



ANZDATA & ANZSN SPECIAL REPORT

Unit Survey 2025:
Nephrology workforce and
peritoneal dialysis practices



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SUGGESTED CITATION

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PLAIN LANGUAGE SUMMARY

People with kidney failure who elect to receive kidney replacement therapy (KRT) are treated with dialysis or a kidney transplant. A survey of kidney units in Australia and New Zealand was undertaken by the Australia and New Zealand Dialysis and Transplant (ANZDATA) Registry, with two major parts:

Part 1

- The types of kidney replacement therapies offered,
- How units are staffed, and how ratios of staff to patients with kidney failure vary.

Survey responses indicated a large and varied workforce caring for people with kidney failure in Australia and New Zealand, with differences in staffing of kidney specialists, kidney specialty trainees, and kidney-specialised Allied Health staff, and the numbers of patients with kidney failure that they care for.

Part 2

A special focus on peritoneal dialysis (PD), a form of dialysis in which fluid is placed in the abdomen, resulting in the removal of toxins and fluid across the lining of the abdominal cavity. This is a treatment that people can undertake independently at home. There are limited data regarding the unit and region-level variation in practices related to this therapy, therefore this Survey also asked units about practices related to the provision of peritoneal dialysis.

We found that:

- Most units in Australia and New Zealand provide peritoneal dialysis
- All respondent units have infection-management protocols for PD peritonitis which have been revised in the last five years
- There are variable delays for patients to begin training for patients to learn to do their own PD
- There are many barriers perceived by clinicians to people undertaking PD
 - The commonest reported was a fear of the responsibility of caring for their own dialysis (55% in Australia, 46% in New Zealand)
 - Housing hygiene factors and lack of space for storage of medical supplies was reported by 82% of units in New Zealand as a barrier to PD.

Results from this report demonstrate the different experiences of kidney units around Australia and New Zealand and will help kidney units understand how their unit compares to other units, informing health services and governments to make improvements to provide quality kidney care.



EXECUTIVE SUMMARY

This Report details results from a survey of public Nephrology Units in Australia and New Zealand. It includes workforce structure and staffing (**Part 1**) and has a special focus on the availability of, barriers to, and policies and practices related to, peritoneal dialysis (PD) (**Part 2**).

The data reported in this Special Report are broad in scope, including all paediatric and over 98% of adult of public Nephrology units in Australia and New Zealand. These data provide important insights into the staffing and workforce structure in adult public Nephrology units bi-nationally.

Australia and New Zealand's kidney workforce is unevenly distributed, with major regional differences in Nephrologist staffing and workloads of care for people receiving kidney replacement therapy.

- The overall ratio of patients receiving KRT to full-time equivalent (FTE) consultant Nephrologists was 69.7 in Australia and 70.5 in New Zealand
- Significantly higher ratios of patients to FTE Nephrologists were observed in Western Australia (165.6), and to a lesser extent in Tasmania (95.5) and South Australia (93.7)
- Some services have more than double the number of patients per Nephrologist than others
- The range of other duties and services provided by Nephrologists within this FTE was not covered in this survey
- There are consultant Nephrologist vacancies in most Nephrology units in New Zealand; these are rarer in Australia.

The high patient to Nephrologist ratio is not accounted for by extra trainee workforce, a similar regional pattern of patient to Nephrologist ratio is observed for Nephrology trainees. There is also variation in the supervision ratios of Nephrologists to Nephrology physician trainees, and a significant reliance on non-specialty training registrars to meet the demands of the workforce.

- The ratio of FTE Nephrologists to Nephrology trainees was 4.4 in New Zealand and 2.4 in Australia
- Basic Physician Trainees (who have not yet passed written and clinical examinations to commence Advanced Physician Training) commonly work in the role of Nephrology Registrar, particularly in New South Wales, Queensland, and New Zealand. New Zealand also has the highest numbers of unaccredited registrars acting in the role of Nephrology registrars.

There were also significant differences in the number of patients with KRT cared for per FTE specialised Nephrology and Allied Health staff.

- Almost all units employed a renal dietitian, however the range of patients receiving KRT cared for per FTE dietitian is 178.4 to 502.0
- Three-quarters of units employed a renal pharmacist, however the range of receiving KRT cared for per FTE renal pharmacist is 200.8-660.0
- There was relatively low access to psychology (41% of units in Australia, 25% in New Zealand) and palliative care physicians (39% in Australia, none in New Zealand).

It should be noted that the number of patients registered with ANZDATA forms the denominator for ratio calculation. This is a major element but not the entirety of the workload where Nephrologists, trainees and specialised Nephrology and Allied Health staff care for patients with acute kidney injury and chronic kidney disease. The actual number of patients cared for in most units is much higher than detailed in this report, and will include people with chronic kidney disease and acute kidney injury, and a variable mixture of in- and out-patient responsibilities.



Within the special focus on peritoneal dialysis, this Report found that:

- Half of New Zealand units and almost two-thirds of Australian units report a “PD preferred” policy that actively encourages uptake of PD
- There was widespread use of incremental PD - with over three-quarters of units initiating PD in this manner
- All respondent units had PD peritonitis protocols which had been revised in the last five years
- Just under half of units undertook root cause analyses for episodes of PD peritonitis
- 90% of units undertook peritoneal equilibration testing and all units undertook small solute testing; variation was observed in timing and indication for testing
- After suitable dialysis access was in place, most units had a waiting time to commence PD of up to four weeks. Some Australian units reported waiting times of greater than four weeks
- Patient and health-system factors were identified as barriers (perceived by clinicians) to PD uptake. The commonest was patients’ concern about the responsibility of caring for their own dialysis (55% in Australia, 46% in New Zealand). Notably, housing hygiene factors and lack of space for storage of medical supplies was reported by 82% of units in New Zealand as a barrier to PD.

By documenting policies, practices and barriers to peritoneal dialysis (PD) across Australia and New Zealand, this Report provides a contemporary benchmark for PD service provision and identifies opportunities to strengthen uptake of this important home-based dialysis modality. In the context of increasing haemodialysis capacity constraints across both countries, these findings highlight the need to address modifiable patient- and health system-level barriers to PD, including delays to treatment commencement after suitable dialysis access is established. They also provide an evidence base to inform quality improvement initiatives, guide service planning and support investment in the infrastructure and workforce required to expand equitable access to PD.

There are limited contemporary data describing the workforce across public Nephrology units in Australia and New Zealand outside of this survey. This Report therefore provides an important benchmark against which units, jurisdictions and policymakers can compare workforce capacity, staffing models and training structures. It also offers new insights into the contribution of junior medical staff beyond accredited Nephrology training positions and highlights variation in consultant supervision of Nephrology trainees.

The marked variation in the number of patients receiving KRT cared for per FTE Nephrologist, trainee and specialised Nephrology and Allied Health professional highlights substantial inequities in workforce capacity across Australia and New Zealand. These findings have important implications for workforce planning, service sustainability, training, patient access and the delivery of equitable kidney care. As demand for kidney services continues to grow, these data provide an evidence base to inform workforce investment, guide future service planning, and support advocacy for appropriately resourced multidisciplinary Nephrology services to meet the needs of patients now and into the future.

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INTRODUCTION: BACKGROUND OF SPECIAL REPORTS

This Special Report is a collaboration between the Australia and New Zealand Dialysis and Transplant (ANZDATA) Registry and the Australian and New Zealand Society of Nephrology (ANZSN). ANZSN is a not-for-profit organisation representing health professionals working in the prevention and treatment of kidney disease. The ANZDATA Registry is a Clinical Quality Registry that collects data regarding individual patients receiving kidney replacement therapy (KRT - dialysis or in receipt of a kidney transplant) in Australia and New Zealand. The Registry does not collect data on patients who are not receiving KRT nor those receiving dialysis for acute kidney injury. As part of annual reporting, the ANZDATA Registry reports on the number and location of people receiving different types of KRT and their outcomes. Individual hospital reports are also generated for internal review, standardising outcomes across Nephrology units, with benchmarking for quality indicators.

Special Reports are undertaken by ANZDATA periodically to collect and release material that is of relevance to contributors but does not fit within annual unit-level reporting structures or publication in a peer-reviewed research journal. These reports are prepared and reviewed internally and released with the aim to complement existing output (such as the Annual Report). The first Special Report was a unit survey,¹ undertaken in 2019 in conjunction with the end-of-year Annual Survey. That publication covered a variety of areas including Nephrology unit staffing, Nephrology physician training, unit resources and clinical practices, with more recent survey and report of these data in the 2024 Unit Survey Special Report.² These important data in unit structure, staffing, clinical practice and service provision may not be otherwise captured in the Registry's traditional data collection but are relevant and of interest to Nephrology units and service providers. These data were collected for this Special Report and are reported in **Part 1**.

Special Reports are also conceived as opportunities to elucidate granular unit-level practices in Nephrology care delivery across Australia and New Zealand, informing practice variation, and identifying opportunities for improved data collection and service optimization. Peritoneal dialysis (PD), which can be performed at home, offers patients greater flexibility and independence compared to in-centre haemodialysis. Amid rising demand for dialysis and pressure on in-centre haemodialysis (HD) provision,²⁻⁴ there is increasing focus on elucidating the barriers to uptake of this treatment type. There is also interest in understanding and optimising data collection related to this treatment type within ANZDATA and broad interest in the Nephrology community in understanding unit-level variation in PD policies and practice. In this context, this special report focuses on these topics in the provision of PD treatment (**Part 2**).



