The article by Robbins et al. (1) in this issue of Anesthesia & Analgesia raises a number of important issues in the debate over the impact of managed care policies on the health outcomes of people with persisting pain. In particular, the Robbins et al. study suggests that managed care policies that result in the selective funding of components of an interdisciplinary pain management program risk compromising the effectiveness of such programs.

While it is an important question to estimate the degree to which any individual element of such programs contributes to the overall outcomes achieved, it is not a simple task and there are little useful data on which to base sensible decisions. It can also be argued that an individual element in a multicomponent program could have an effect beyond its expected domain due to synergistic effects in interaction with other elements. For example, an exercise component may not only enhance fitness and strength, but may also provide a greater sense of confidence in tackling activities previously thought by the patient to be impossible. In this sense, Robbins et al. add useful information, to a fairly bare cupboard, on the possible impact of removing the physical therapy component of their program. At the same time, the results may be seen to demonstrate the disadvantages of using externally formulated policies to determine the components of a multicomponent program.

It also needs to be said (e.g., Turk (2)) that attempting to select the active components of pain management programs may be asking the wrong question. Instead, it may be more useful to ask which treatment program is appropriate for which patient. In this sense it could be argued that it would make more sense for those providing a given program to make a case on the effectiveness of their tailored program(s) for patients with particular characteristics.

In evaluating the evidence provided by the Robbins et al. study, it is important to bear in mind the methodological limitations that restrict their conclusions. In large part, many of the limitations were imposed on the authors by the nature of the system in which they operate. Specifically, the study could not use random allocation to treatment components, so there may have been some unknown bias operating to produce the outcomes achieved. The small number in the group denied physical therapy raises questions over the adequacy of statistical power to draw conclusions. This concern is compounded by the use of multiple uncorrected tests in the analyses, which risked increasing the chance of Type I errors (i.e., finding a significant difference when there isn’t one). However, even bearing in mind these methodological issues, Robbins et al. have at least produced some evidence that should promote informed questioning of current managed care policies in relation to the treatment of those with persisting pain conditions.

References