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**Reply**

At a relatively early stage in comparison with other Central and Eastern European countries, Hungarian nephrologists together with private investors started a privatization of the dialysis sector, after political and economical revolution in this region. Privatization positively influenced, both quantitatively and qualitatively, this part of renal replacement therapy [1]. Looking at the rest of the region, including my own country Poland, privatization has also had a positive impact on dialysis facilities. I mentioned in my article that many public hospitals have financial problems causing a lack of modern equipment to replace old and worn-out material [2]. In this case, privatization of the dialysis unit is only one way to keep in touch with modern technology and maintain standards of treatment. On the other hand, throughout the Central and Eastern European region, the word ‘privatization’ appears to be very unpopular. In their Letter, our Hungarian colleagues seek to avoid this word, introducing instead two different phrases: ‘private finance initiative’ or ‘public–private partnership’. In my opinion, this is caused by the continued presence of a ‘homo sovieticus’ mindset. It is thus advisable to use simple words and no matter how it is called, privatization means the process by which private investors will provide, nearly all dialysis procedures in Hungary for at least a 15–25 year period. This investment is clearly made on the basis of future profit, and is not a charitable activity. Nevertheless, we should remember the old Polish proverb, which says that ‘harmony is building and discord is damaging’.

I would like at the end of this polemic to propose a new term: ‘Functional Privatization’; this term hopefully embraces both points of view.

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Department of Nephrology Boleslaw Rutkowski
Transplantology and Internal Medicine, Institute of Internal Medicine
Medical University of Gdańsk
Poland
Email: bolo@amedec.amg.gda.pl
prut@amg.gda.pl


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**Commentary on the highlights of the epidemiology of renal replacement therapy in Central and Eastern Europe**

Sir,

We read with interest an article by Rutkowski [1] published in the January issue of NDT. We found several concerns within this article that we feel warrant some comment.

There is general agreement that during the last 15 years there have been dramatic political changes in the former Communist countries within the part of Europe informally known as ‘Central and Eastern Europe’. In the majority of these countries, political changes were followed by rapid economical changes, including changes in renal health care. In our opinion, it is impossible to attempt a comparison of this large region, since some of the mentioned countries were industrially quite developed, even before the Second World War. Thus, the common political history that joined the countries of this region is very short.

There is another, more important concern about Rutkowski’s article. The data that is shown was obtained from colleagues from the Central and Eastern European Advisory Board for Chronic Renal Failure or members of the National Renal Registries, but the recent list of such experts was not provided. Renal registries already exist in some of these countries, but not in all of them; the provided figures might thus come from individual feelings rather than from objective numbers.

The weakness of the article is particularly illustrated in Figure 2 of [1], where Rutkowski presents renal transplant activity in 2002 according to absolute numbers of kidney transplants. This comparison lacks an objective base, since it was not related to the total population of the country. Thus, readers cannot obtain relevant information on the real transplant activity of the mentioned countries. Using Rutkowski’s data, we recalculated the renal transplant activity of the aforementioned countries per million of population (Figure 1). Surprisingly, Bosnia was shown to have one of the best transplant programmes in the region, contradictory to Rutkowski’s statement that after the disintegration of former Yugoslavia, renal transplantation ceased completely.

Similarly, the obtained mortality data are incomparable among those countries. That is why the information on its definition is missing. In the Czech Republic, the national registry of dialysis therapy has just been recently introduced; thus, data used in Rutkowski’s article may suffer from a biased view.

Recently, the International Registry of Organ Donation and Transplantation was established [2]. Already published data showed that within the ‘Central and Eastern European’ countries, the renal transplant activity in the Czech Republic has recently reached 39.3, in Latvia 30.9, Hungary 28.4, Poland 27.1, Estonia 24.0, Slovakia 18.3, Lithuania 16.7 and Romania 0.7 deceased donor kidney transplants p.m.p., respectively. Similarly, the living donor kidney transplantation programme has been rather developed in Slovakia (3.9 living donor transplants p.m.p.), the Czech Republic (3.8), Estonia (3.6), Georgia (1.6), Lithuania (1.2), Hungary (1.1), Poland (1.0) and Latvia (0.4), respectively [2].

In order to compare renal health care among European countries, the establishing of reliable databases and registries is obviously necessary. Confusing information might underestimate the general view on renal health care in the region.

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2. 2004 Donation and transplantation preliminary figures. IRODaT. Organs and Tissues 2005; 8: 7–10

Reply

Sir,

In their letter, Viklicky et al. raised the important point of epidemiological data reliability. Unfortunately in Europe, the ‘old’ system, introduced by the EDTA Registry and based on individual patient data collection, failed in the late 90s of the last century. Nowadays, the ERA-EDTA Registry is rather a Federation of the National Renal Registries. It is obvious that individual patient data collection is more reliable, nevertheless, the vast majority of Registries from Central and Eastern Europe (CEE) are still collecting data using centre questionnaires. Viklicky et al. also gathered data concerning dialysis treatment in the same way. This information is published annually, in small booklets entitled: ‘Annual Statistics of Dialysis Therapy in Czech Republic’ [1]. This data was analysed together with other information delivered by Prof. Vladimir Teplan, former President of the Czech Society of Nephrology and present Chief of the Czech National Kidney Foundation, as a member of the Advisory Board of Chronic Renal Failure in CEE. Other members of this Board were enlisted from the top nephrology leaders in the CEE region. Their names were enlisted for several earlier common publications [2–5]. In these articles, good results for Czech transplantology were also shown and underlined. I do hope that, by taking into account all the information presented above, Viklicky et al. will find the data published in my article more reliable.

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Department of Nephrology
Institute for Clinical and Experimental Medicine
Videnska 1958, 14000 – Prague 4
Email: ondrej.viklicky@medicon.cz

Ondrej Viklicky
Eva Pokorna
Stefan Vitko
On behalf of the Transplant Society

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Fig. 1. Renal transplantation in ‘Central and Eastern European’ countries per million of population (according to Rutkowski data).