SPECIAL REPORT OVERVIEW

This Special Report summarises information from a survey from Australian and New Zealand Nephrology units on unit structure, staffing, and dialysis policies and practices, particularly peritoneal dialysis. The ANZDATA Registry conducted this survey in conjunction with the annual Registry end-of-year survey in 2025. This report primarily covers data from public Nephrology units, providing summary information from survey responses, to inform contributing units in Australia and New Zealand and others about:

1. Unit composition,
2. Ratios of patients to staff and Nephrology advanced trainees, and
3. Policies and practices relating to peritoneal dialysis.

Data collected from paediatric units regarding peritoneal dialysis will be reported separately.

METHODS

Survey question formulation was undertaken in consultation with the ANZDATA Executive (**Part 1**) and the Peritoneal Dialysis Working Group (**Part 2**). The survey was distributed via the REDCap^{5,6} electronic data capture tool hosted at the South Australian Health and Medical Research Institute, in conjunction with the end-of-year ANZDATA survey in December 2025. This was sent to the heads of all 'parent' Nephrology units in Australia and New Zealand, with the request that it be completed by someone with the relevant knowledge about their unit. ANZDATA Registry staff made frequent contact with units to achieve comprehensive and complete survey responses.

'Parent' units are the principal care-providing unit within the ANZDATA Registry. Parent units have the overall responsibility of care provision and coordination of patients receiving kidney replacement therapy in their unit. Typically located in hospitals, these units often oversee multiple haemodialysis satellite facilities, provide access to home therapies including PD and home HD, and provide access to kidney transplantation services (either at their centre, or by referral to another service).



DESCRIPTIVE DATA

In this report, basic descriptive data of survey responses are presented for each of the survey items. Where appropriate, these data are presented by region and/or as a ratio to:

1. Prevalent patients receiving kidney replacement therapy (dialysis or transplant), as determined by prevalent patients under the parent unit for the corresponding ANZDATA Annual Survey,
2. Consultant Nephrologists,
3. Nephrology registrars (RACP-accredited and unaccredited Advanced Trainees and Basic Physician Trainees), and
4. Specialised Nephrology and Allied Health staff.

As the ANZDATA Registry collects data regarding patients with kidney failure receiving KRT, this report presents numbers of patients receiving KRT under the care of each unit and the ratio of patients receiving KRT to trainees and staff. It should be noted however, that a substantial component of units' workload involves inpatient and outpatient care for patients with chronic kidney disease, acute kidney injury, and Kidney Supportive Care, who are not included in the ANZDATA Registry. Therefore, reported ratios do not include these patients and associated workload for units in their entirety.

Data were analysed using Stata v18.0⁷ and Microsoft Excel⁸ to report discrete counts and proportions.

RESULTS

Responders and non-responders by state and country, public and private units

Overall, 80% of parent units responded to the survey (Table 1). Survey response rate was 100% for paediatric units and 93% for adult units, accounted for by lower response rates from private units which provide treatment for adult patients. The overall response rate was 98.6% from adult public Nephrology units. Due to limited response numbers from private Nephrology units, they have been excluded from subsequent analyses.

Table 1

Number and proportion of Nephrology 'parent' unit respondent to the survey

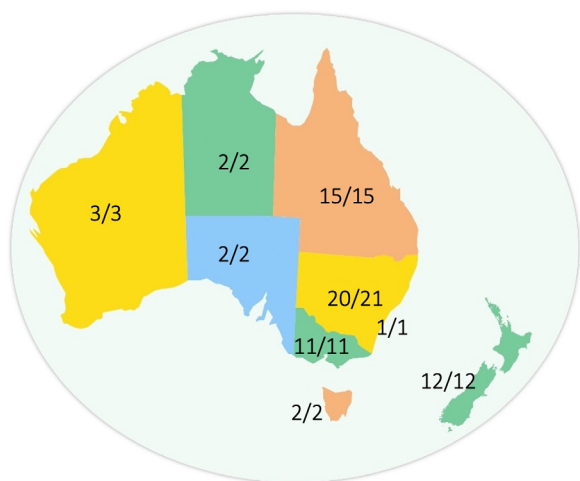
Type of unit	Units (n)	Responses (n)	Units responding (%)
All	110	88	80.0
Public	77	76	98.7
Private	33	12	36.4
Public			
Adult	69	68	98.6
Australia	57	56	98.2
New Zealand	12	12	100.0
Paediatric	8	8	100.0



SECTION 1: ADULT PUBLIC NEPHROLOGY UNITS

Section 1 of this Special Report details responses from adult public Nephrology units in Australia and New Zealand. Number of survey-respondent units over total number adult public units by New Zealand/Australian state/territory is shown in *Figure 1*; response rates for subsequent questions may total less than the number of respondent units as not all units completed all questions.

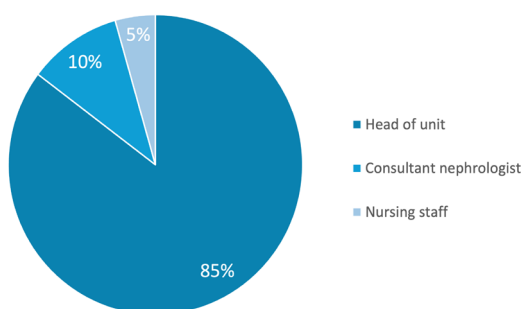
Figure 1
Number of responses from adult public Nephrology parent units by the total number of adult public Nephrology units in the region (New Zealand/Australian state/territory)



1. Individuals completing the survey

Most surveys were completed by Nephrology Heads of Unit, followed by a consultant Nephrologist or nursing staff member within the unit (*Figure 2*).

Figure 2
Survey respondents for adult public Nephrology units in Australia and New Zealand





2. Total patients receiving kidney replacement therapy

The median number of patients receiving kidney replacement therapy (KRT) in each unit was 327 (IQR 182-565) overall, 385 (IQR 218-651) in Australia (Figure 3) and 327 (IQR 171-526) in New Zealand (Figure 4).

Figure 3

Number of prevalent patients receiving kidney replacement therapy (dialysis and transplant) in adult public Nephrology units in Australia

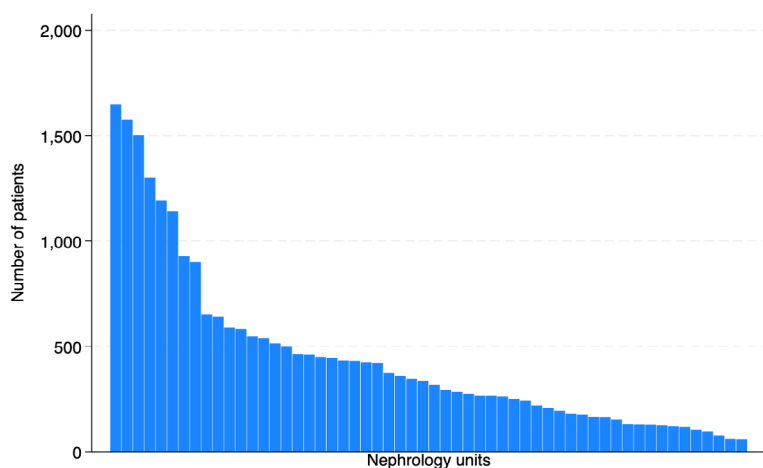
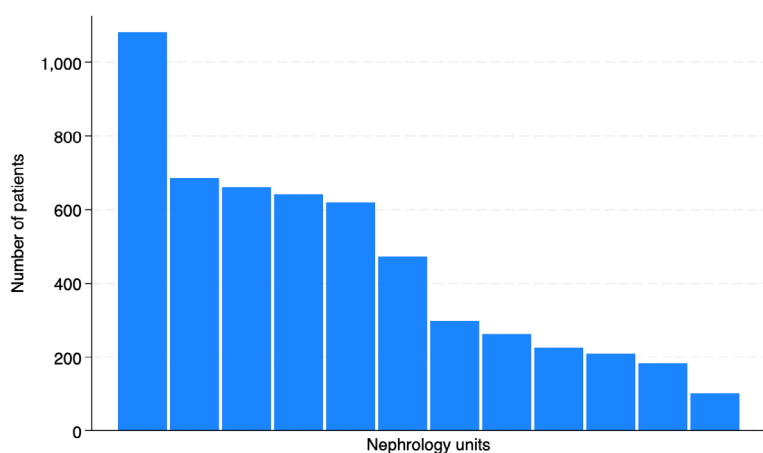


Figure 4

Number of prevalent patients receiving kidney replacement therapy (dialysis and transplant) in adult public Nephrology units in New Zealand

