# Letters

## Response to: Changes to rehabilitation after total knee replacement

The authors read the recent article 'Changes to rehabilitation after total knee replacement' by Sattler et al (*AJGP* September 2020)[1] with great interest. We would like to make a contribution to this article. It was pointed out that the seemingly indiscriminate use of inpatient rehabilitation following primary total knee replacement (TKR) might be considered 'low-value care' in Australia. In May 2019, the Rehabilitation Medicine Society of Australia and New Zealand produced a position statement with indicators for patients requiring inpatient rehabilitation following TKR.[2]

These indicators were based on evidence from the HIHO randomised control trial, a study that specifically excluded from its study cohort any patient who would have normally been referred to inpatient rehabilitation following primary TKR. Furthermore, a separate study, funded by Medibank Private Ltd, which mined their own data, coined the term 'low-value care' in order to highlight their plan to fund rehabilitation in the home, which, until late 2019, was unfunded.[3] It would appear that Sattler et al failed to read all the grey literature or carefully examine the HIHO study's inclusion criteria. Had the researchers explored all the relevant literature, they may have been more academic with their use of the term 'indiscriminate'.

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**References**

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3. Schilling C, Barker A, Wilson SF. Predictors of inpatient rehabilitation after total knee replacement: An analysis of private hospital claims data. Med J Aust 2019;210(2):101. doi: 10.5694/mja2.12065.

## Reply

We appreciate the interest in our article 'Changes to rehabilitation after total knee replacement'.[1]

We acknowledge that the position statement produced by the Rehabilitation Medicine Society of Australia and New Zealand includes clinical indicators and safety standards for the assessment of suitability for home-based rehabilitation after total knee replacement (TKR). Although these consensus statements are subject to confirmation bias, they are an important step forward if they accurately reflect existing literature. Transparent guidelines that aim to assist decision making for the most appropriate discharge destination following TKR surgery are valuable tools for clinicians.

Unfortunately, despite the position statement making the recommendation for rehabilitation destination to be determined by clinical drivers, there is robust evidence that non-clinical factors are still the major determinant of discharge destination in the private sector.[2–4] In Australia, the mean rate of discharge to inpatient rehabilitation in the private sector (40%) is double that in the public sector (20%).[5] This high variation of inpatient rehabilitation discharge rates cannot be explained by clinical factors alone, with research suggesting that hospital- and surgeon-level factors and patient preference have the strongest influence.[2–5] Accordingly, when referring to the rate of inpatient rehabilitation discharge after uncomplicated primary TKR, the authors consider the term 'seemingly indiscriminate' to be appropriate. With more patients discharging to inpatient rehabilitation than clinically indicated, the authors agree that the results of the HIHO trial are highly relevant, demonstrating that there is no greater functional benefit to a patient discharging to inpatient rehabilitation who would otherwise be suitable for discharge home.

Moreover, with respect to the use of the term 'low-value care', the authors believe the use of the term in the context of rehabilitation is appropriate within this narrative review. Four years prior to the Medibank-funded study, the *Medical Journal of Australia* described 'low-value care' as care that confers benefit that is disproportionately low when compared with its cost.[6] The authors agree with Schilling et al that given the

increased financial burden of inpatient rehabilitation without demonstration of superior outcomes, alternative models of care should be explored.[7]

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