

Ethnicity disparities in patients with kidney failure in England and Wales

A UK Kidney
Association
Disparities
Sub-report



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| What is this document?

This document is part of the UK Kidney Association's Disparities Report, which looks at age, sex, ethnicity, and social and economic factors amongst people with kidney failure. The analyses presented here are for ethnicity. The reports looking at age, sex, and social and economic factors are available [here](#).

The decision to share these routinely collected data reflects increasing awareness that kidney health is strongly influenced by people's backgrounds. A document published by Kidney Research UK in 2018 highlighted how kidney disease is more likely, progresses faster, and is associated with earlier death amongst people from more deprived backgrounds. It also progresses faster in people from Black, Asian and UK minority ethnic populations, who are also less likely to receive a transplant. Women are more likely to get kidney disease, but men are more likely to start dialysis. Older people are less likely to receive a transplant. Organisations like the UK Kidney Association were advised in Kidney Research UK's report to make reporting and analysis of inequalities in kidney care part of their role.

Reporting of these disparities is the purpose of this document. We use the term 'disparities' as opposed to 'inequalities' for this report because it only looks at differences in the care and outcomes of patient groups. We are not able to provide insight on whether care and outcomes would be equal or fair, if all differences between the groups were considered. This is discussed further under *A note on statistics*, below.

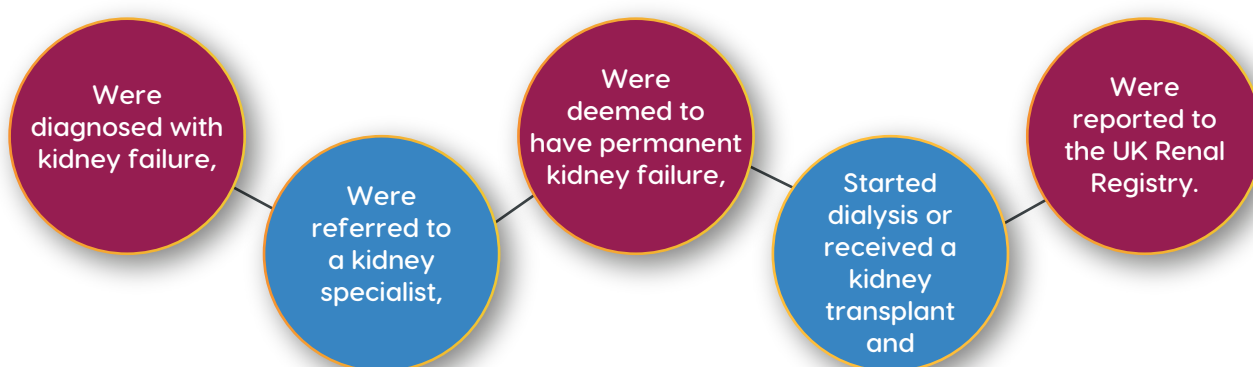
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Whose data are shown?

This report includes all adults and children in England and Wales reported to the UK Renal Registry as having started long-term treatment for kidney failure between 1st January 2014 and 31st December 2020. UK Kidney centres provide care for either adults or children. Adult centres reported 49,078 people. Children’s centres reported 755 people under the age of 16. These are the same people who were in the UK Renal Registry’s [annual reports](#), where you can find more information about how these data reach us.

All people included in this report:



The UK Renal Registry does not reliably capture information on individuals who reach kidney failure, but do not start dialysis or receive a transplant – so these people cannot be included. Individuals who needed temporary dialysis are also not included.

What data are shown?

Whilst we hold detailed information about individuals' kidney care, we hold only limited information about who they are, taken from the health record provided by the kidney unit providing the person's care.

We present the following characteristics:

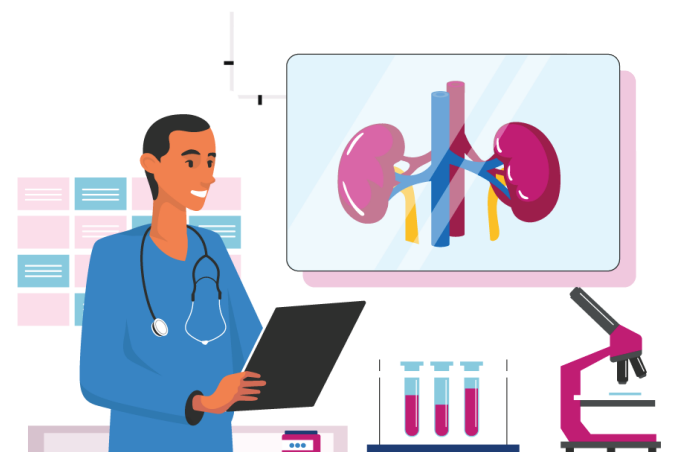
- Age in years
- Binary male / female sex as assigned at birth
- Ethnicity categorised as per the [Office of National Statistics](#) – Asian, Black, Mixed, Other, White, or missing
- Socioeconomic deprivation - This is based on a measure of deprivation called the "Index of Multiple Deprivation" [based on where the individual lives](#).

We do not hold any data relating to the following protected characteristics: disability, gender and gender reassignment, marital and partnership status, pregnancy and maternity, religion and beliefs, or sexual orientation. The absence of these characteristics – or others such as mental illness – from this report does not mean that they are not associated with disparities in kidney care.

We present the following medical and health factors:

Diagnosis of diabetes, since this is a common cause of kidney failure	Whether the individual first met a kidney specialist more than three months (early presentation), or less than three months (late presentation) before starting treatment
Survival one year after starting treatment for kidney failure	Starting treatment type: hospital haemodialysis, home treatment (peritoneal dialysis or home haemodialysis), or a pre-emptive kidney transplant (transplantation without first doing dialysis)
Whether or not the person has been transplanted within three years of reaching kidney failure	

| How were these factors chosen?



The presented factors were chosen by people living with kidney disease, supported by clinicians and researchers. Our aim was to provide accessible data describing the care and outcomes of people living with kidney disease, without overwhelming detail. If you think something is missing, or you would like access to the UK Renal Registry data, please contact us [ukka@ukkidney.org].

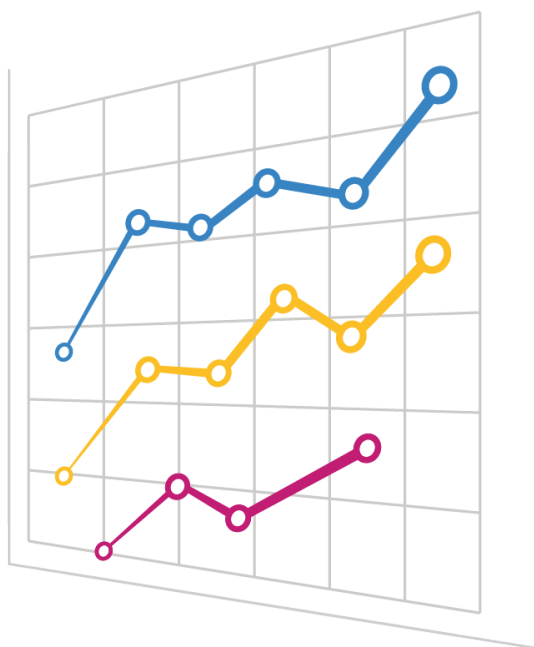
We chose to present data from 2014 onwards as the UK Kidney Association last formally reported on [inequalities in kidney health in 2013](#).

Some analyses use general population data, drawn from the Office of National Statistics, whose data are [openly available](#). At the time of preparing this document, the published 2021 census data were incomplete, so data were drawn from the 2011 census, or ONS annual reports, where available.

While the data held by the UK Renal Registry provide the most reliable indicators of national kidney care, some of the data are incomplete. Complete data means that we have information for every person about a factor in a given centre or country – for example we have the age of every person in the database.

