



Kidney Disease

*Invest now to control
rising healthcare
costs*

Pre-Budget Submission 2027

*"Because advanced CKD is a leading cause of **catastrophic health expenditures**, countries should include tests and treatments needed for early detection and timely treatment in universal healthcare packages"¹*

¹ <https://www.thelancet.com/series-do/chronic-kidney-disease>

Executive Summary

Chronic kidney disease (CKD) affects almost 500,000 people in Ireland, and 98% of those affected are unaware they have the condition². Despite this, kidney disease has historically been “*the neglected of the neglected*”³

The European Renal Association (ERA) notes that at least 30% of people with cardiovascular disease also have kidney disease, and vice versa, and the European Commission’s Safe Hearts Plan acknowledges the need to include CKD screening within cardiovascular risk-factor check-ups⁴. Left unaddressed, CKD is projected to become the fifth leading cause of death worldwide by 2040⁵.

A Kidney Disease: Improving Global Outcomes (KDIGO) Controversies Conference concluded that early detection is justified precisely because evidence-based interventions exist to slow CKD progression and reduce its complications, with treatment choice directly shaped by accurate diagnosis and staging⁶.

The cost of inaction is unsustainable:

- End-stage kidney disease (ESKD) currently costs the State close to €1 million per day (2023 figures) and is increasing annually. In the 5 years to year end 2023, the number of people on dialysis increased from 2,197 to 2,502 (an increase of 13.9%).⁷
- Despite welcome recent investment, dialysis units nationwide are operating at, or near, capacity. Patients are unable to travel within Ireland (including to attend family funerals) and EU citizens visiting Ireland cannot access dialysis during their stay. Legal advice received by the Irish Kidney Association indicates this may be in breach of Regulation (EC) No 883/2004 and EU Decision No S3 of 12 June 2009.
- Based on 2023 figures, a typical deceased donor kidney transplant functions for approximately 15 years at a total cost of **€255,299 per patient**. Dialysis for one patient over the same period costs **€1.87 million**.⁸

² [Chronic Kidney Disease in community-dwelling adults aged 50+ years in Ireland: A Report from TILDA and the National Renal Office \(NRO\)](#)

³ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(26\)00755-5/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(26)00755-5/fulltext)

⁴ https://www.era-online.org/wp-content/uploads/2026/01/ERA-Statement_EU-CVD-plan_2026.pdf

⁵ [World Health Organisation, Reducing the burden of noncommunicable diseases through promotion of kidney health and strengthening prevention and control of kidney disease.](#)

⁶ [The case for early identification and intervention of chronic kidney disease: conclusions from a Kidney Disease: Improving Global Outcomes \(KDIGO\) Controversies Conference - Kidney International](#)

⁷ National Renal Office Annual End of year figures 2019, 2023* See appendix at end of this document

⁸ Pg-7216-23 Colm Burke TD*See appendix at end of this document

- Early detection and treatment of CKD along with growth in the organ donation and transplantation programme would see a reduction in hospitalisations, emergency care demand, and productivity losses. Put another way, better patient outcomes whilst reducing costs to the health service.

The environmental cost is significant and growing:

- Studies have shown that heat exposure accelerates kidney function decline and increases hospitalisations for renal diseases.⁹
- Dialysis is among the most carbon-intensive forms of healthcare, with high energy, water, and single-use plastic demands.
- **Each haemodialysis session generates emissions equivalent to a 100km car journey¹⁰.** At year-end 2023, 2,197 patients were attending dialysis units around the country for treatment¹¹. Typically, this requires 156 sessions (3 times per week) per patient per year (342,732 sessions in total) - equivalent to emissions generated by over 34 million Km of car travel.
- In addition to the above, every in-centre dialysis session requires transport to and from the Unit. Taking the 2023 figures again, that is over 340,000 return journeys and the consequent emissions associated with the travel.

Early intervention, prevention, and system reform will reduce the financial, health, and environmental burden of kidney disease. Ireland currently has no overarching clinical model, programme or strategy spanning both transplantation and kidney health more broadly. As additional investment to expand dialysis capacity (in-centre, home, and assisted home dialysis) is expected to be proposed separately by the HSE, this submission focuses on measures that prevent or delay the need for that capacity in the first place.