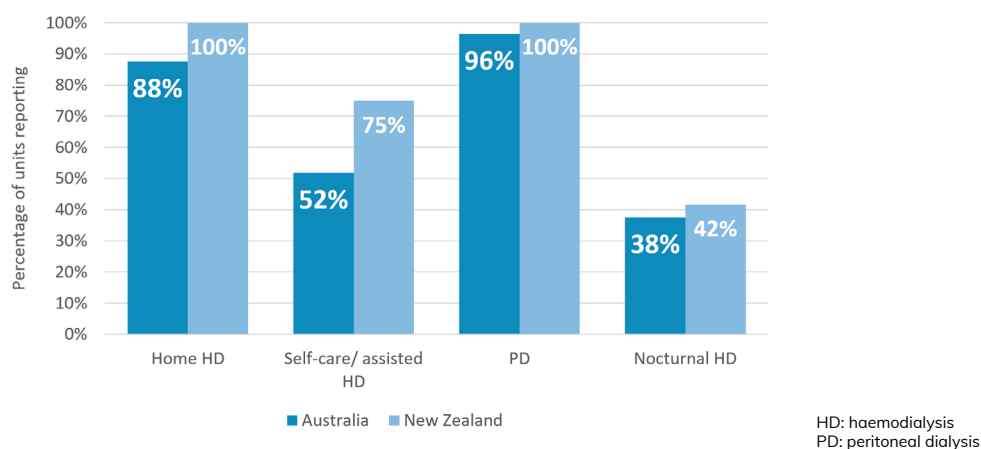




3. Treatment modalities

All units responded to questions regarding dialysis treatment modalities available in their service. All units in New Zealand and almost all units (96%) in Australia offered peritoneal dialysis. All units in New Zealand and most units (88%) in Australia offered home haemodialysis. Self-care/ assisted haemodialysis (performed at a location other than home with reduced or no nursing/dialysis technician assistance) was offered by most units in both countries. Approximately one-third of units offered nocturnal (overnight) haemodialysis, within their facilities (Figure 5).

Figure 5
Proportion of adult public Nephrology units in Australia and New Zealand providing different dialysis modalities





PART 1: AUSTRALIAN AND NEW ZEALAND ADULT PUBLIC NEPHROLOGY UNIT WORKFORCE

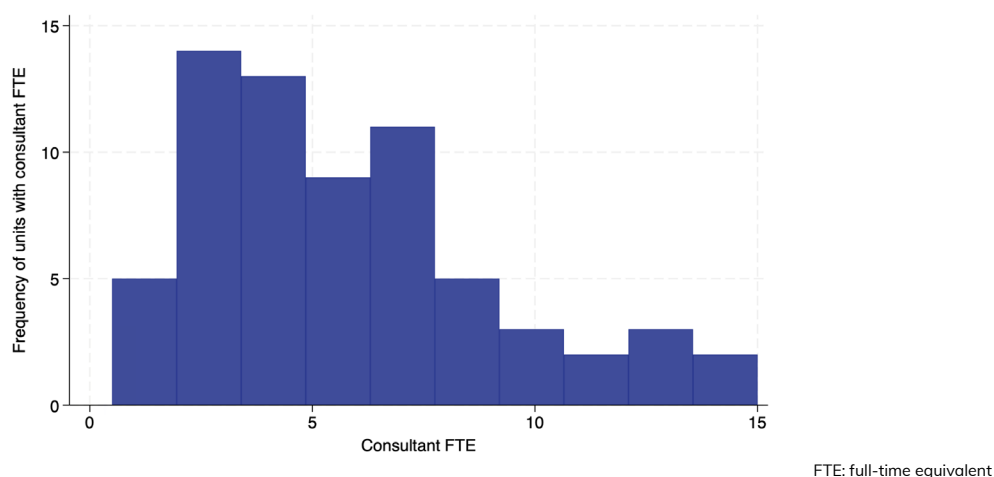
1.1.2. Consultant Nephrologists

a) Full-time equivalent (FTE) Consultant Nephrologists by Unit

67 units (99% of respondents) completed questions regarding full-time equivalent (FTE) consultant Nephrologists. The median number of FTE consultant Nephrologists per unit was 4.0 overall (inter-quartile range (IQR) 2.0-6.9), median FTE was 5.1 (IQR 2.5-7.3) for Australia and 4.9 (IQR 3.5-8.1) for New Zealand (Figure 6).

Figure 6

Number of units with full-time equivalent consultant Nephrologists in adult public Nephrology units in Australia and New Zealand



b) Ratio of full-time equivalent consultant Nephrologists to prevalent patients receiving KRT

The ratio of patients receiving KRT to FTE consultant Nephrologists in the unit was 69.7 (IQR 53.3-89.2) in Australia and in New Zealand was 70.5 (IQR 60.9-92.1); differences in this ratio were observed between Australian states and territories (Table 2, Figures 7,8).



Table 2

Full-time equivalent (FTE) consultant Nephrologists within adult public Nephrology units in Australia and New Zealand and ratio of prevalent patients receiving kidney replacement therapy (dialysis and transplant) to Nephrologists, by region

Region	FTE Consultant Nephrologists			KRT Patients*/FTE Consultant Nephrologists		
	Median (IQR)	Min	Max	Median (IQR)	Min	Max
Australia	5.1 (2.5-7.3)	0.5	14.4	69.7 (53.3-89.2)	26.0	200.0
Northern Territory	7.1 (6.7-7.4)	6.7	7.4	64.1 (58.9-69.3)	58.9	69.3
New South Wales	4.2 (2.8-7.1)	1.0	13.2	60.6 (44.9-87.2)	31.2	180.0
Victoria	6.8 (5.1-10.0)	1.8	13.1	77.9 (53.7-137.8)	39.2	158.3
Queensland	3.6 (2.0-5.5)	0.5	11.3	65.0 (43.3-82.5)	26.0	118.0
South Australia	10.1 (5.7-14.4)	5.7	14.4	93.7 (77.9-109.4)	77.9	109.5
Western Australia	6.9 (4.5-7.2)	4.5	7.2	165.6 (134.3-200.0)	134.3	200.0
Tasmania	2.8 (2.3-3.2)	2.3	3.2	95.5 (75.3-115.7)	75.3	115.7
Australian Capital Territory	6.8 (N/A)	6.8	6.8	73.2 (N/A)	73.2	73.2
New Zealand	4.9 (3.5-8.1)	1.0	15.0	70.5 (60.0-92.1)	51.0	102.0

Figure 7

Ratio of prevalent patients receiving kidney replacement therapy (dialysis and transplant) to full-time equivalent consultant Nephrologists in adult public Nephrology units in Australia

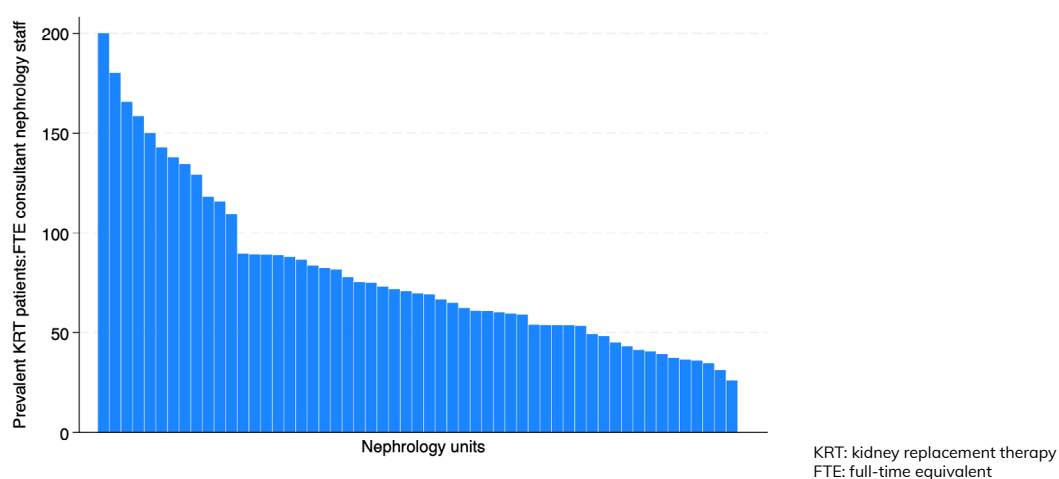
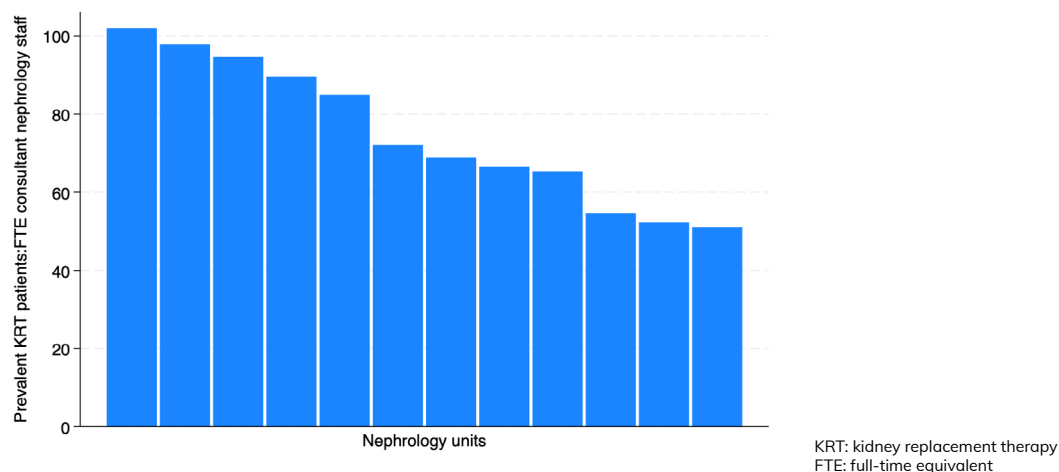




Figure 8

Ratio of prevalent patients receiving kidney replacement therapy (dialysis and transplant) to full-time equivalent consultant Nephrologists in adult public Nephrology units in New Zealand



Nephrology units can be categorised according to transplant centre status (Nephrology units performing kidney transplants compared to those not providing this service and instead referring their patients to transplant hospitals). Nephrology units in Australia and New Zealand performing kidney transplants had higher patient: FTE consultant Nephrologist ratios (Table 3).

