeliver.pdf. Accessed April 26, 2018.
20. United Nations. The Universal Declaration of Human Rights. http://www.un.org/en/universal-declaration-human-rights/. Accessed April 26, 2018.
21. United Nations Human Rights Office of the High Commissioner. Human Rights by Country. www.ohchr.org/EN/Countries/Pages/HumanRightsintheWorld.aspx. 2018.
22. United Nations Human Rights Office of the High Commissioner. International Covenant on Civil and Political Rights. www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx. 2018.
23. United Nations Human Rights Office of the High Commissioner. International Covenant on Economic, Social and Cultural Rights. www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx. 2018.
24. United Nations Human Rights Office of the High Commissioner. Convention on the Rights of the Child. www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx. 2018.
25. Central Intelligence Agency. The World Factbook: Kenya. 2011. https://www.cia.gov/library/publications/the-world-factbook/geos/ke.html. Accessed April 26, 2018.
26. Mostert S, Njuguna F, Kemps L, et al. Epidemiology of diagnosed childhood cancer in Western Kenya. *Arch Dis Child*. 2012;97:508–512.
27. NHIF: National Hospital Insurance Fund. Kenya. www.nhif.or.ke/healthinsurance. 2018.
28. World Medical Association. Declaration of Geneva. https://www.wma.net/policies-post/wma-declaration-of-geneva/ Accessed April 26, 2018.
29. Kippenberg J, Sahokwasama JB, Amon JJ. Detention of insolvent patients in Burundian hospitals. *Health Policy Plan*. 2008;23:14–23.
30. Mostert S, Njuguna F, Olbara G, et al. Corruption in health-care systems and its effect on cancer care in Africa. *Lancet Oncol*. 2015;16:e394–e404.
31. Transparency International. Global Corruption Report. 2006. http://www.transparency.org/whatwedo/publication/global_corruption_report_2006_corruption_and_health.
32. Lewis M; Center for Global Development. Governance and Corruption in Public Health Care Systems. Working Paper Number 78. 2006. http://www.cgdev.org.
33. Vian T. Review of corruption in the health sector: theory, methods and interventions. *Health Policy Plan*. 2008;23:83–94.
34. Narayan D, Chambers R, Shah MK, Petesch P; The World Bank. Voices of the poor. Crying out for change. 2000. http://openknowledge.worldbank.org/handle/10986/13848.
35. Save the children. The costs of coping with illness. East and Central Africa. 2005. https://www.savethechildren.org/content/dam/usa/reports/advocacy/annual-report/sc-2005-annualreport.pdf. Accessed April 26, 2018.

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