⁹ [Valcheva E, Dimov N. Rising Global Temperatures and Kidney Health: A Comprehensive Review of Current Evidence. Life \(Basel\). 2025 Dec 11;15\(12\):1897. doi: 10.3390/life15121897. PMID: 41465836; PMCID: PMC12734593.](#)

¹⁰ [www.kidney-international.org/article/S0085-2538\(22\)01095-X/fulltext](http://www.kidney-international.org/article/S0085-2538(22)01095-X/fulltext)

¹¹ HSE National Renal Office . See Appendix at end of this document

This submission proposes four focused, high-impact measures, prioritised for their capacity to control rising healthcare costs:

These priorities represent different levels of the kidney care continuum:

1. **Measure and improve the system** (An Irish Kidney Disease Registry' embedded within the 'Irish Kidney Disease Data System (IKDDS)' national registry)
2. **Prevent disease progression** (screening and appropriate follow up care)
3. **Provide leadership for implementation** (primary care clinical lead)
4. **Optimise specialist treatment** (living donor transplantation target)

From a health system perspective, priorities 1 and 2 above are synergistic. Screening identifies patients earlier; and the registry measures performance, outcomes and equity while informing continuous improvement. Together, these initiatives would strengthen kidney care across the entire population and help mitigate the increase in healthcare costs.

Priority 1: Establish a National Kidney Disease Registry (including both End Stage Kidney Disease (ESKD) and the much larger CKD population).

Rationale:

A comprehensive national registry provides the infrastructure needed to measure disease burden, monitor quality of care, evaluate outcomes, support service planning, benchmark performance, and underpin research and policy.

Unlike screening, it does not directly improve patient outcomes, but it enables continuous quality improvement and informed resource allocation across the entire CKD pathway. Importantly, Ireland now has much of the necessary digital infrastructure, making this an achievable and strategically important investment.

A proof-of-concept pilot registry initiative (The Irish Kidney Disease Data System-IKDDS)¹² has made significant progress and will be transformative in providing the foundation for a broad set of functions that we currently lack and have historically lacked i.e.

- Comprehensive population-level surveillance of renal disease
- Evidence-based health service planning
- Equitable and efficient resource allocation
- Continuous quality improvement in clinical care
- Improved patient outcomes through earlier intervention and better coordinated care.

Proposal:

Formally establish a national kidney disease registry, integrated with existing health IT systems and governed by a formal oversight structure, tracking:

- Diagnosis and progression.
- Treatment pathways.
- Outcomes and service demand.

Impact:

- Enables evidence-based planning and resource allocation.
- Supports early intervention strategies.
- Improves transparency and accountability in care delivery, reducing regional inequities
- Enables earlier identification of high-risk patients with co-morbidities, allowing more targeted, cost-effective intervention.

¹² [An Irish Kidney Disease Registry' embedded within the 'Irish Kidney Disease Data System \(IKDDS\)](#)

Estimated cost:

€300,000 in 2027, offset over time by savings from earlier, better-targeted interventions reducing unnecessary hospitalisations.

Priority 2: Implement previous commitments to include chronic kidney disease screening within the Chronic Disease Management Programme.

Rationale:

As reported in the Lancet

"Because advanced CKD is a leading cause of catastrophic health expenditures, countries should include tests and treatments needed for early detection and timely treatment in universal healthcare packages"¹³.

In June 2025, speaking about the Chronic Disease Management Programme (CDMP), the Minister for Health stated in the Dáil that, "...a further expansion of the programme to **include chronic kidney disease is planned for the end of the year**, and further expansion would include rigorous clinical assessment and engagement with stakeholders."¹⁴

This has the greatest potential population health impact. CKD affects approximately 10–15% of adults, yet most individuals remain undiagnosed until advanced disease is present because symptoms are often silent. A simple urine and blood test which is in routine use enables CKD to be detected¹⁵.

The testing infrastructure already exists, through the Opportunistic Case Findings Programme, which is part of the HSE Chronic Disease Management Programme.¹⁶ This reported that it has enrolled approximately 27.9% of the eligible General Medical Services (GMS) card holders in the over 65 population and that CKD was detected in 14,370 people which represents 23.4% of the population screened¹⁷. It is unclear whether treatment protocols are being followed for this cohort, so there may be significant legal and financial risk to the State as patients have been identified as having CKD but may not be receiving treatment to prevent progression to end stage kidney disease.