Table 3

Ratio of prevalent patients receiving kidney replacement therapy (dialysis and transplant) to Full-time equivalent consultant Nephrologists, by country and Nephrology units' transplant status (median, IQR)

Country	Transplant centre	PD patients: consultant FTE	HD [^] patients: consultant FTE	Transplant patients: consultant FTE	Total patients*: consultant FTE
Australia	Yes	10.5 (7.2-13.0)	44.7 (32.7-53.9)	52.3 (38.6-64.8)	99.5 (81.9-146.4)
	No	5.7 (3.3-8.3)	33.3 (37.1-44.3)	20.2 (10.0-27.5)	60.3 (43.3-75.3)
New Zealand	Yes	14.8 (3.4-16.6)	29.3 (16.2-30.8)	42.1 (18.2-63.6)	89.5 (51.0-94.6)
	No	8.6 (6.1-17.9)	34.0 (28.1-45.4)	28.6 (24.7-31.0)	68.8 (65.4-84.9)
Overall		7.3 (2.0-11.6)	34.7 (27.4-47.7)	26.1 (15.5-42.1)	69.7 (53.6-89.5)

IQR – Inter-quartile range. [^]includes home haemodialysis, *Per total patients receiving dialysis or in receipt of a kidney transplant in the with that unit as registered in the ANZDATA Annual Survey)

c) Medical leads

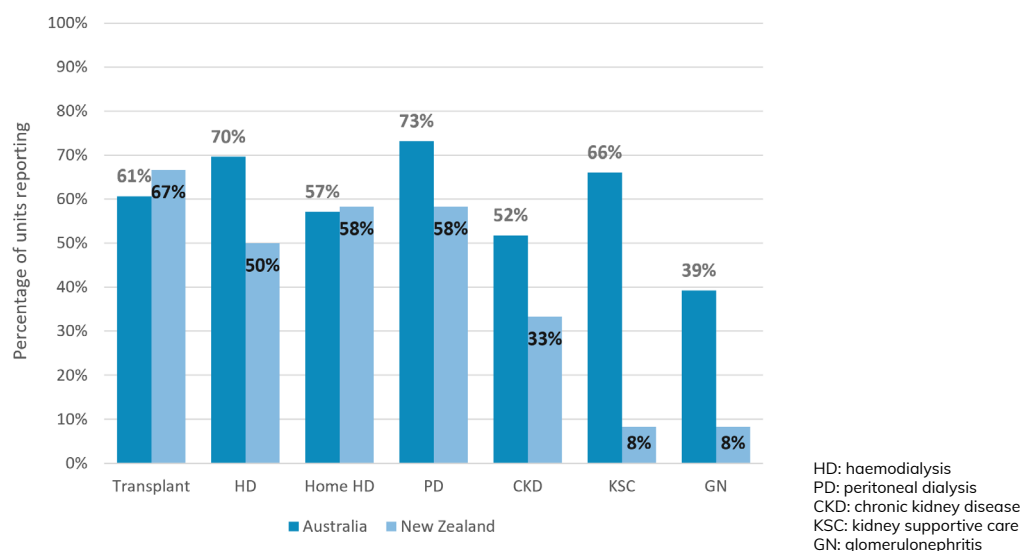
Units were asked about Medical Leads (i.e.. Consultant Nephrologist responsible) for different domains of Nephrology care at their health service. The most commons areas for which a Medical Lead was appointed was peritoneal dialysis (73% of Australian units, 58% of New Zealand units), followed by transplant (67% of New Zealand units, 61% of Australian units) and haemodialysis (70% of Australian units, 50% of New Zealand units). (Figure 9).

Further information was not collected about the range of clinical roles undertaken by Nephrologists (e.g. the extent to which the unit provided extensive consulting services for other hospital units, support for rural consulting, the proportion of clinical time spent on dialysis vs transplant vs CKD vs other Nephrology consulting).



Figure 9

Proportion of units with Medical Leads (Consultant in Charge) of areas of Nephrology in adult public Nephrology units in Australia and New Zealand



d) Consultant vacancies

Seven of twelve Nephrology units in New Zealand reported vacancies for consultant Nephrologists. One unit in each of New South Wales, Victoria, Western Australia and Tasmania reported vacancies for consultant Nephrologists. There were no vacancies for consultant Nephrologists reported in other Australian states and territories.

1.1.2. Nephrology Fellows

40% of Australian Nephrology units (n=22) and 17% of New Zealand units (n=2) employed a Nephrology Fellow (either a Nephrologist that has completed training accredited by The Royal Australasian College of Physicians (RACP) undertaking a specialised rotation, or a trainee that is working in a specialised area of Nephrology independent to standard Nephrology Advanced Trainee Registrar position), at a median FTE of 0.83 (IQR 0.25-4.0) in Australia and 0.75 (IQR 0.5-1.0) in New Zealand. These were most common in transplant, haemodialysis and CKD (Figure 10). Although not specifically asked, two Australian units also employed Fellows in interventional Nephrology.

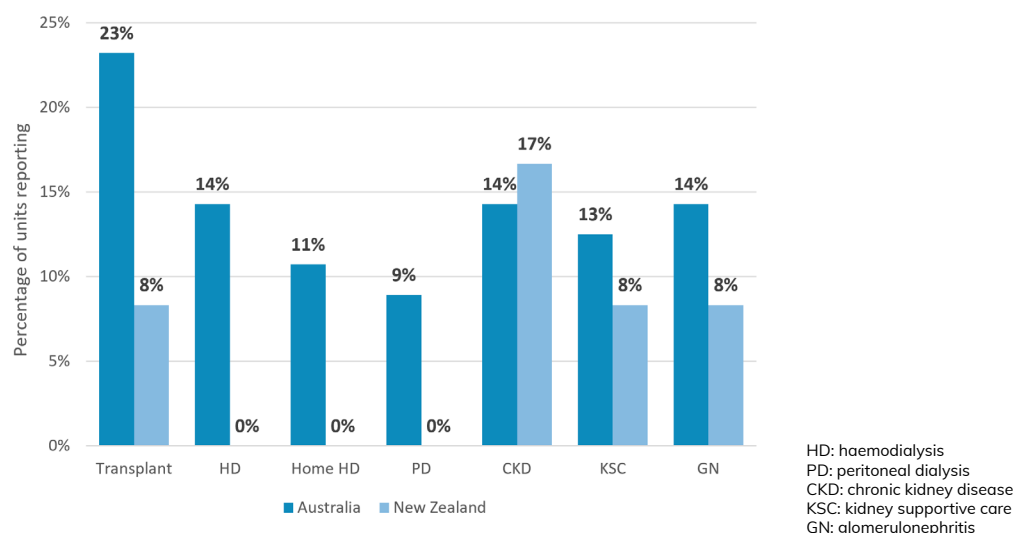
a) Fellow vacancies

Two Australian units reported vacancies for Nephrology Fellow roles.



Figure 10

Proportion of units employing Nephrology Fellows in different areas of Nephrology in adult public Nephrology units in Australia and New Zealand



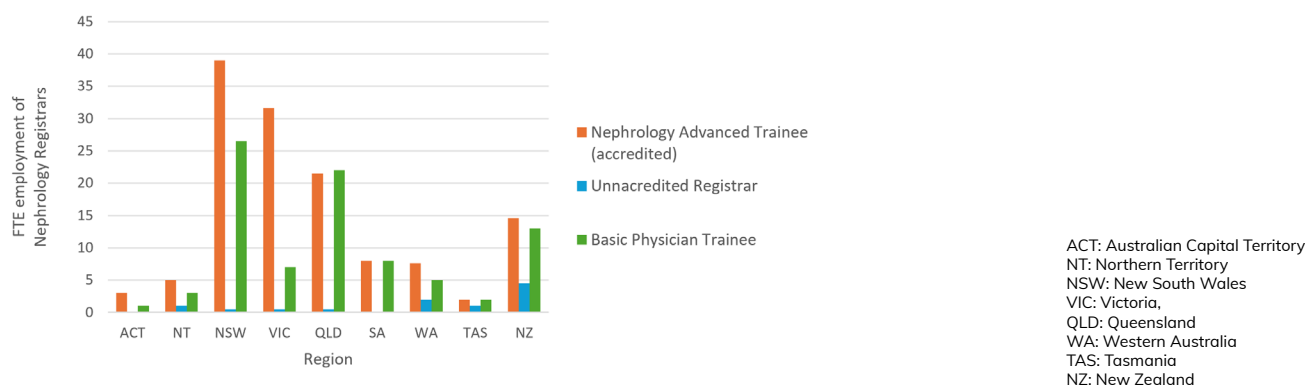
1.1.3. Nephrology Registrars

Nephrology Units are routinely staffed by junior doctors accredited by the RACP as undertaking Advanced Training in Nephrology. Some units may also employ junior doctors to work as registrars who are unaccredited in Nephrology training (i.e.. Advanced Physician trainees in other specialties) or Basic Physician trainees who have yet to commence Advanced Physician training.