Completeness varies by centre. This means that we can be less certain about the importance and effects of some factors, especially when making comparisons between centres. Completeness is not the same as accuracy – we may hold a diabetic status for every record, but some of those listed as not having diabetes may have it, and some listed as having it may not.

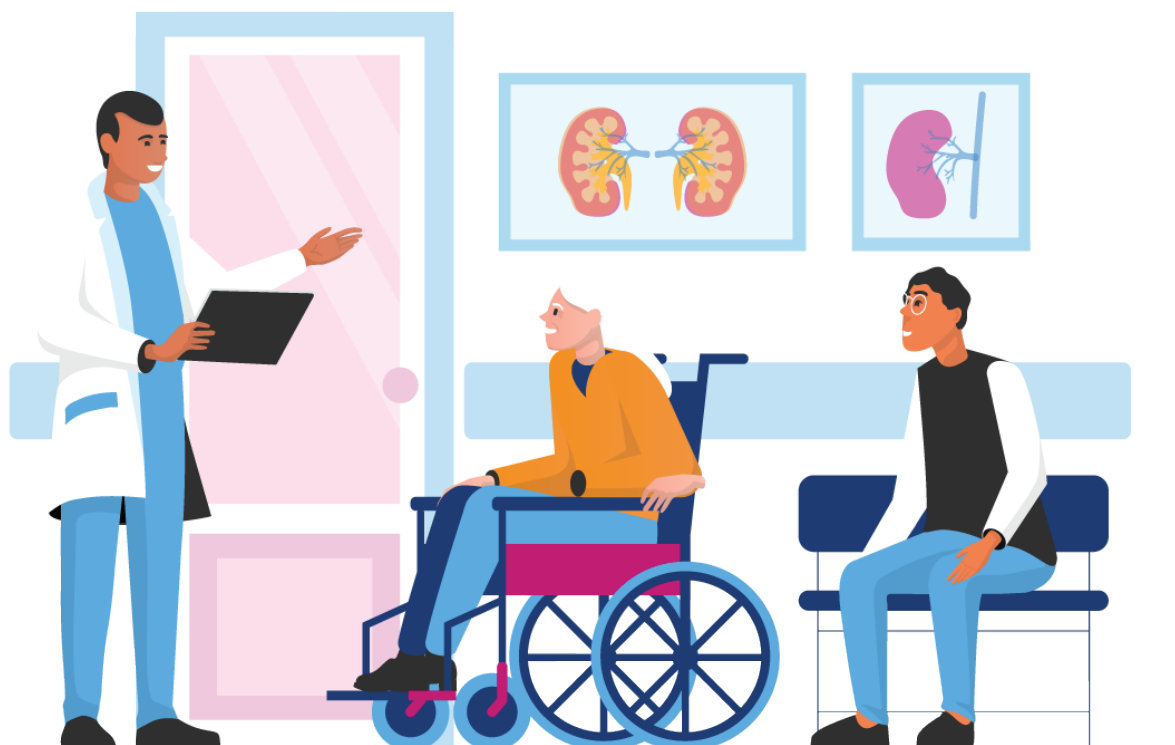
A note on statistics



Associations between people's characteristics and healthcare must be made carefully, because one thing may not cause the other. This gets complicated because people's characteristics tend to group together, and it is not straightforward to tell which is 'most important'. For example, diabetes is one of the main causes of kidney failure, and a risk factor for other health problems such as heart disease. Rates of diabetes differ markedly between ethnicities. So, when comparing ethnicities, comparisons are also unintentionally made between those with higher and lower rates of diabetes. On the other hand, comparing those with and without diabetes leads to unintentional comparisons between people from different ethnicities. Ethnicity is itself a risk factor for kidney failure and is associated with social and economic factors.

Researchers often use statistics to 'adjust' for such effects. This means using maths to unpick how much of one thing would be explained by another if all other things were equal. For example, examining how the age of onset of kidney failure would differ between ethnic groups if diabetes were equally common in each. These approaches can improve understanding of data, often revealing 'invisible' patterns. However, the output is less intuitive, and 'real-life' meaning can be lost. For example, such analysis would 'adjust away' the association between ethnicity and diabetes. This may not be meaningful if higher rates of diabetic kidney disease are genetic – a risk factor that cannot be eliminated. No statistical adjustment is provided in this report. Instead, the tables and figures have been designed to help people see patterns in the data.

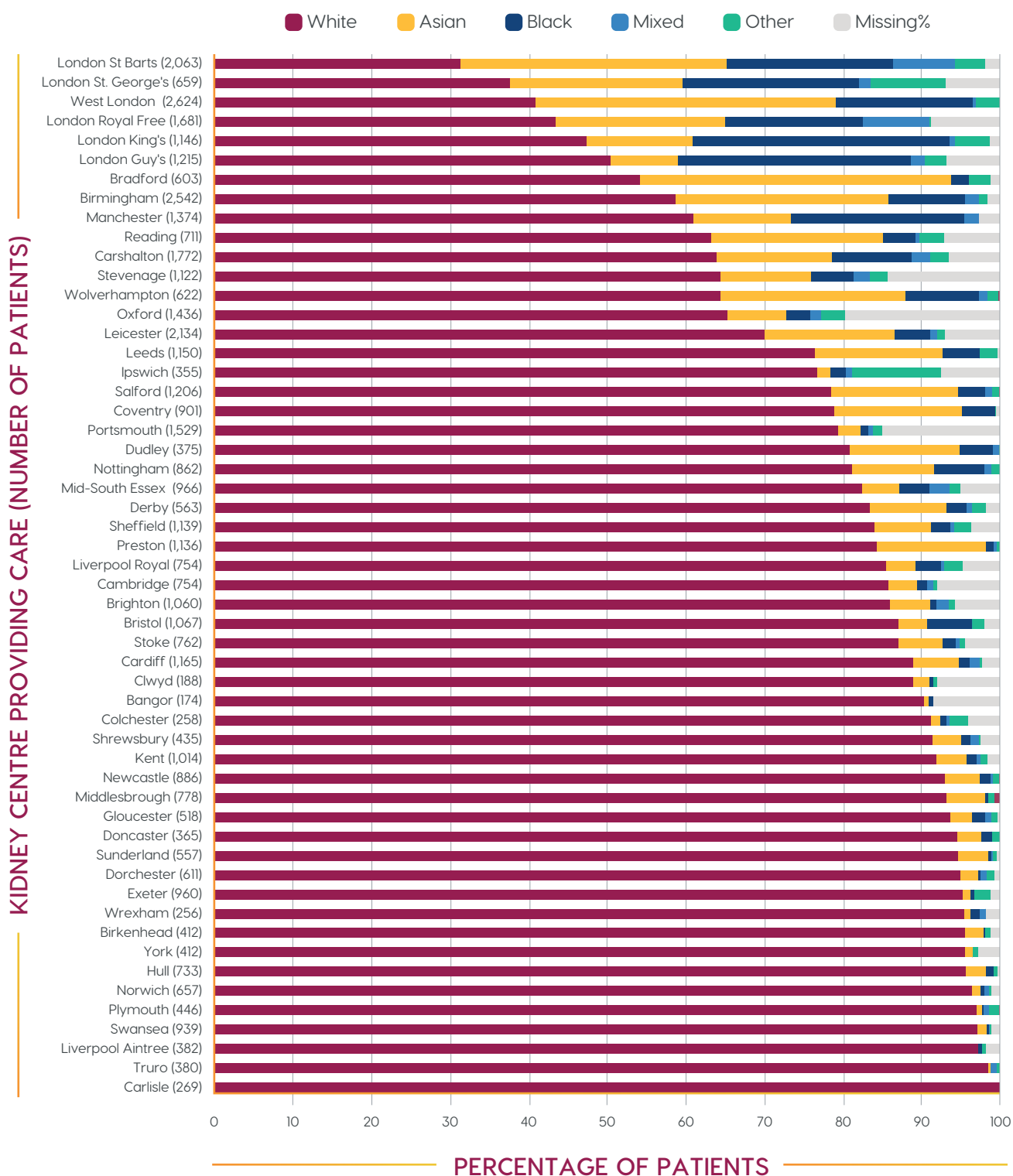
1 Ethnicity at each kidney centre



The following figures show the ethnicity breakdown for the kidney failure population at each of the adult and children’s kidney centres in England and Wales. The populations cared for differ in their size and ethnic diversity. These differences represent the regional populations served by each centre.