By putting a focus on CKD, it enables earlier diagnosis, evidence-based interventions (including SGLT2 inhibitors, RAAS blockade and cardiovascular risk reduction), and prevention of kidney failure. It aligns with Sláintecare, chronic disease policy, and international recommendations while leveraging existing GP infrastructure rather than creating a new programme.

The HSE's National Renal Office (NRO) has been working on the guidance for early identification and management of CKD screening in primary care. A review

¹³ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(26\)00755-5/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(26)00755-5/fulltext)

¹⁴ <https://www.oireachtas.ie/en/debates/question/2025-06-26/9/speech/54/>

¹⁵ <https://www.nhs.uk/conditions/kidney-disease/diagnosis/>

¹⁶ PQ-7214/23, Colm Burke TD*, see Appendix at the end of this document

¹⁷ PQ-7213/23, Colm Burke TD*, see Appendix at the end of this document

group is currently being established to look at the guidance, to allow for screening to be rolled out in 2027.

Proposal:

- Implement the commitment to add CKD to the Chronic Disease Management Programme
- Ensure the completion of the guidance for early identification and management of CKD screening in primary care.
- Include CKD in all future screening/prevention strategies
- Resource the pathways required to manage CKD in primary care.(see also priority three)

Impact:

- Reduces progression to dialysis through earlier detection.
- Earlier diagnosis reduces the numbers moving to dialysis dependence, lowering the carbon footprint of renal care.
- Reduces the growth in long-term healthcare costs and improves patient outcomes - improving their ability to remain in work.

Estimated cost:

It is not possible to fully quantify the cost of the screening and follow up programmes as this is dependent on fees agreed with GP's¹⁸. It should be noted that deferral of dialysis by one year in just 24 patients would postpone additional dialysis and inpatient costs of €3 million.¹⁹ The additional cost of CKD screening is more than offset by its value for money and return on investment.

¹⁸ <https://ika.ie/wp-content/uploads/2024/12/Election-Manifesto-Budget-Sub-Online.pdf> Page 10

¹⁹ Annual cost of dialysis plus inpatient admissions is €125,000.(see appendix) multiplied by 24 gives €3 million

Priority 3: GP Liaison for Kidney Disease in Primary Care

Rationale:

CKD Stages 1 to 3 (the majority of cases) can be managed in primary care, but no structured coordination currently exists between primary care and specialist nephrology services.

Proposal:

Appoint a national dedicated GP liaison for kidney disease within the National Renal Office, working with regional primary care networks and stakeholders such as the ICGP. The role would:

- Work with the review group, update existing CKD management protocols, as other countries — including Australia — have already done, incorporating the latest treatments.²⁰
- Support earlier screening, diagnosis and treatment pathways.
- Coordinate care pathways with specialist nephrology services.
- Standardise referral and management protocols.
- Work with health promotion agencies to raise awareness of kidney health protection strategies, such as SADMANS guidance on medications to withhold during acute illness.²¹

Impact:

- Improves awareness of strategies to prevent or delay progression to dialysis amongst health care professionals in primary care
- Improves consistency of care across HSE regions.
- Reduces hospital pressures and late-stage presentations.
- Supports integration of services as set out in Sláintecare.
- Lead on delivery of self-learning digital education tools which enable patients to manage their kidney disease and reduce the speed or eliminate altogether the need for dialysis²²

Estimated cost:

Delaying dialysis by one year in a single patient would cover the cost of this part-time role.

²⁰ <https://kidney.org.au/health-professionals/ckd-management-handbook/>

²¹ [Protecting your high risk patients, produced by the IKA in association with the HSE National Renal office](#)

²² See Australian example, <https://kidney.org.au/ways-we-help/kidneyhealth4life/>

Priority 4: Establish 16-Week Target for Living Donor Transplantation

Rationale:

Transplantation is both clinically superior and significantly more cost-effective than dialysis, yet delays persist because of system constraints.²³

Proposal:

- Introduce a maximum 16-week target pathway from work-up to surgery for living donor transplantation, in line with practice elsewhere, including the UK. In Northern Ireland, most work-up tests are completed in a single day, with a maximum 12-week target to surgery.²⁴
- Ensure protected diagnostic, theatre, and bed capacity for living donor work-up and transplantation.
- Publish performance against target.
- Establish altruistic living donor panel as set out in the Human Tissue Act 2024 (part 2 transplantation) that was commenced in June 2025.