99% of units (n=67) reported the details of Nephrology registrars in their units. The median FTE Nephrology registrar employment was 2.0 (IQR 1.0-3.0, range 0.0-6.0). Twelve units had no Nephrology Advanced trainees. The highest FTE for accredited Nephrology advanced trainees were in New South Wales (n=39) and Victoria (n=31.6), followed by New Zealand (n=14.6). Units in New Zealand and all Australian states and territories additionally employed Basic Physician Trainees acting in the role of Nephrology Registrar. Unaccredited Nephrology Advanced trainees were less frequently employed (Figure 11).

Figure 11

Full-time equivalent of different Nephrology registrar types in adult public Nephrology units in Australian states/territories and in New Zealand





There was variability in ratio of numbers of patients receiving KRT to Nephrology registrars (accredited, unaccredited and basic physician trainee registrars), shown by Region (*Figure 12*) and unit (*Figure 13*). The ratio of number of patients receiving KRT to Nephrology registrars was highest in Western Australia.

Figure 12

Ratio of patients receiving kidney replacement therapy to Nephrology registrars (accredited, unaccredited and Basic Physician trainee Registrars) in adult public Nephrology units

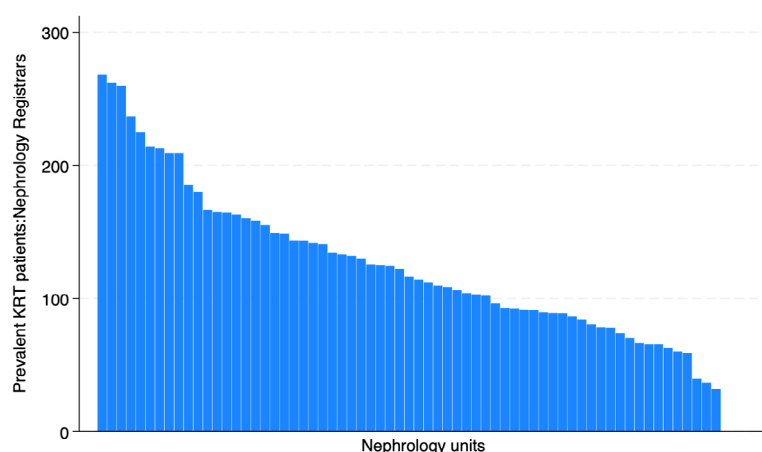


Figure 13

Ratio of patients receiving kidney replacement therapy to Nephrology registrars (accredited, unaccredited and Basic Physician trainee Registrars) in adult public Nephrology units in Australian states/territories and in New Zealand, by unit



ACT: Australian Capital Territory
NT: Northern Territory
NSW: New South Wales
VIC: Victoria
QLD: Queensland
WA: Western Australia
TAS: Tasmania
NZ: New Zealand



a) Nephrology physician trainee vacancies

Nine units (13%) reported Nephrology Registrar vacancies, six in Australia and three in New Zealand.

b) Consultant Nephrologist to Nephrology registrar ratio

The ratio of consultant Nephrologists to Nephrology registrar FTE was 1.7 overall (IQR 1.3-2.0), and for accredited Nephrology Advanced Trainees was 2.5 (IQR 2.2-3.7) (Table 4). The range of consultant Nephrologist to accredited Nephrology Advanced Trainee FTE by unit is shown in Figure 14.

Table 4

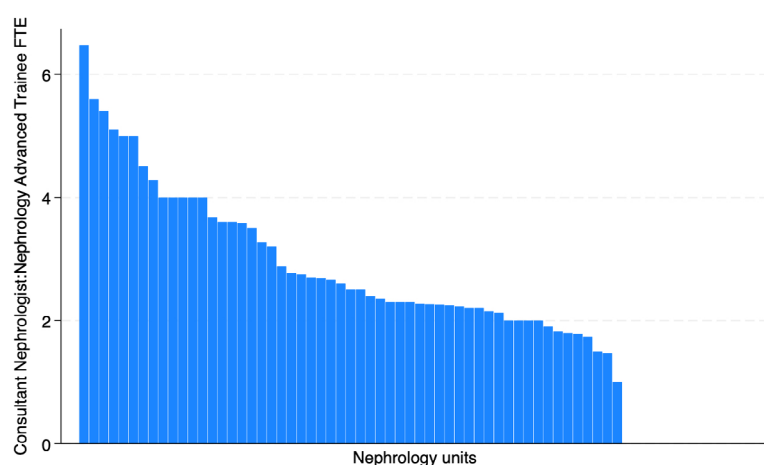
Ratio of FTE consultant Nephrologists to accredited Nephrology Advanced Trainees in adult public Nephrology units in Australia and New Zealand

Consultant Nephrologist FTE: Nephrology advanced trainees*			
Region	Median (IQR)	Min	Max
Australia	2.4 (2.1-3.5)	1.0	5.6
Northern Territory	3.0 (2.2-3.7)	2.2	3.7
New South Wales	2.4 (2.0-3.6)	1.0	5.0
Victoria	2.1 (1.8-2.7)	1.7	5.1
Queensland	2.7 (2.5-4.0)	2.2	5.6
South Australia	2.4 (1.9-2.9)	1.9	2.9
Western Australia	2.3 (2.3-2.8)	2.3	2.8
Tasmania	2.8 (2.3-3.2)	2.8	3.2
Australian Capital Territory	2.3 (N/A)	2.3	2.3
New Zealand	4.4 (3.1-4.8)	2.0	6.5

*Of units with Nephrology advanced trainees. FTE – Full-time equivalent, IQR – Inter-quartile range (N/A where only 1 respondent unit for that subgroup)

Figure 14

Ratio of consultant Nephrologist to accredited Nephrology advanced trainee full-time equivalent in adult public Nephrology units in Australia and New Zealand, by unit



FTE: full-time equivalent



1.1.4. Specialised Nephrology and Allied Health staff

A range of specialised Nephrology and Allied Health staff work within Nephrology units in Australia and New Zealand. All units completed questions regarding specialised Nephrology and Allied Health staff within their unit and FTE staffing of each role. The proportion of units that reported employing specific specialised Nephrology and Allied Health staff in their units is shown in *Figure 15*. Units' specialised Nephrology and Allied Health workforce varied (*Table 5*).

Figure 15

Proportion of units employing Specialised Nephrology and Allied Health Staff in adult public Nephrology units in Australia and New Zealand