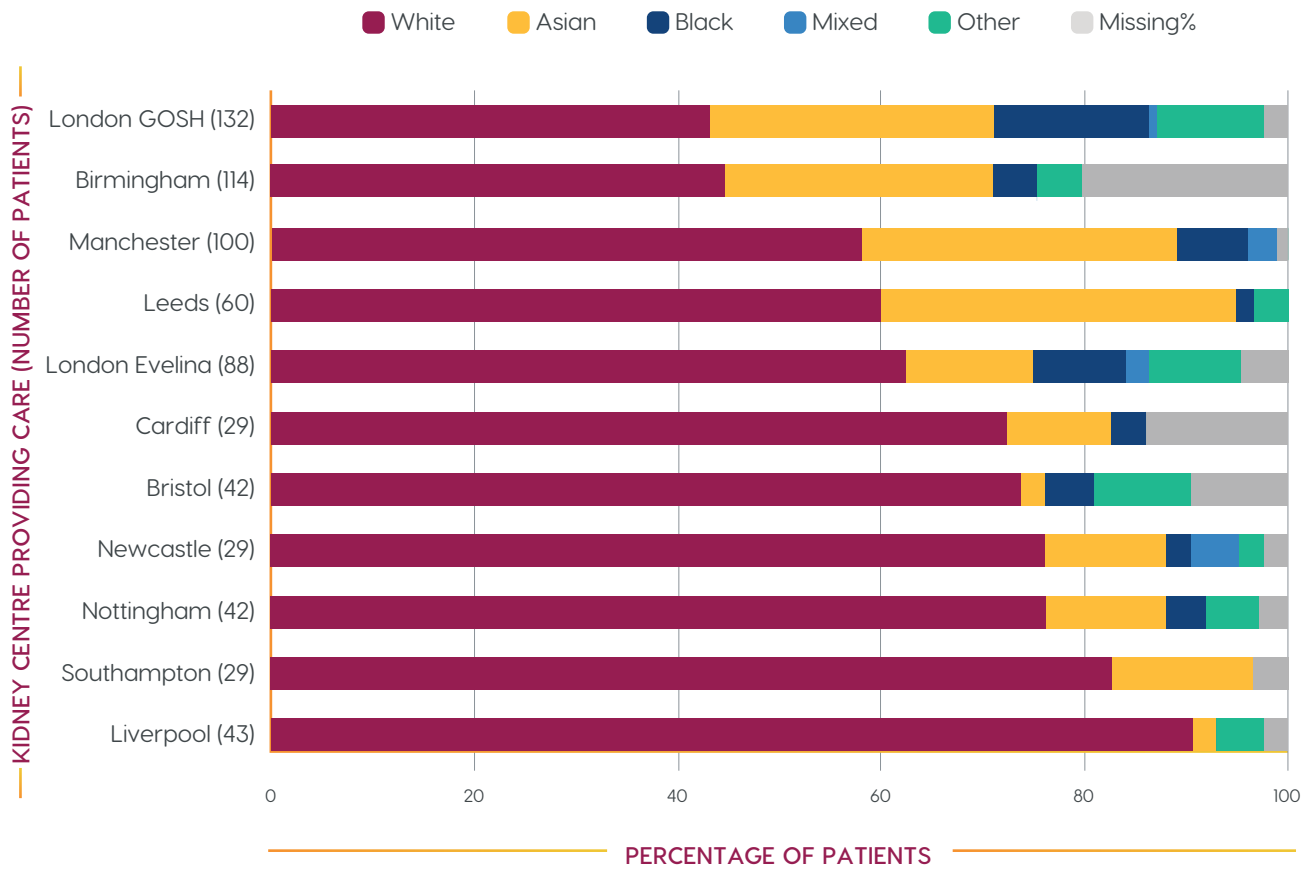
The total number of individuals cared for in each centre is listed next to the centre name. The coloured bars show the ethnic breakdown of the population with kidney failure treated at each centre. Ethnic groups are displayed in the following order: White / Asian / Black / Mixed / Other / Missing %. This ordering was chosen to allow easy comparison between centres – most of which care for a majority-White population. Elsewhere in this report, ethnicity is listed alphabetically.

Figure 1a – Ethnicity of adults by treating centre (%)



Number and ethnicity of adults reported to the UK Renal Registry who started treatment for kidney failure between 2014 and 2020

Figure 1b – Ethnicity of children by treating centre (%)

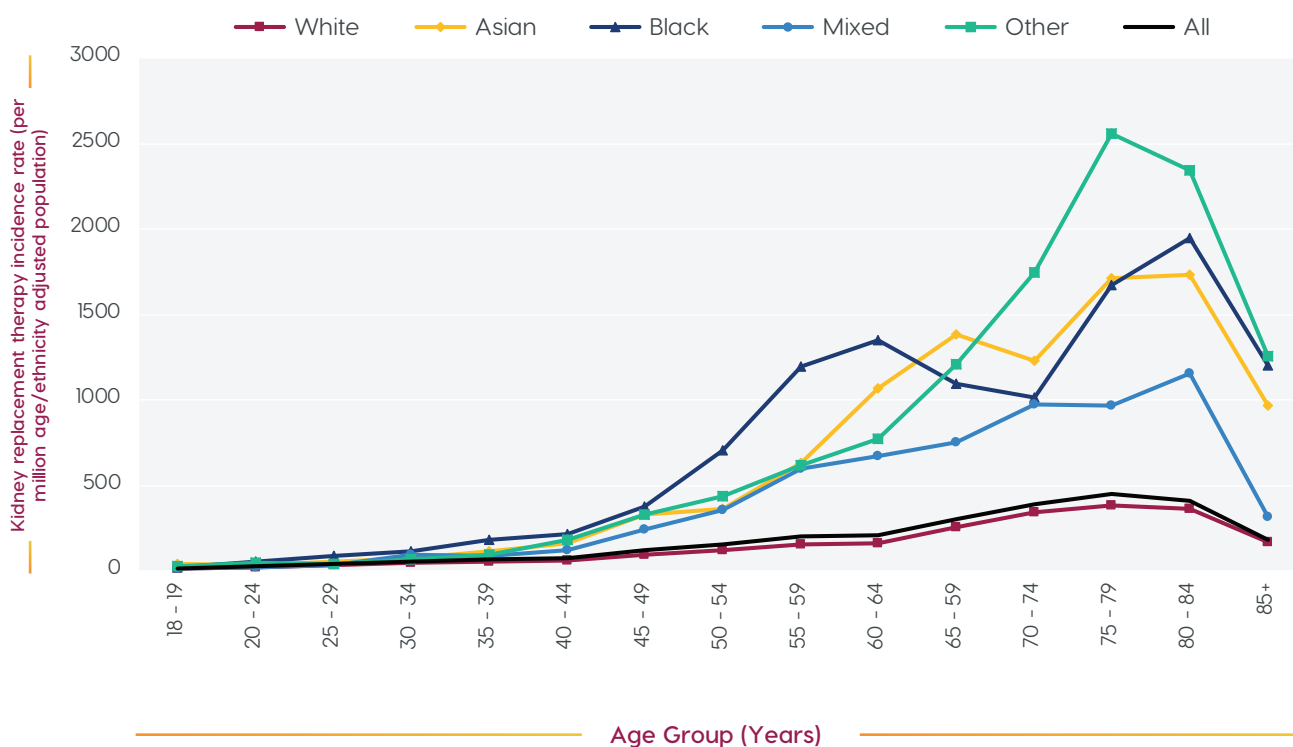


Number and ethnicity of children reported to the UK Renal Registry who started treatment for kidney failure between 2014 and 2020. GOSH- Great Ormond Street Hospital.