Impact:

- Reduces or eliminates time on dialysis and associated costs.
- The longer the length of time on dialysis the greater risk of additional health issues consuming more health care resources
- Improves patient survival and quality of life.
- Maximises use of living donor opportunities.

Cost implications:

This measure initially primarily requires process and procedural change, giving higher clinical priority to living donor assessments and setting up the independent altruistic living donor panel. Living donor transplant numbers have fallen sharply, from 50 in each of 2016 and 2017 to just 29 in 2025 - representing scope to deliver at least 21 additional transplants a year through improved service pathways.

²³ <https://www.medicalindependent.ie/in-the-news/paucity-of-transplant-infrastructure-leaves-services-vulnerable-to-failure/>

²⁴ http://www.donatelife.co.uk/?page_id=267

Conclusion

The time has come to redefine success in chronic kidney disease: remission should no longer be viewed as exceptional — it must become the standard of care.”²⁵

Kidney disease represents a silent epidemic with escalating human, financial, and environmental costs. Without action:

- Dialysis demand and healthcare expenditure will continue to rise. In the UK it was reported that kidney disease is a public health emergency that threatens to “overwhelm the NHS.”²⁶
- Hospitalisations and workforce losses will increase.
- The environmental impact of renal care will grow and remain unavoidable.

By contrast, targeted investment in screening, primary care coordination, faster transplantation, and data infrastructure will:

- Deliver substantial long-term savings.
- Improve patient outcomes.
- Align healthcare delivery with sustainability goals.
- **Every patient prevented from progressing to, or remaining on, dialysis is a win for patients, taxpayers, and the health service. Budget 2027 provides an opportunity to invest now and reduce greater costs in the years ahead.**

²⁵ [www.kidney-international.org/article/S0085-2538\(25\)00847-6/fulltext](http://www.kidney-international.org/article/S0085-2538(25)00847-6/fulltext)

²⁶ <https://www.kidneyresearchuk.org/2023/06/05/kidney-disease-is-a-public-health-emergency-that-threatens-to-overwhelm-the-nhs-major-new-report-reveals/>

Appendices

1. National Renal Office Statistics
 - a. 2019
 - b. 2023
2. PQ 7216/23, Colm Burke TD Costs of treating kidney disease
(It should be noted that these costs assume one dialysis session per hospital in patient stay, though patients need three to four dialysis sessions per week, so costs are understated.)
3. PQ 7214/23 Colm Burke TD, Blood and renal function tests performed in the chronic disease management programme.
4. PQ 7213/23, Colm Burke TD, Number of patients screened in the chronic disease management programme who had kidney disease.

National Renal Office Year End Statistics 31st December 2019																					
		HD contracted										HD HSE		Total							
Hospital Group	CHD Centre	SHD Satellite	Beacon Dialysis			Northern Ireland			Fresenius Dialysis				Wellstone Dialysis		Portlaoise	Total Incentre / contract	HHD	PD	Transplant	ESKD total	
			Drogheda	Sandford	Tallaigh	Newry	Omagh	Derry	NCross	Kilkenny	Limerick	Wexford	Galway								
Beaumont	163		61	5				1	47					18	48	798	277	18	48	798	1141
Cavan General Hospital	72															19	72			19	91
RCSI	235	0	61	5	0	0	0	1	47	0	0	0	0	0	0	1232	349	18	48	817	1232
St Vincent's University Hospital	86			62													148		9	167	324
Mater Misericordiae	83		19	2					34					0	9	274	138	0	9	127	274
Ireland East	169	0	19	64	0	0	0	0	34	0	0	0	0	0	0		286	0	18	294	598
Trinity Health Kidney Centre	110			29	87									5	44	341	226	5	44	341	616
Midlands Regional Hospital Tullamore	101															170	111		59	170	
Dublin Midlands	211	0	0	29	87	0	0	0	0	0	0	0	0	5	44	400	337	5	44	400	786
CUH/UHK	163	58												15	29	395	221	15	29	395	660
University Hospital Waterford	107													44	2	184	209	2	29	184	424
SSWHG	270	58	0	0	0	0	0	0	0	58	0	44	0	17	58	579	430	17	58	579	1084
University Hospital Limerick	130																199	9	20	132	360
UHG	130	0	0	0	0	0	0	0	0	69	69	0	0	9	20	132	199	9	20	132	360
MPUH/UHM	66	66															199	3	16	231	449
University Hospital Sligo	56																56		37	93	
Limerick University Hospital	64																69		76	145	
Scotia	130	122	0	0	0	0	1	4	4	0	0	0	67	3	16	344	324	3	16	344	687
National Adults	1145	180	80	98	87	0	1	5	81	58	69	44	67	52	204	2566	1975	52	204	2566	4747
Paediatrics																					
Temple St University Hospital	8													8	0	3	8	0	3	58	69
Crumlin Children's Hospital	0													0	4	1		0	4	1	5
Children's Hospital Group	8	0	0	0	0	0	0	0	0	0	0	0	0	8	7	59	8	0	7	59	74
Overall Total														1933	52	211	1933	52	211	2625	4821
Including Paediatrics																					