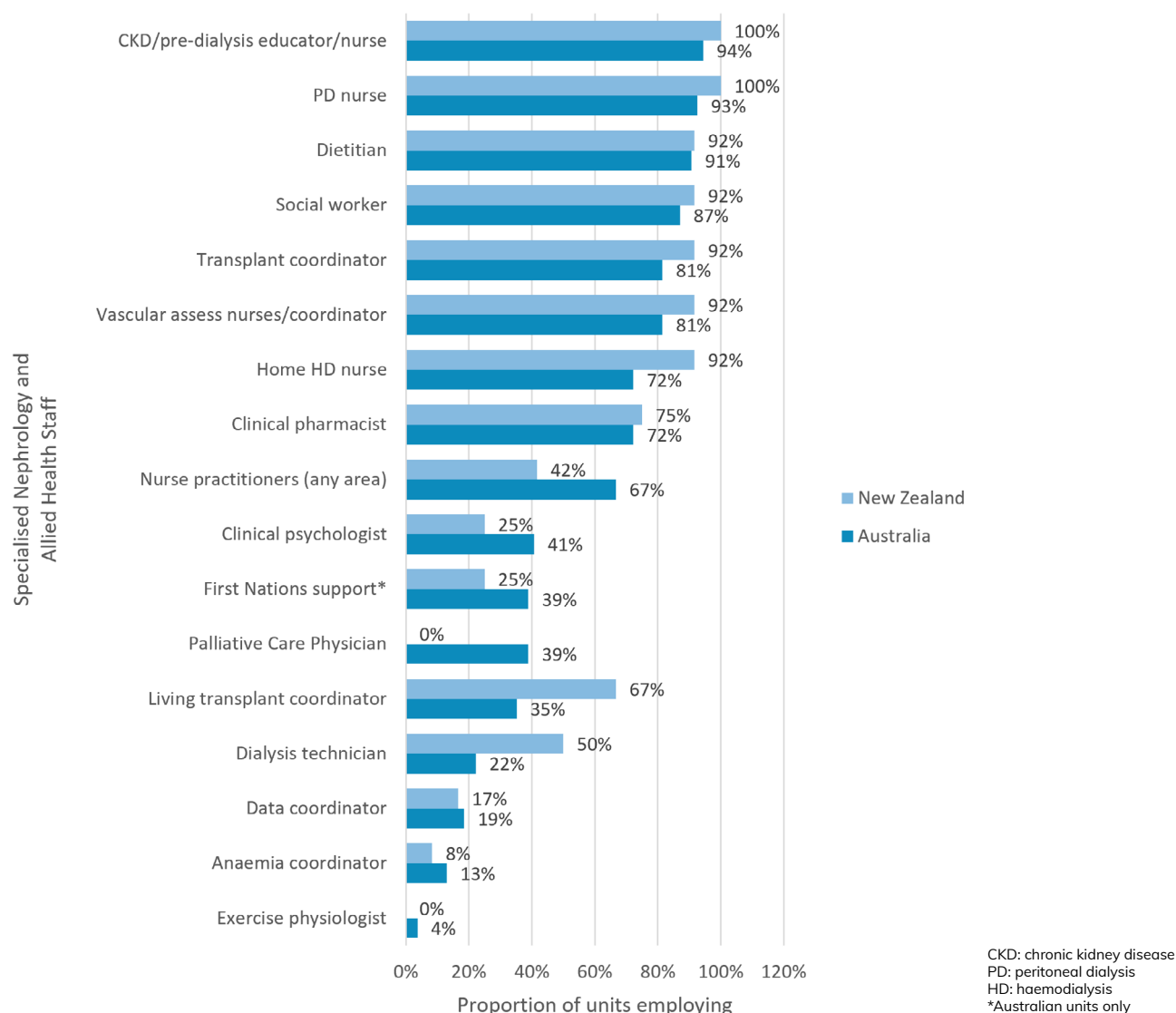




Table 5

Full-time equivalent specialised Nephrology and Allied Health staff, and ratio of patients (dialysis, transplant, and total patients receiving kidney replacement therapy) to these staff, for adult public Nephrology units in Australia and New Zealand employing these staff

Specialised Nephrology and Allied Health staff	FTE Median, (IQR)	Dialysis patient: staff FTE ratio, median (IQR)	Transplant patient: staff FTE ratio, median (IQR) ^{&}	KRT patient: staff FTE ratio, median (IQR)
Allied Health				
Dietitian	1.0 (0.5-2.0)	174.5 (116.7-304.0)	573.3 (218.7-696.8)	311.0 (178.4-502.0)
Pharmacist	1.0 (0.5-1.2)	207.4 (128.5-424.0)	505.0 (236.0-630.0)	340.8 (200.8-660.0)
Psychologist	0.6 (0.4-1.0)	397.0 (257.0-875.0)	1453.3 (786.7-1790.0)	538.8 (378.0-1310.0)
Coordinators[#]				
Anaemia coordinator	0.7 (0.6-1.0)	342.7 (276.2-465.0)	-	-
CKD/ pre-dialysis coordinator	1.0 (0.8-1.0)	226.3 (137.8-344.0)	-	-
Living kidney donor coordinator	0.9 (0.6-1.0)	339.0 (245.8-760.0)	302.0 (244.0-554.0)	641.5 (440.0-1219.5)
Transplant coordinator	1.0 (0.9-2.0)	198.5 (112.5-300.0)	208.5 (149.0-563.3)	320.5 (209.4-498.0)
Vascular access coordinator	1.0 (0.7-1.0)	250.0 (172.0-384.0)	-	-
Social Work				
Aboriginal Torres Strait Islander liaison officer/ health worker [*]	1.0 (0.5-1.0)	257.0 (147.0-648.0)	263.7 (166.5-642.7)	386.0 (180.0-866.0)
Maori/Tauwhiro social worker [^]	0.5 (0.2-1.0)	775.0 (142.0-936.0)	1590.0 (N/A)	1370.0 (226.0-2365.0)
Social worker (any)	1.0 (0.5-1.2)	189.6 (112.5-372.5)	352.0 (302.0-554.0)	302.4 (188.0-650.0)
Specialty nursing				
Home HD nurse [@]	2.0 (0.9-3.0)	10.0 (6.0-13.3)	-	-
Nurse practitioner (any area)	1.0 (1.0-2.0)	147.0 (99.0-239.0)	236.0 (143.2-302.0)	241.0 (115.7-448.0)
PD nurse ["]	2.0 (1.25-3.0)	14.5 (11.0-22.9)	-	-
Data manager	0.75 (0.5-0.75)	471.0 (374.0-806.0)	655.0 (539.0-1068.0)	963.0 (464.0-1282.0)
Palliative care physician	0.5 (0.2-0.9)	600.0 (472.0-1305.0)	705 (432.9-2185.0)	1096.0 (630.0-1900.0)

[&]Transplanting units only

^{*}Australian units only

[^]New Zealand units only

[@]ratio only includes home HD patients

["]ratio only includes PD patients

["]May include specialist nursing staff.

FTE – Full-time equivalent, IQR – Inter-quartile range (N/A where only 1 respondent unit for that subgroup), CKD – Chronic kidney disease, HD – Haemodialysis, KRT – Kidney replacement therapy, PD – Peritoneal dialysis.



PART 2: PERITONEAL DIALYSIS IN AUSTRALIA AND NEW ZEALAND ADULT PUBLIC NEPHROLOGY UNITS

62 of 66 units offering PD (94%) responded to questions regarding PD practices in their unit. Proportions reported below are of respondent units.

1.2.1. PD practices

Units were surveyed about their “PD preferred” policy, defined as actively encouraging or prioritising PD over haemodialysis as the first dialysis modality. 54% of units (n=37) reported that they had a PD preferred policy, 45% of New Zealand units (n=5) almost 63% of Australian units (n=32). 2% of Australian units were unsure.

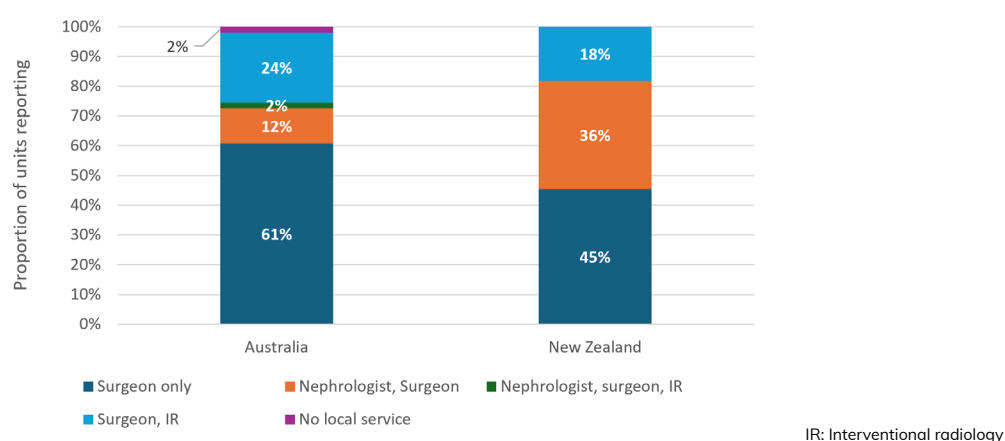
Over three-quarters of units (n=48, 77%) undertook incremental peritoneal dialysis. Defined as a reduced dose of PD prescription at time of PD initiation with the intention to increase to full prescription at a later stage. 80% (n=40) in Australia and 73% (n=8) in New Zealand).

1.2.2. PD catheter insertion

Nephrologists, surgeons and interventional radiologists were the only proceduralists inserting peritoneal dialysis catheters in respondent units. Almost all units bi-nationally reported PD catheter insertion by surgeons in their units; over one-third of units in New Zealand also reported PD catheter insertion by nephrologists (*Figure 16*).

No service was wholly reliant on Nephrologist or interventional radiologist-insertion alone. No service utilised Nephrologist and interventional radiologist-insertion without also utilising surgeon-insertion.

Figure 16
Percentage of adult public Nephrology units in Australia and New Zealand with insertion of peritoneal dialysis catheters by different specialist groups





1.2.3. Infection

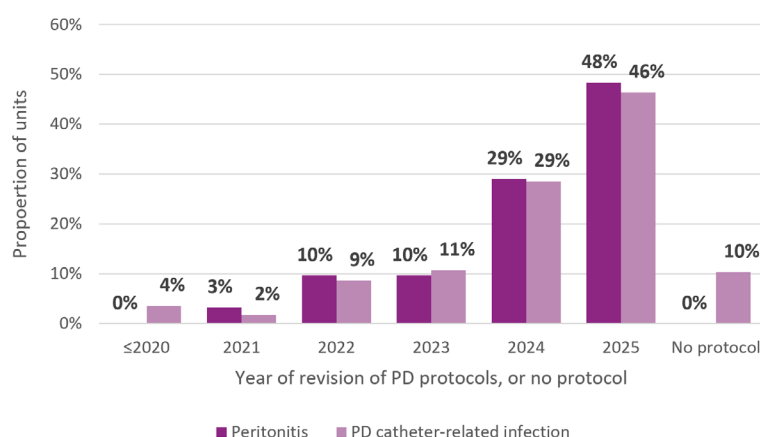
All respondent units had PD peritonitis protocols, all of which had been revised in the last five years (**Figure 17**). 91% of units (n=58) additionally had a protocol for PD catheter infections (including exit site and tunnel infections), the same proportion of units in both Australia and New Zealand. Of these, 56 units provided the year of their protocol revision, which ranged from 2018 to 2025.