2 Ethnicity, age and sex

Figure 2 shows rates of adults starting treatment for kidney failure – so called incidence. Along the horizontal axis is age, so that incidence rates can be compared between age groups. The vertical axis shows the number of people who started per million people in the population, labelled ‘age/ethnicity adjusted population’. For each ethnicity, the rate is calculated using the number of people of that ethnicity who started treatment, per million people in the population with the same ethnicity. For each age group, the rate is calculated using the number of people who started treatment, per million people in the population in the same age group. The rates for the total population (solid black line) and the White ethnic group (solid dark red line) look very similar because White is the most common ethnic group in the UK.

Figure 2 – Incidence rates for adults by ethnicity per year



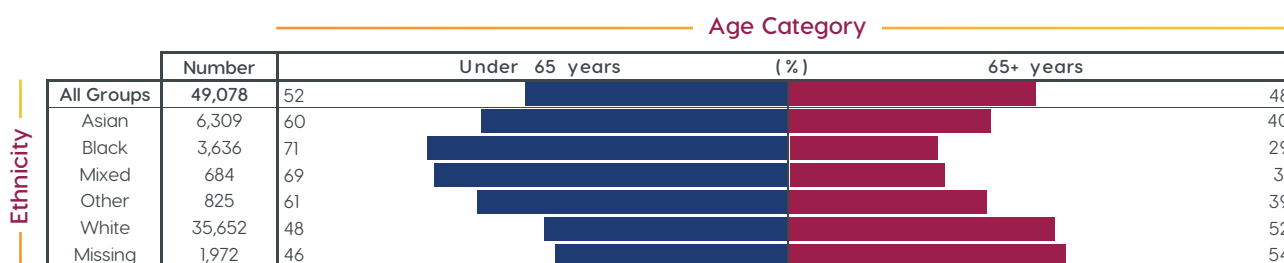
The rate of new adult patients starting kidney replacement therapy (incidence) between 2014 and 2020 by age group and ethnicity per year per million age/ethnicity adjusted population (using age and ethnicity data from the 2011 Census).

Main Findings

- Adults whose ethnicity is Other, Black, Asian or Mixed have a much higher likelihood of kidney failure, and develop the disease at a younger age on average, than those of White ethnicity.
- The highest rate is for those whose ethnicity is listed as 'Other', and aged 75-79 years, at approximately 2,500 in a million (one in 400 people).
- The lowest rate for people in this age band is for people of White ethnicity: six times lower at approximately 400 in a million (one in 2,500 people).

The following tables show the percentage of patients of each ethnicity who are under or over 65 years old, and the percentage who are male or female. An age of 65 was chosen because approximately half the total kidney failure population is older than 65. The percentages for the whole kidney failure population (all groups) are also shown. The size of each coloured bar matches the percentage in its cell – the bigger the number, the longer the bar.

Table 2a – Age of adults (all people over 18 years of age, %)



Adults aged over and under 65 years who started treatment for kidney failure between 2014 and 2020, by ethnic group.

Main Findings

- People of White ethnicity and those whose ethnicity is missing are the oldest groups starting kidney replacement therapy.
- People of Black and Mixed ethnicity are the youngest groups starting kidney replacement therapy.

Table 2b – Sex of adults (all people over 18 years of age, %)

Ethnicity	Number	Sex	
		Male (%)	Female (%)
All Groups	49,078	64	36
Asian	6,309	62	38
Black	3,636	60	40
Mixed	684	62	38
Other	825	65	35
White	35,652	64	36
Missing	1,972	66	34

Sex of adults who started treatment for kidney failure between 2014 and 2020, by ethnicity.

Main Findings

- Despite the higher levels of kidney disease amongst women, more men have kidney failure across all ethnic groups.

Table 2c – Sex of children (under 16-year-olds treated in children’s centres, %)

Ethnicity	Number	Sex	
		Male (%)	Female (%)
All Groups	755	60	40
Asian	153	60	40
Black	48	65	35
Mixed	8*	38	62
Other	40	65	35
White	462	60	40
Missing	44	55	45

Sex of children who started treatment for kidney failure between 2014 and 2020, by ethnicity.

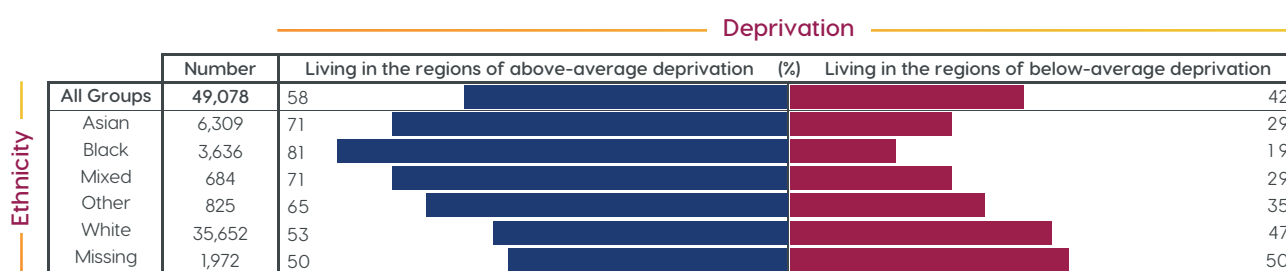
Main Findings

- More boys than girls get kidney failure across ethnic groups.
- *Due to small numbers of children, it is not advised to compare any differences by ethnicity to those seen in adults. Even comparisons between childhood ethnic groups are sensitive to chance effects given the small numbers.

3 Ethnicity and socioeconomic factors

The following tables show the percentage of patients of each ethnicity who live in regions of above-average deprivation (left) or below-average deprivation (right). Statistics for the whole kidney failure population (all groups) are also shown. The size of the bar represents the percentage in each cell – the bigger the number, the longer the bar.

Table 3a – Deprivation amongst adults (%)



Adults living in the most and least deprived 50% of regions (by *Index of Multiple Deprivation*) for each ethnic group who started treatment for kidney failure between 2014 and 2020.

Main Findings

- Patients of Black ethnicity are more likely to live in the most deprived regions than any other ethnic group.
- Those whose ethnicity is White or missing are least likely to live in the most deprived regions.
- The finding that more people of ethnic minority groups are living in areas of higher deprivation is not only found in people with kidney disease, but often in the [general UK population too](#).

Table 3b – Deprivation amongst children (%)

Ethnicity	Number	Deprivation	
		Living in the regions of above-average deprivation (%)	Living in the regions of below-average deprivation
All Groups	755	65	35
Asian	153	84	16
Black	48	79	21
Mixed	8*	75	25
Other	40	85	15
White	462	54	46
Missing	44	70	30

Children living in the most and least deprived 50% of regions (by Index of Multiple Deprivation) for each ethnic group who started treatment for kidney failure between 2014 and 2020.

Main Findings

- Children with kidney failure who are of Asian, Black, Mixed or Other ethnicity, and those whose ethnicity is missing, are more likely to live in deprived regions than those of White ethnicity. This is consistent with the patterns seen in the general population.
- *Due to the very small numbers of children, it is not advised to compare any differences by ethnicity to those seen in adults. Even comparisons between childhood ethnic groups are sensitive to chance effects given the small numbers.