CUH = Cork University Hospital UHK = University Hospital Kerry MPUH = Merlin Park University Hospital UHM = University Hospital Mayo

Hospital Group	HD HSE		HD contracted							Status				
	cHD Centre	sHD Satellite	Beacon Dialysis				Northern Ireland			Fresenius Dialysis		Braun Dialysis		Total in-centre / contract HD
			Draghda	Sandyford	Tallaght	Newry	Omagh	Derry	McCross	Kilkenny	Limerick	Wexford	Galway	Portlaoise
Beaumont	184		88	1					59					910
Cavan General Hospital	76													76
RCSI	260		88	1					59					366
														16
St Vincent's University Hospital	87			90										167
Mater Misericordiae	96		20						44					168
Ireland East	163		20	90					44					335
														17
Tallaght Hospital	154		1	21	72									248
St James Hospital	3				29									32
TCD Associated Hospitals	157		1	21	101									280
M&HT	101													54
Dublin Midlands	253		1	21	101									435
														5
Cork University Hospital / UHK	177	59												236
University Hospital Waterford	105								48			59		210
SSWHG	262	53							48			59		446
														10
University Hospital Limerick	129										107			236
ULHG	129										107			236
														10
Galway University Hospital / UHGA	88	75										60		331
University Hospital Sligo	64													64
Letterkenny University Hospital	57							1						50
Scotia	209	75					1					60		333
														6
														19
														331
National Adults	1321	134	95	102	101			1	103	46	107	59	68	2191
Children's Health Ireland	6													6
Temple St University Hospital	6													11
OCH Crumlin														3
Grand Total	1327	134	95	102	101			1	103	46	107	59	68	2197
														57
														237
														2485
														2705
														17
														90
														3
														9
														3
														2502
														2755
														5190
														67
														59
														8
														5257

CUH = Cork University Hospital UHK= University Hospital Kerry
 VPUH = Merlin Park University Hospital UHM = University Hospital Mayo



22nd February, 2023

Deputy Colm Burke, TD
Dáil Éireann
Leinster House
Kildare Street
Dublin 2

RE: PQ 7216/23

To ask the Minister for Health the estimated cost of care for patients with end-stage renal failure in Ireland; and if he will make a statement on the matter.

Dear Deputy Burke,

The Health Service Executive has been requested to reply directly to you in relation to the above parliamentary question, which you submitted to the Minister for Health for response. I have consulted with the National Renal Office (NRO) on your question and have been informed that the following outlines the position.

The NRO monitors closely the number of patients with end-stage renal failure, also known as end-stage kidney disease (ESKD) receiving treatment in Ireland. These patients are treated either by dialysis or kidney transplantation.

In 2022, the number of patients requiring treatment by dialysis or kidney transplantation increased to 5,077 adults and 71 children. On January 1, 2023, the number of patients receiving dialysis was 2,466, with a further 2,682 patients living with a functional kidney transplant.

The cost of providing care for patients with end stage renal failure can be broken down to outpatient dialysis treatment, inpatient dialysis care and care of patients with kidney transplantation. The total is estimated to be in excess of €352 million per annum.

These costs are detailed below.