48% of units (n=30) undertook root cause analyses (RCA) of episodes of PD peritonitis (defined as a formal structured, systematic review by a multidisciplinary team to prevent PD peritonitis recurrence by identifying the fundamental causes and potential preventive actions for the causes). The remainder either did not undertake RCA of episodes of PD peritonitis (n=30, 48%) or the respondent was unsure (n=2, 4%).

Of units undertaking RCA for PD peritonitis, half undertook RCA of every episode of PD peritonitis, 20% (n=6) for recurrent episodes of PD peritonitis, and 30% (n=9) 'when indicated'.

Figure 17

Percentage of adult public Nephrology units in Australia and New Zealand with revision of their peritoneal dialysis catheter infection protocol, by year*



*Exit site infection protocol revision year reported as the proportion of those units with an exit site infection protocol

1.2.4. PD testing

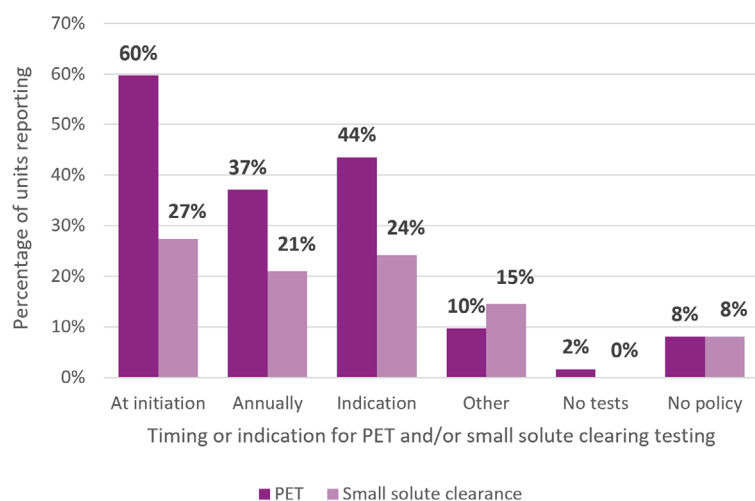
47% of units (n=29) had a unit policy regarding Peritoneal Equilibration (PET) testing alone and 45% of units (n=28) had a policy regarding PET and small solute testing. Five units (8%) had no policy for either PET or small solute testing. All responded to questions regarding when they undertook PET testing and 60 units (95%) responded to questions about when they undertook small solute testing (**Figure 18**).

Most units (60%, n=37) undertook PET testing at initiation (defined as within 6 weeks of commencement), and approximately one-quarter (27%, n=17) undertook small solute testing at the same time. PET was more commonly undertaken annually and for indication testing than small solute testing. Other reported frequencies of PET testing included quarterly (n=3) and six-monthly (n=3), and for small solute clearance testing quarterly (n=2) and six-monthly (n=2).



Figure 18

Percentage of adult public Nephrology units in Australia and New Zealand with policies regarding peritoneal dialysis equilibration and/or small solute clearance testing*



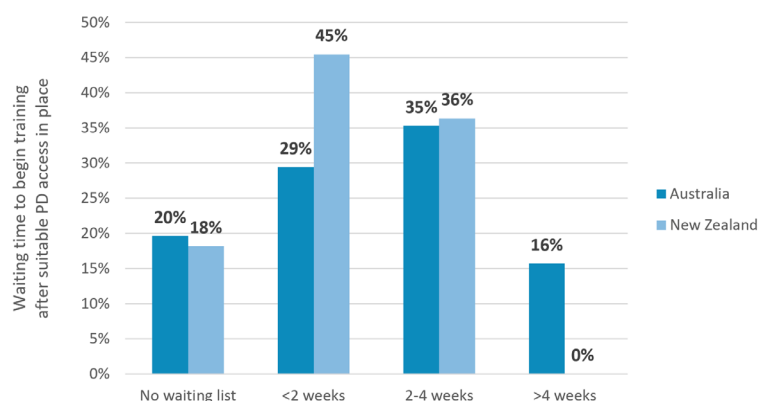
*Proportions total 95% for small solute testing as two units did not provide details about timing of small solute testing. Proportions >100% of PET testing as some units undertook PET testing as multiple intervals and/or for indication testing.

1.2.5. Waiting lists

After suitable dialysis access was in place and ready for use, approximately one-fifth of units bi-nationally had no waiting time to commence PD training; most had a waiting time of up to four weeks. Only Australian units reported waiting times of greater than four weeks (Figure 19).

Figure 19

Percentage of adult public Nephrology units in Australia and New Zealand and waiting time to begin peritoneal dialysis training after suitable dialysis access is in place





64 units of 66 units offering PD (97%) responded to questions regarding barriers to PD in their unit. Proportions reported below are of respondent units.

1.2.6. Barriers to PD

Units were surveyed about perceived barriers to peritoneal dialysis experienced by patients cared for by their unit. These were broadly categorized as patient factors, health system factors, and other factors (Table 6). The commonest barrier to peritoneal dialysis was patients' fear of the responsibility of caring for their own dialysis (55% in Australia, 46% in New Zealand). Notably, housing hygiene factors and lack of space for storage of medical supplies was reported by 82% of units in New Zealand. Other patient factors detailed as barriers to PD uptake included age, frailty and physical disability, and patient preference for satellite haemodialysis where this treatment modality was available close to home.

Although surveyed, no units reported lack of a local PD champion or poor pre-dialysis education as a barrier to PD uptake.

Table 6

Units' reported barriers experienced by their patients, impacting uptake of peritoneal dialysis

	Australia n (%)	New Zealand n (%)
Patient factors	39 (73.6)	10 (90.9)
Fear of independent responsibility for dialysis care	29 (54.7)	5 (45.5)
Fear of PD peritonitis or PD complications	15 (28.3)	7 (63.6)
Body image concerns	13 (24.5)	6 (54.6)
Out of pocket costs for electricity for APD machine	2 (3.8)	2 (18.2)
Lack of space in home for storing medical supplies	21 (39.6)	9 (81.8)
Housing hygiene factors	24 (45.3)	9 (81.8)
Cultural factors	18 (34.0)	8 (72.7)
Poor health literacy	27 (50.1)	6 (54.6)
Other	11 (20.8)	1 (9.1)
Health system factors	17 (32.1)	4 (36.4)
Lack of expertise/ availability/ delay in PD catheter insertion	7 (13.2)	2 (18.2)
Lack of training/ limited expertise among staff	3 (5.7)	0 (0)
Lack of infrastructure	8 (15.1)	2 (18.2)
Financial incentives to perform in-centre HD*	6 (11.3)	1 (9.1)
Other factors	5 (9.4)	0 (0)
No barriers	8 (15.1)	1 (9.1)

Note: May add up to >total unit number as units could select multiple barrier types. *Example: Changes by the IHACPA (Independent Health and Aged Care Pricing Authority) which reduced reimbursement for PD by approximately 50%, lower reimbursement for supervision of facility HD compared to PD in the private sector.

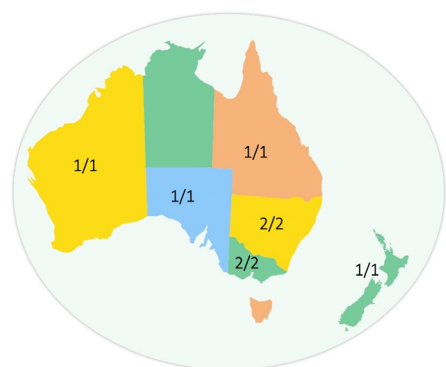


SECTION 2: PAEDIATRIC PUBLIC NEPHROLOGY UNITS

Section 2 of this Special Report details responses from paediatric public Nephrology units in Australia in New Zealand. Number of survey-respondent units over total number paediatric public units by New Zealand/Australian state/territory is shown in Figure 20. Survey response rate was 100% for all questions.

Figure 20

Number of responses from paediatric public Nephrology parent units by the total number of paediatric public Nephrology units in the region (New Zealand/Australian state/territory)



1. Individuals completing the survey

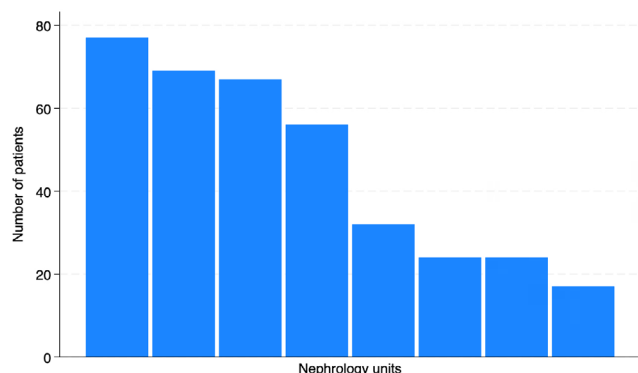
All surveys were completed by the Head of the paediatric Nephrology unit.

2. Total patients receiving kidney replacement therapy

Number of prevalent patients receiving KRT cared for by each Nephrology unit varied (Figure 21).