4 Ethnicity and cause of kidney failure

Whenever possible, doctors try to identify the cause of a person’s kidney failure, their “primary kidney disease”. Kidney failure tends to have different causes in children than in adults, as they experience different health conditions from one another.

The list of causes in adults is as follows:

- **Diabetes** – diabetes mellitus type 1 or 2
- **Glomerular disease** – conditions that damage the microscopic filters of the kidney, such as IgA disease or vasculitis
- **Hypertension** – kidney damage associated with high blood pressure
- **Polycystic kidney disease** – a genetic disorder that causes fluid-filled cysts to grow in the kidneys
- **Pyelonephritis** – damage to the kidney from infection and/or reflux (backwashing) of urine
- **Renovascular disease** – damage to the blood vessels of the kidneys
- **Uncertain** – used when no cause of kidney failure can be diagnosed
- **Other** – any other cause of kidney failure listed

The list of causes in children is as follows:

- **Familial / hereditary nephropathies** – conditions that affect the kidneys which may run in families, or may be due to a new genetic mutation. Includes conditions such as nephronophthisis and cystinuria
- **Glomerular disease** – conditions that damage the microscopic filters of the kidney, such as nephrotic syndrome and IgA nephropathy
- **Miscellaneous kidney disorders** – where no primary kidney problem was identified
- **Systemic diseases affecting the kidney** – conditions that affect the body and can also damage the kidney. Includes Systemic Lupus Erythematosus (SLE)
- **Tubulo-CAKUT** – conditions that people are born with which affect the kidney and/or urinary tract
- **Tubulo-non-CAKUT** – conditions that are acquired after birth which affect the kidney and/or urinary tract

In table 4a, the breakdown of primary kidney diseases is shown for each adult ethnic group. Data are shown for patients with a recorded primary kidney disease, even when recorded as 'uncertain'. Six percent of adults had no recorded primary kidney disease. The cells for each ethnic group add up to 100%. The size of the bar represents the percentage in each cell – the bigger the number, the longer the bar.

Table 4a – Adult primary kidney disease by ethnicity (%)

Ethnicity	Primary Kidney Disease	Total %
Asian	Diabetes	46
	Glomerular disease	12
	Hypertension	5
	Polycystic kidney disease	3
	Pyelonephritis	3
	Renovascular disease	4
	Uncertain	15
	Other	12
Black	Diabetes	35
	Glomerular disease	10
	Hypertension	16
	Polycystic kidney disease	4
	Pyelonephritis	2
	Renovascular disease	2
	Uncertain	13
	Other	19
Mixed	Diabetes	33
	Glomerular disease	12
	Hypertension	8
	Polycystic kidney disease	6
	Pyelonephritis	4
	Renovascular disease	3
	Uncertain	18
	Other	16
Other	Diabetes	31
	Glomerular disease	15
	Hypertension	10
	Polycystic kidney disease	5
	Pyelonephritis	4
	Renovascular disease	3
	Uncertain	18
	Other	15
White	Diabetes	25
	Glomerular disease	13
	Hypertension	6
	Polycystic kidney disease	8
	Pyelonephritis	6
	Renovascular disease	6
	Uncertain	15
	Other	20
Missing	Diabetes	28
	Glomerular disease	10
	Hypertension	8
	Polycystic kidney disease	5
	Pyelonephritis	5
	Renovascular disease	5
	Uncertain	18
	Other	21

Primary kidney disease by ethnicity for adults who started treatment for kidney failure between 2014 and 2020. Not including those with no recorded primary kidney disease.

Main Findings

- Diabetes is the most commonly attributed cause of kidney failure in all ethnic groups.
- Diabetes is especially common amongst Asian and Black populations, and least common for White populations and those whose ethnicity is missing.

In table 4b, the breakdown of primary kidney diseases is shown for each childhood ethnic group. Data are shown for patients with a recorded primary kidney disease. Two percent of children had no recorded primary kidney disease. The cells for each ethnic group add up to 100%. The size of the bar represents the percentage in each cell – the bigger the number, the longer the bar.

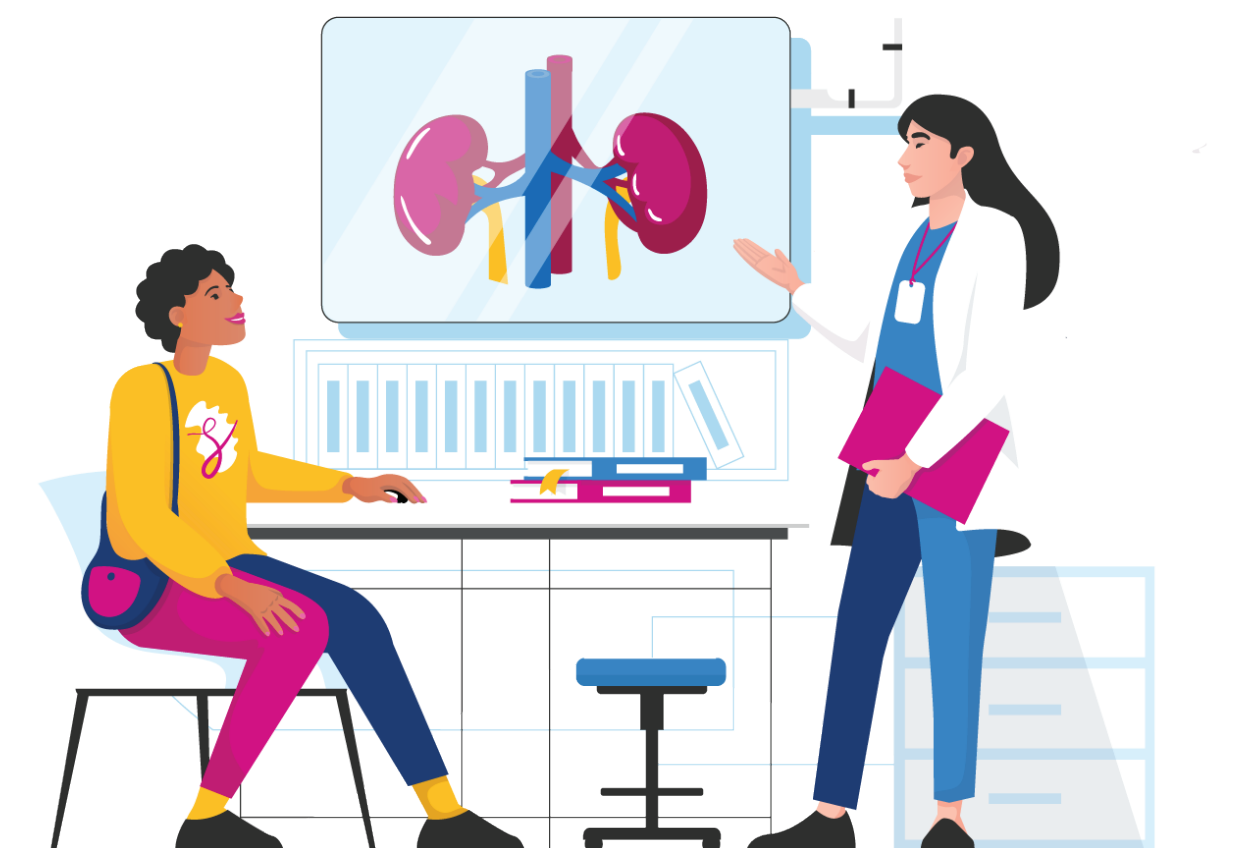


Table 4b – Children’s primary kidney disease by ethnicity (%)