Outpatient dialysis care

The costs of providing In-Centre Haemodialysis is €228 million per annum broken down to €154.5 million for treatment in HSE hospitals and €73.5 million for treatment in HSE contracted satellite dialysis units. The costs of providing home dialysis therapy is €15 million per annum.

Inpatient dialysis care

Patients on dialysis require inpatient care to treat the complications of dialysis. This is estimated to be in excess of 75,000 bed days and cost an additional €65 million per annum

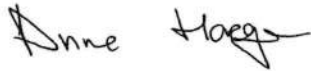


Kidney Transplant care

The costs associated with the provision of immunosuppressive therapy and close monitoring of kidney transplant patients is estimated as €27 million per year. In 2022, 163 kidney transplants were carried out by the National Transplant Programme at a cost of €17 million.

I trust this information is of assistance to you, but should you have any further queries please do not hesitate to contact me.

Yours sincerely



Anne Horgan
General Manager



Oifig an Stiúrthóra Cúnta Náisiúnta
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Deputy Colm Burke
Dáil Eireann,
Leinster House,
Dublin 2.

6th March 2023

PQ7214/23 - To ask the Minister for Health the blood tests and renal function tests offered to patients as part of the opportunistic case finding assessment under the chronic disease management programme are routinely being used by GPs to diagnose chronic kidney disease; and if he will make a statement on the matter. -Colm Burke

Dear Deputy Burke,

I refer to your parliamentary question, which was passed to the HSE for response.

The blood tests included in the Opportunistic Case Finding Programme of the CDM are;

Full blood count

Creatinine,

Urea and Electrolytes

eGFR

The following are also included if clinically indicated;

HbA1c

Lipid profile

Pro BNP

Urine is tested for proteinuria and haematuria.

Chronic Kidney Disease is important to identify and properly manage, if kidney damage is identified through the OCF Programme patients are enrolled in the Prevention Programme. It is hoped to extend the CDM Programme in 2024, if funding is made available, through the 2024 NSP, to include Chronic Kidney Disease in the CDM Treatment Programme.



I trust this is of assistance.

Yours sincerely,

A handwritten signature in blue ink, which appears to read 'G. Crowley', is positioned below the 'Yours sincerely,' text.

**Geraldine Crowley,
Assistant National Director,
Enhanced Community Care Programme &
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Date: 15/02/2023

Deputy Colm Burke, TD
Dáil Éireann
Leinster House
Dublin 2

PQ No. 7213/23

To ask the Minister for Health the number of public patients aged 65 years and over diagnosed with chronic kidney disease in 2022; and if he will make a statement on the matter.

Dear Deputy Burke,

The Health Service Executive has been requested to reply directly to you in the context of the above Parliamentary Question, which you submitted to the Minister for Health for response. I have examined the matter and the following outlines the position.

Response:

Chronic Kidney Disease (CKD) is the general term for persistent irreversible damage to the kidney. In its earliest stages, the patient has no symptoms and the kidneys have little or no structural damage.

Guidelines do not support a national screening programme to measure CKD as 90% of patients with CKD have mild disease and can be safely managed in a primary care setting by their GP and will not require specialist interventions. Chronic Kidney Disease tends to progress if undetected and untreated. In some cases, the kidney damage can progress to a point where there is complete kidney failure and such patients require treatment with dialysis and/or kidney transplantation.

The National Renal Office is tasked to manage the strategic governance of patients with complete kidney failure. The national monitoring system of patients with complete kidney failure known as the Kidney Disease Clinical Patient Management System

shows that as of Dec 2022 over 40% of patients with EKSD (n= 2006) were over 65 years.

Attached is a link to patients with ESKD data for 2022:

<https://www.hse.ie/eng/about/who/cspd/ncps/renal/resources/nro-statistics-end-of-year-2022.pdf>

There are approximately 10% of the adult population ~ (450,000 people) suffer from some form of chronic kidney disease (CKD). The prevalence of patients with Chronic Kidney Disease is increased in the elderly. Based on the 2016 CSO census, it is estimated that approximately 150,000 Irish people over the age of 65 have some degree of Chronic Kidney Disease.

The HSE Chronic Disease Management Program reported recently that it has enrolled approximately 27.9% of the eligible GMS over 65 population and that CKD was detected in 14,370 which represents 23.4% of the population screened

I trust this answers your question to your satisfaction.

Yours sincerely,



Emma Benton

General Manager

Acute Operations