Figure 21

Number of prevalent patients receiving kidney replacement therapy (dialysis and transplant) in paediatric Nephrology units in Australia and New Zealand





PART 1: AUSTRALIAN AND NEW ZEALAND PAEDIATRIC PUBLIC NEPHROLOGY UNIT WORKFORCE

2.1.1. Number of full-time equivalent consultant Nephrologists in each Nephrology unit

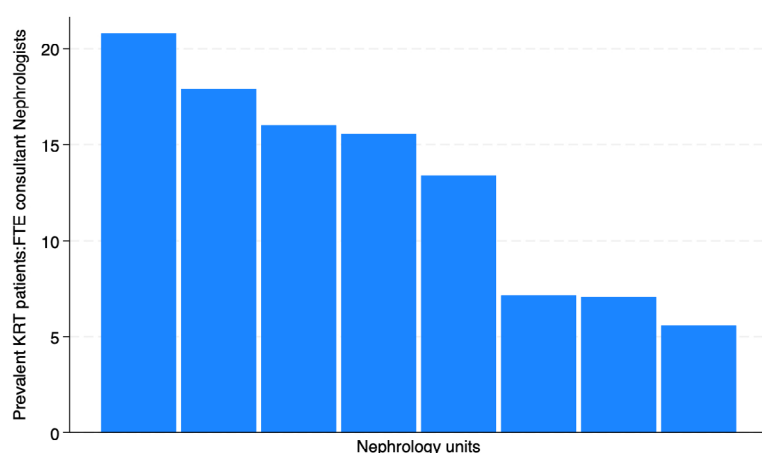
The median number of FTE consultant Nephrologists in paediatric Nephrology units was 3.5 (IQR 3.2-3.8, range 2.0-5.0). One unit reported consultant Nephrologist vacancy.

2.1.2. a) Ratio of full-time equivalent consultant Nephrologists to prevalent patients receiving KRT

The ratio of prevalent patients receiving KRT to FTE consultant Nephrologists in paediatric Nephrology units was 14.5 (IQR 7.1-17.0, range 5.6-20.8) but varied (*Figure 22*). The ratio of prevalent patients receiving dialysis to consultant Nephrologists was 1.7 (IQR 1.4-4.0, range 0.4-6.5) and the ratio of prevalent patients in receipt of a kidney transplant to consultant Nephrologists was 11.3 (IQR 5.6-13.8, range 4.3-16.8).

Figure 22

Ratio of prevalent patients receiving kidney replacement therapy (dialysis and transplant) to full-time equivalent consultant Nephrologists in paediatric Nephrology units in Australian and New Zealand



2.1.3. Medical leads

Numbers of units reporting medical leads in different areas of Nephrology varied. The commonest medical lead portfolios were transplant (n=3, 38%), haemodialysis (n=3, 38%), peritoneal dialysis (n=2, 25%), glomerulonephritis (n=2, 25%) and CKD (n=1, 13%). No units reported medical leads in any of home haemodialysis, kidney supportive care.

2.1.4. Nephrology Fellows

Five units (63%) employed Nephrology Fellows, in Transplant (n=3, 60%) and haemodialysis (n=2, 40%). There were no reported Fellow vacancies.



2.1.5. Nephrology trainees

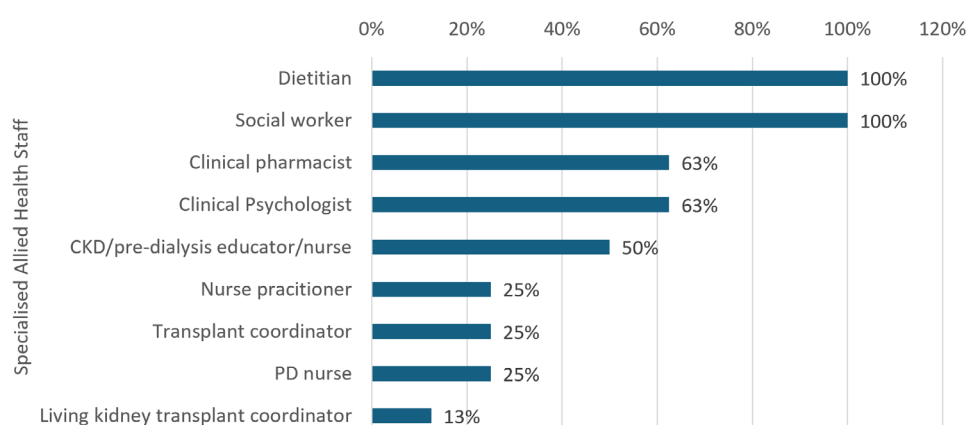
All Australian paediatric Nephrology units reported 1.0 FTE Nephrology physician trainees within their unit. The ratio of consultant Nephrologists to paediatric Nephrology trainees was 1.8 (IQR 1.6-2.2, range 1.0-3.4).

2.1.6. Specialised Nephrology and Allied Health staff

All units responded to questions regarding the employment of specialised Nephrology and Allied Health staff in their units. A narrower range of staff were employed in paediatric Nephrology units compared to adult Nephrology units (**Figure 23**). All units employed a dietitian and a social worker, and the majority also employed a PD nurse and a psychologist. 50% of units employed a CKD/pre-dialysis coordinator. The FTE of these staff is shown in **Table 7**.

Figure 23

Percentage of paediatric Nephrology units in Australia and New Zealand employing specialised Nephrology and Allied Health staff within their units



CKD: chronic kidney disease
PD: peritoneal dialysis



Table 7

Full-time equivalent specialised Nephrology and Allied Health staff, and ratio of patients (dialysis, transplant, and total patients receiving kidney replacement therapy) to these staff, for paediatric public Nephrology units in Australia and New Zealand employing these staff

Specialised Allied Health staff	FTE Median, (IQR)	Dialysis patient: allied health FTE ratio, median (IQR)	Transplant patient: allied health FTE ratio, median (IQR) ^{&}	KRT patient: allied health FTE ratio, median (IQR)
Allied Health				
Dietitian	0.6 (0.3-0.9)	13.8 (5.9-23.0)	47.5 (31.7-65.0)	66.5 (50.0-84.4)
Pharmacist	0.2 (0.1-0.2)	70.0 (40.0-75.0)	200.0 (130.0-380.0)	345.0 (170.0-385.0)
Psychologist	0.2 (0.2-0.5)	30 (14.0-40.0)	108 (98.0-130.0)	160.0 (138.0-170.0)
Social Work				
Social worker	0.5 (0.1-0.6)	31.3 (14.4-45.0)	108.3 (47.5-190.0)	132.8 (83.1-205.0)
Specialty nursing				
Nurse practitioner (any area)	0.9 (0.85-1.0)	8.7 (2.4-15.0)	76.5 (N/A)	77.9 (77.0-78.8)
PD nurse	0.9 (0.2-1.0)	1.0 (5.6-15.0)	-	-
Coordinators[#]				
CKD/ pre-dialysis coordinator	0.4 (0.2-1.3)	19.5 (10.8-32.5)	-	-
Living kidney donor coordinator	0.1 (N/A)	40 (N/A)	130 (N/A)	170 (N/A)
Transplant coordinator	0.6 (0.3-0.8)	16.0 (13.3-18.8)	55.4 (43.3-67.5)	71.5 (56.7-86.3)

[#]May include specialist nursing staff.

[&]Ratio only includes PD patients.

FTE – Full-time equivalent, IQR – Inter-quartile range (N/A where only 1 respondent unit for that subgroup), HD – Haemodialysis, KRT – Kidney replacement therapy, PD – Peritoneal dialysis, CKD – Chronic kidney disease.

2.1.7. Therapy training offered to patients at each Nephrology unit

All units reported access to PD training; one unit additionally reported access to home haemodialysis training.



CONCLUSION

This report provides the most comprehensive contemporary picture of workforce capacity, service provision and peritoneal dialysis practice across Nephrology units in Australia and New Zealand. It reveals a highly skilled, multidisciplinary workforce delivering care to people with kidney failure across diverse geographic and health service settings. At the same time, it highlights substantial variation in workforce capacity, staffing models and workloads of care provision across jurisdictions between individual units.

Most notably, the number of patients receiving kidney replacement therapy cared for per Nephrologist, Nephrology trainee, specialist Nephrology and Allied Health professional varies markedly across Australia and New Zealand. These differences have important implications in equitable access to timely kidney care, staff wellbeing and workforce sustainability, quality of Nephrology training and clinical supervision.

The report also demonstrates that, although peritoneal dialysis is widely available across both countries, its uptake is constrained by barriers that frequently lie beyond individual patient control, including housing, infrastructure and health service limitations. Addressing these barriers represents an important opportunity to strengthen access to home-based dialysis where appropriate, reduce pressure on in-centre haemodialysis and improve the sustainability of dialysis care in Australia and New Zealand.

As the number of people living with kidney failure continues to grow, the findings of this report provide a strong evidence base to inform workforce and health service planning, and guide future investment. The workforce variation identified in Australia and New Zealand risks inequitable access to kidney care based on where people live and receive treatment. Addressing these disparities will be critical to delivering equitable, high-quality kidney care and meeting the needs of Australian and New Zealanders living with kidney failure now and into the future.

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Units may provide feedback on this Report at: anzdata@anzdata.org.au



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ANZDATA & ANZSN SPECIAL REPORT

Unit Survey 2025:
Nephrology workforce and
peritoneal dialysis practices