Ethnicity	Primary Kidney Disease	Total %
Asian	Familial / hereditary nephropathies	23
	Glomerular disease	22
	Miscellaneous kidney disorders	13
	Systemic diseases affecting the kidney	3
	Tubulo-CAKUT	38
	Tubulo-non-CAKUT	1
Black	Familial / hereditary nephropathies	14
	Glomerular disease	21
	Miscellaneous kidney disorders	14
	Systemic diseases affecting the kidney	2
	Tubulo-CAKUT	49
	Tubulo-non-CAKUT	0
Mixed	Familial / hereditary nephropathies	14
	Glomerular disease	14
	Miscellaneous kidney disorders	14
	Systemic diseases affecting the kidney	0
	Tubulo-CAKUT	43
	Tubulo-non-CAKUT	14
Other	Familial / hereditary nephropathies	24
	Glomerular disease	12
	Miscellaneous kidney disorders	9
	Systemic diseases affecting the kidney	0
	Tubulo-CAKUT	53
	Tubulo-non-CAKUT	3
White	Familial / hereditary nephropathies	13
	Glomerular disease	16
	Miscellaneous kidney disorders	16
	Systemic diseases affecting the kidney	5
	Tubulo-CAKUT	48
	Tubulo-non-CAKUT	2
Missing	Familial / hereditary nephropathies	32
	Glomerular disease	11
	Miscellaneous kidney disorders	16
	Systemic diseases affecting the kidney	11
	Tubulo-CAKUT	32
	Tubulo-non-CAKUT	0

Primary kidney disease by ethnicity for children who started treatment for kidney failure between 2014 and 2020. Not including those with no recorded primary kidney disease.

Main Findings

- Tubulo-CAKUT disorders – conditions that people are born with which affect the kidney and/or urinary tract – are the most common causes of kidney failure in all ethnic groups.

5 Ethnicity and diabetes

People with kidney failure often have multiple other health conditions (comorbidities). Table 5 shows the percentage of adults in each ethnic group who have diabetes, as diabetes is especially common amongst adults with kidney failure. Sometimes diabetes is also their primary kidney disease (the cause of their kidney failure). The size of the coloured bars represents the percentage in each cell – the bigger the number, the longer the bar.

Approximately two in three adults (66%) and less than half of children (<50%) in our system have comorbidity data. Whether comorbidity data are reported may depend upon a person’s characteristics, or where they receive their care. Given these high levels of missing data, no figures are provided for conditions other than diabetes. Given its importance in kidney disease, we expect coding for diabetes to be better than that for many other conditions. However, it is likely that some adults with missing data have diabetes too.

Table 5 – Diabetes amongst adults (%)

		Diabetes					
		Yes		No		Missing	
Ethnicity	All Groups	49,078	33	32	35		
	Asian	6,309	49	19	32		
	Black	3,636	37	27	36		
	Mixed	684	33	20	47		
	Other	825	33	28	39		
	White	35,652	30	36	34		
	Missing	1,972	28	21	51		

Percentage of adults with diabetes in each ethnic group who started treatment for kidney failure between 2014 and 2020.

Main Findings

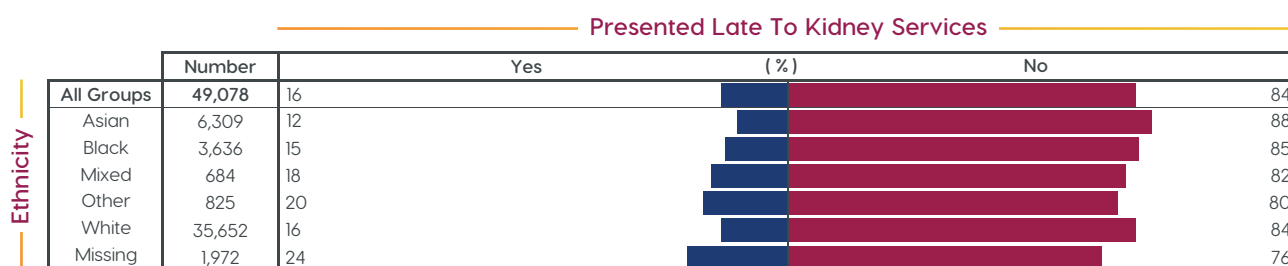
- Higher levels of diabetes are seen amongst people of Asian ethnicity, in keeping with the higher levels of kidney failure caused by diabetes.

6 Ethnicity, presentation and first treatment

Individuals in this report all received dialysis or a kidney transplant for kidney failure. They may have started treatment with a transplant, or they may have first had haemodialysis or peritoneal dialysis. These treatments all require a person to have met a kidney specialist. The time between first meeting a specialist and starting treatment influences the kind of treatment someone will begin. If there is a short time (fewer than 90 days) between someone first seeing a specialist and starting dialysis or having a transplant, the person is said to have presented late. An individual might present late because their kidney disease was new and rapidly progressing, because their disease was advanced when first detected, or if their kidney condition was diagnosed, but their referral or appointment was delayed.

The following tables show the **percentage of people presenting late** to a kidney specialist, and the **breakdown of first treatment type**. The size of the coloured bars represents the percentage in each cell – the bigger the number, the longer the bar.

Table 6a – Late presentation amongst adults (%)



Percentage of adults in each ethnic group who started treatment for kidney failure after a late presentation between 2014 and 2020.

Main Findings

- Late presentation to kidney services is least common amongst people of Asian ethnicity.
- Late presentation is most common amongst those whose ethnicity data are missing.

Table 6b – First treatment type amongst adults (%)

		First treatment for kidney failure			
		Number	Hospital dialysis	Home dialysis	Transplanted
Ethnicity	All Groups	49,078	74	21	5
	Asian	6,309	74	22	5
	Black	3,636	77	21	2
	Mixed	684	73	20	7
	Other	825	75	21	4
	White	35,652	74	21	5
	Missing	1,972	80	16	4

Percentage of adults starting treatment for kidney failure with hospital haemodialysis, home dialysis, or transplanted between 2014 and 2020, by ethnicity.

Main Findings

- Hospital dialysis is the most common first treatment across adult ethnic groups.
- Home dialysis is least commonly used as initial treatment by individuals whose ethnicity data are missing.
- Transplantation before starting dialysis is rare across all ethnic groups, but especially so for those of Black ethnicity.

Table 6c – Late presentation amongst children (%)

		Presented Late To Kidney Services		
		Number	Yes	No
Ethnicity	All Groups	755	23	77
	Asian	153	18	82
	Black	48	27	73
	Mixed	8*	13	88
	Other	40	33	68
	White	462	24	76
	Missing	44	23	77

Percentage of children in each ethnic group who started treatment for kidney failure after a late presentation between 2014 and 2020.

Main Findings

- Late presentation to kidney services is least common amongst children of Asian ethnicity.
- *Due to the very small numbers of children, it is not advised to compare any differences by ethnicity to those seen in adults. Even comparisons between childhood ethnic groups are sensitive to chance effects given the small numbers.

Table 6d – First treatment type amongst children (%)

		First treatment for kidney failure			
		Number	Hospital dialysis	Home dialysis	Transplanted
Ethnicity	All Groups	755	38	40	21
	Asian	153	37	49	14
	Black	48	42	50	8
	Mixed	8*	88	13	0
	Other	40	45	40	15
	White	462	36	37	27
	Missing	44	45	36	18

Percentage of children starting treatment for kidney failure with hospital haemodialysis, home dialysis, or transplanted between 2014 and 2020, by ethnicity.

Main Findings

- Overall, home and hospital dialysis are started equally frequently.
- Transplantation is the first treatment for one in five children.
- Children of White ethnicity are more likely to be transplanted as their first treatment than other ethnic groups.
- Children of Black and Mixed ethnicity children appear to be less likely to be transplanted as their first treatment than other groups.
- *Due to the very small numbers of children, it is not advised to compare any differences by ethnicity to those seen in adults. Even comparisons between childhood ethnic groups are sensitive to chance effects given the small numbers.

