**JOURNAL OF RENAL CARE EDITORIAL FOR ISSUE 3/2016**

The theme of this year’s EDTNA/ERCA’s 2016 conference in Valencia, Spain is “Quality versus cost: sustainable renal care”. The Editorial in the September (conference) issue of the Journal of Renal Care often complements the theme of the conference, so this year my thoughts have turned to the tension that often results when the quality of kidney care is debated alongside the costs of renal replacement therapy (RRT).

So what does kidney care actually cost? Of course this varies in different European countries, but a recent report (Kerr et al, 2012) estimated the financial cost of chronic kidney disease to the National Health Service (NHS) in England. Economic modelling was used to estimate the annual cost of Stages 3-5 chronic kidney disease (CKD) to the NHS in England, including CKD-related medication and renal replacement therapy (RRT). The cost of CKD to the NHS in 2009-10 was estimated at £1.44 to £1.45 billion (1.72 to 1.73 billion euros), which was ≈ 1.3% of all NHS spending in that year. However more than half this sum was spent on RRT, which was provided for only 2% of the population who had been diagnosed with kidney disease. The report’s authors estimated that the mean annual cost of direct care for each patient on dialysis to be £27,000 (32,300 euros), the cost per transplant recipient at £12,000 (14,400 euros) and the cost per patient not on RRT at £235 (281 euros) (Kerr et al 2012).

The report acknowledged that the accuracy of cost estimates is of course dependent on the quality of the underlying data sources and the appropriateness of the assumptions made in the economic modelling. However, it is clear, that if a good quality CKD prevention programme can be implemented, the costs compare very favourably when comparing with the costs of dialysis.

If prevention is a favourable option, why are the numbers of people requiring dialysis still rising? This is a complex question to answer, but reasons include the ageing population, the rise in obesity leading to conditions such as Type 2 diabetes, plus people already undergoing dialysis living longer on RRT. It could also be that health care professionals working in kidney care are not focussing their attention enough on community awareness and prevention programmes.

So how many members of the general public are aware of kidney disease? A recent survey of 2000 people in the UK (Think Kidneys/Ipsos MORI, 2014), found that just 50% of those questioned knew that kidneys made urine. Just over two-thirds (68%) thought that too much alcohol damages kidneys, whilst only 10% knew that the kidneys had a role in blood pressure control. To raise awareness of kidney disease, the UK has recently focused the public’s attention on the ‘Think Kidneys’ campaigns – both on Acute Kidney Injury (AKI) and also on CKD. In July 2016 there was a national awareness campaign to raise awareness of kidneys – their importance for life and health and how to look after them. Messages, posters and an infographic (Think Kidneys 2016) were sent out to all communications teams in hospitals, press releases about the programme were sent out to local radio stations and posters were sent out to family doctors and pharmacies for display in public areas.

Awareness on its own is not enough. People with progressive kidney disease are not always being identified early enough in primary care. Data from the UK Renal Registry show major variation in late presentation rates (applied to patients who are first seen at a Renal centre less than 90 days before starting RRT): in 2013-2014, this proportion varied across UK renal 22 centres from 4.9% to 33.9% (Gilg et al 2016). A number of initiatives in the UK are focusing on earlier identification of people with progressive CKD. One such project (Managed by Kidney Research UK) uses software to map data from routine blood tests (eGFR), creating graphs of kidney function over time. For patients with deteriorating kidney function, participating laboratories in hospitals send a report, including the graph, to family doctors, with a prompt that specialist advice may be needed. This is based on an initiative that was reported in this Journal in 2013 (Kennedy et al 2013) and since 2005, the number of patients starting dialysis per year at this hospital has fallen by 16% compared with an increase of 8% in England as a whole. The unit also has the lowest late presentation rate for dialysis in the UK since CKD graphical surveillance was introduced.

As health care professionals working in the field of renal care, I would urge you to reflect on how far your renal unit focuses on prevention of kidney disease. Achieving outstanding quality care for patients and their families must be our highest priority, but often we are too busy to stand back and reflect on where best to spend the health care budget. The Benjamin Franklin axiom that “*an ounce of prevention is worth a pound of cure*” is as true today as it was when originally made in 1840.

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Think Kidneys Infographic (2016)

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