7 Ethnicity and treatment outcomes

The UK Renal Registry reports annually on survival and transplant listing, and its reports are available [here](#). NHS Blood and Transplant also provide data and summaries of transplantation rates, available [here](#). This diagram shows what happens in the first year after starting kidney replacement therapy. Here, 42,443 adults of all ethnic groups are included. Most people continued the modality they started, but others changed modality, and some died.

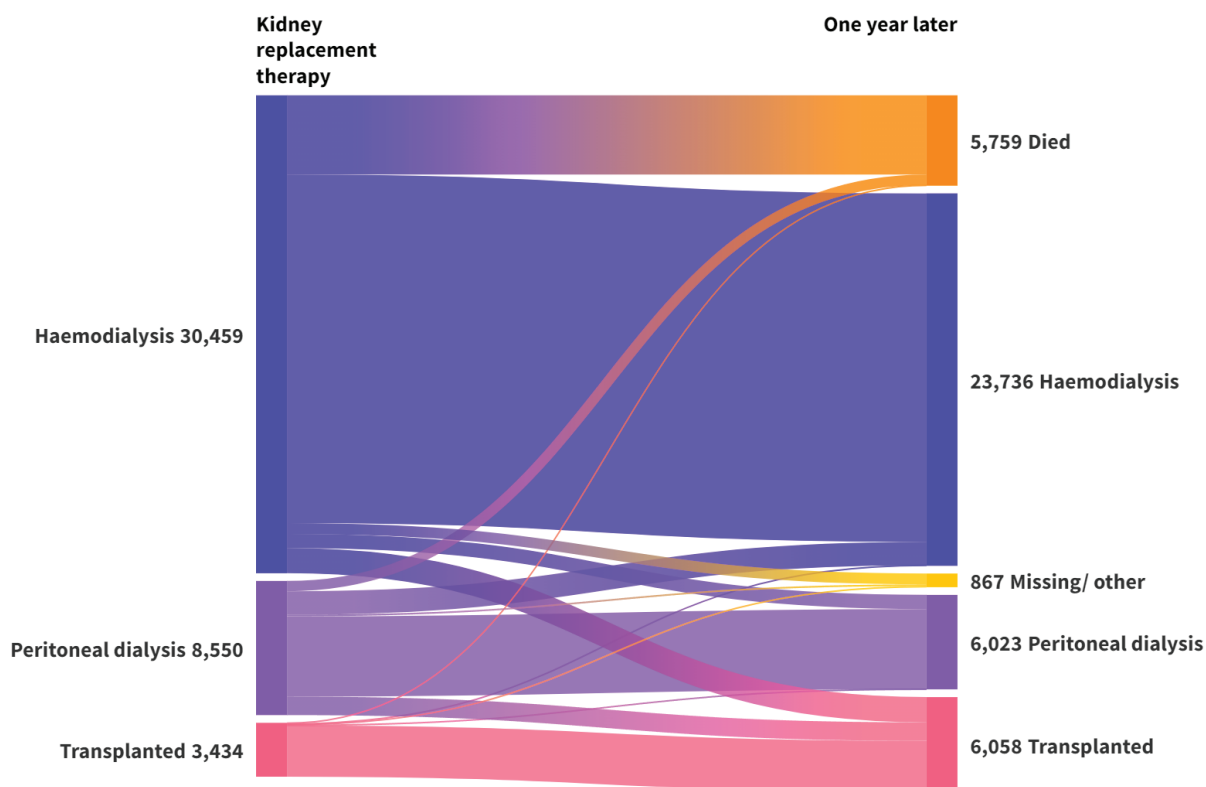
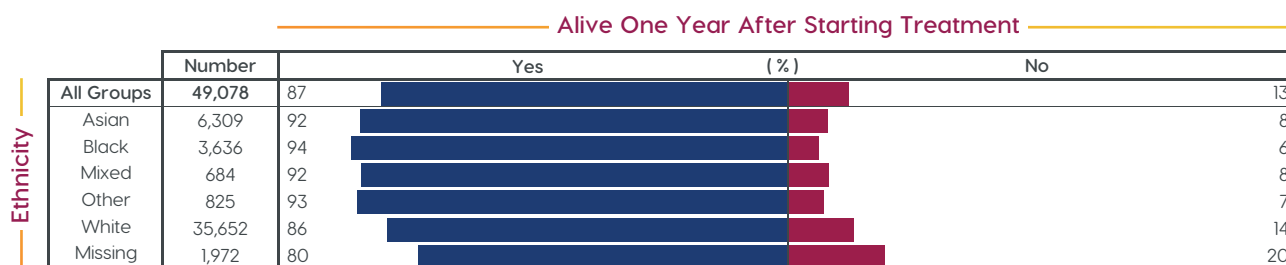


Figure 7 - outcomes one year after starting kidney replacement therapy

[Click here](#) to go to an interactive page where you can look at these data for each ethnic group.

The following tables show the percentage of adults and children from each ethnic group who were alive one year after starting treatment for kidney failure and the percentage who were transplanted within three years of starting treatment. The statistics for the whole kidney failure population are also shown. The size of the coloured bars represents the percentage in each cell – the bigger the number, the longer the bar.

Table 7a – Adult survival after starting treatment for kidney failure (%)

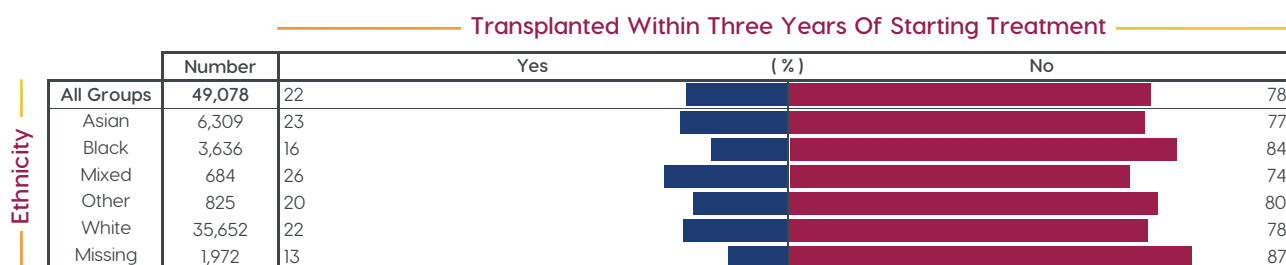


Percentage of adults in each ethnic group who were alive one year after starting treatment for kidney failure between 2014 and 2020.

Main Findings

- The worst one-year survival is seen amongst those whose ethnicity data are missing, which could be due to the fact that they represent a different group of patients with more severe illness.
- Survival is also lower in the White population. This is incompletely understood, but is partly because people of White ethnicity are, on average, older and have a higher number of additional health problems than other ethnic groups at the time of starting treatment.

Table 7b – Adult transplantation after starting treatment for kidney failure (%)



Percentage of adults in each ethnic group who were transplanted within three years of starting treatment for kidney failure between 2014 and 2020.

Main Findings

- Rates of transplantation three years after starting treatment are lowest for those of Black ethnicity, and those whose ethnicity data are missing.

Table 7c – Child survival after starting treatment for kidney failure (%)

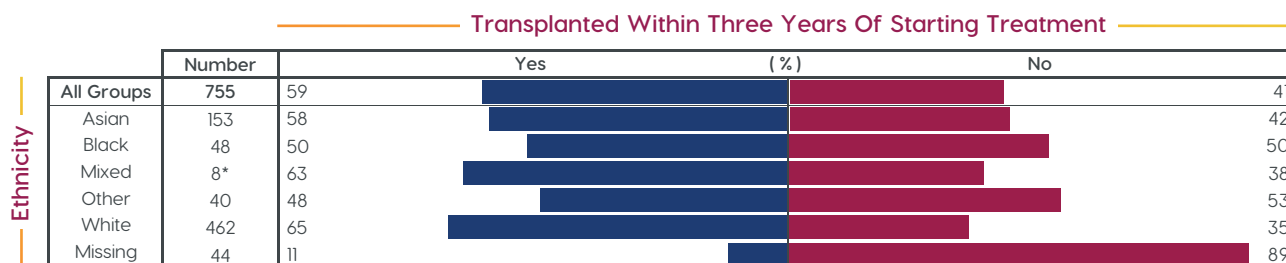
		Alive One Year After Starting Treatment		
Ethnicity	Number	Yes (%)		No
		All Groups	755	97
Asian	153	97	3	
Black	48	98	2	
Mixed	8*	100	0	
Other	40	98	3	
White	462	98	2	
Missing	44	91	9	

Percentage of children in each ethnic group who were alive one year after starting treatment for kidney failure between 2014 and 2020.

Main Findings

- One-year survival exceeds 97% across ethnic groups.
- The much lower survival for children with missing ethnicity data suggest they represent a different group of children, with more severe illness.
- *Due to the very small numbers of children, it is not advised to compare any differences by ethnicity to those seen in adults. Even comparisons between childhood ethnic groups are sensitive to chance effects given the small numbers.

Table 7d – Child transplantation after starting treatment for kidney failure (%)



Percentage of children in each ethnic group who were transplanted within three years of starting treatment for kidney failure between 2014 and 2020.

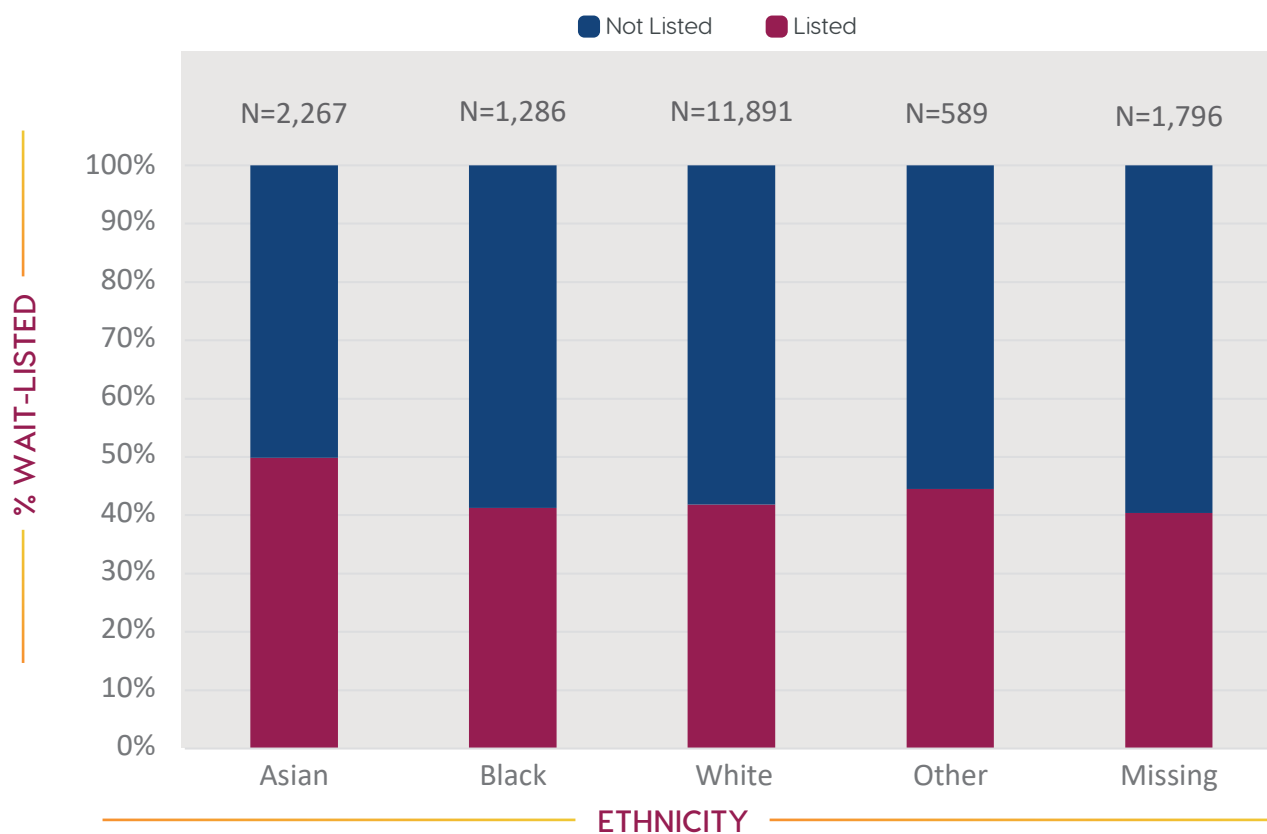
Main Findings

- Transplant rates are highest for children of White ethnicity, and lowest for children of Other and Missing ethnicity.
- The much lower transplant rates for children with missing ethnicity data suggest they represent a different group of children, with more severe illness.
- *Due to the very small numbers of children, it is not advised to compare any differences by ethnicity to those seen in adults. Even comparisons between childhood ethnic groups are sensitive to chance effects given the small numbers.

8 Ethnicity and transplant wait-listing

Transplant ‘wait-listing’ refers to the point at which an individual is placed on the waiting list to receive a donated kidney. A report of a separate piece of work looking at wait-listing will be available on the UK Kidney Association website soon. Early findings are provided below. These data come from 17,829 adults aged between 18 and 75 who started treatment for kidney failure between March 2017 and February 2020. This report does not include children.

Figure 8 – Adult transplant wait-listing by ethnicity



Number of 18–75-year-olds who started kidney replacement therapy between March 2017 and February 2020 by ethnicity. Red and blue shading indicates the proportion listed, and not listed for transplantation within two years of starting.

Main Findings

- The proportion of people listed for a kidney transplant is approximately 40% for all ethnic groups, except for people of Asian ethnicity, for whom proportions are higher, at 50%.

The full analysis of these data shows that people of Asian ethnicity remained more likely to be wait-listed than those of White ethnicity, even once other factors were considered. People of Black ethnicity were less likely to be wait-listed than those of White ethnicity, once other factors were considered.

9 Conclusion

This descriptive report using UK Renal Registry (UKRR) data presents well-recognised disparities: Black and minority ethnic populations have higher rates of kidney failure and are affected at younger ages. At the same time, however, this report shows that these patterns are complicated.

Both within and between ethnic groups there are different patterns of disease, treatments and outcomes. This complexity reflects the fact that ethnic groups are not easily compared because they differ in many ways other than ethnicity. These ‘ways’ include the different ages at which each ethnic group reaches kidney failure and the sociodemographic groups from which they tend to come.

Since this report describes rather than analyses UKRR data, a robust scientific approach will be needed if we are to understand the precise factors that lead to suboptimal outcomes and, critically, the factors that we can modify. In the meantime, further descriptive work will help reveal how demographic factors such as age, sex and socioeconomic deprivation intersect to influence outcomes. And in the future, regular reporting will help us to identify rising or declining standards of care, and guide where we should invest to address inequalities.

Acknowledgements

Members of the UK Kidney Association Patient Council,
Prof James Medcalf,
Prof Dorothea Nitsch,
Dr Retha Steenkamp,
Esther Wong,
Dr Anna Casula,
Dr Shalini Santhakumaran,
Dr Katharine Evans and
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