165/8 ONE ITEM ENOUGH TO MEASURE HEALTH STATUS?
Jose L. Pais-Ribeiro, Psychology, Oporto University, Porto, Portugal

A traditional way to measure health perception is “How is your health in general?” with answer alternatives in a five-point Likert response scale from “very good” to “very poor”. Many studies report that it has proven to be a powerful and consistent predictor of health outcomes including measures of mortality and morbidity, but others report that “single item measures of health status may not provide a sufficiently accurate indicator of health status...”. It is used in National surveys namely in Portugal. Within the European Union the number of people considering their health “very good” is reported by as much as 56% of the Danish and as little as 8% of the Portuguese. It is considered that self-reported health status may be sensitive to differences in language and culture. The objective of the present study is to compare the answer to a single item self-perception question with the answers to the SF-36 and with measures of disease behavior like number of visits to physicians, 2007 and non-patients, and in the SF-36, aged between 15 and 88 years of age, participated in the study. The SF-36 status was assessed with SF-36 which includes one item with that form. Correlations between the self-assessed health status and dimensions of SF-36 were Physical Functioning (r0.5); Role Physical (r0.3); Bodily Pain (r0.3); General Health (r0.5) (corrected for overlap); Vitality (r0.3); Social Functioning (r0.4); Role Emotional (r0.3); Mental Health (r0.4); age (r0.51); schooling level (r<0.0.33). The correlations were statistically significant but modest and they are similar to the correlations of SF-36 dimensions and the same indicators of disease behavior. Results suggest that one single item self-assessed health status can be a satisfactory measure of perceived health status in general.

165/9 HEALTH STATUS AND QUALITY OF LIFE: THE EFFECT OF DEPRESSIVE SYMPTOMS
Nausa S. Rocha, Department of Psychiatry, Federal University of the State of Rio Grande do Sul, Porto Alegre, Rio Grande do Sul, Brazil, Zulmira N. Borges, Department of Anthropology, Federal University of Santa Maria, Santa Maria, Rio Grande do Sul, Brazil, Marcelo F. D. de Oliveira, Department of Psychiatry, Federal University of Porto Alegre, Porto Alegre, Rio Grande do Sul, Brazil

The occurrence of depressive symptoms in sick people has been extensively demonstrated. The degree to which depressive symptoms can impair patients' quality of life remains unclear. We select a sample composed of 253 individuals divided into 5 groups: a control sample of 118 healthy individuals, by sex and age, patients from our university hospital. Instruments used were: a) WHOQOL-100; b) BDI c) BHS and c) The Scale of Importance given for the facets of life. The study was focused on the Spirituality. Religiosity and Personal Beliefs module of the WHOQOL (WHOQOL-SRPR). Patients had higher BDI means than controls. BHS means also were higher in the patients group when compared with control group. Significant depression levels were measured in about 46% of patients and 16% of controls. In most WHOQOL-100 domains, controls had higher means than patients, except for the domain related with religiosity. Using multiple regression analysis for depression symptoms and QOL, a psychological domain yielded beta of 0.39 (p<0.01) for depression symptoms; in a psychological domain, beta for health status was -0.32 (p<0.0001) and -0.41 (p<0.0001) for depression symptoms; the social relations domain yielded beta = 0.41 (p<0.0001) for sociocultural level and -0.43 (p<0.0001) for depression symptoms; in the environment domain, beta was 0.13 (p<0.02) for age, 0.33 (p<0.0001) for sociocultural level, -0.39 (p<0.0001) for depression symptoms and 0.15 (p<0.02) for health condition; finally, the aspects of spirituality and religiosity yielded beta of 0.14 (p<0.0001) for depression symptoms. Although health condition had a more important influence on patients' quality of life, but depression seems to be more strongly correlated with quality of life than health status.

166/4 SENSITIVITY TO CHANGE OF THE SF-36 IN PATIENTS WITH OSTEOARTHRITIS OF HIP OR KNEE
Sonia Bothemer, Department of Health Psychology, Freie Universitats-Berlin, Berlin, Germany, Thomas Kohlmann, Institute for Social Medicine, Medical University of Luebeck, Luebeck, Germany, John Bredahl, Health Economics Group, University of Sheffield, Sheffield, United Kingdom

The SF-36 (Seligman et al. 2002) is a new preference-based measure of health that can be used in economic evaluation. As this instrument aggregates multiple information about the health status into an unidimensional index it could be hypothesized that it may be less sensitive to change than a multidimensional measure of HRQoL. 109 patients with osteoarthritis of the hip or knee answered a survey at the beginning (T1), at the end (T2) and after a stay in a rehabilitation clinic (T3). The survey comprised the SF-36, the Nottingham Health Profile (NHP), the Pain Disability Index (PDI), the Center for Epidemiologic Studies Depression Scale (CES-D) and the Hannover Functional Ability Questionnaire for Osteoarthritics (HAQ). Responses to the SF-36 were used to calculate the index SF-6D, which had improved over their stay and remained almost stable for the next two months, respectively. For the SF-36 SF-6Rs of 0.04 (T1-T2) and 0.34 (T1-T3) were found. The SF-6Rs of the SF-36 subscales fell in between 0.01 (Role Emotional, T1-T3) and 0.64 (Bodily Pain, T1-T2). All the other instruments ranged from 0.06 (NHP Emotional Reaction, T1-T2) to 0.71 (HAQ, T1-T3). In this sample correlation analysis showed higher associations of the SF-36 with psychological dimensions of health than with physical dimensions of health. It can be concluded that the SF-36 is capable of measuring changes of health in patients with osteoarthritics of the hip or knee. The results of our study suggest that the SF-6D is at least as sensitive to change as most of the SF-36, and if other established QoL measures. More research will be needed to confirm these findings in other patient and population samples.

166/11 STUDY OF REDUCED FORMS OF SF-36 IN A PORTUGUESE SAMPLE
Jose L. Pais-Ribeiro, Psychology, Oporto University, Porto, Portugal

Quality of life (QOL) and perceived health status have become a primary end-point in clinical intervention. The assessment of perceived health status and QOL are time consuming and require daily routine practice. This is one of the reasons why health care units are using the utilization of shorter forms that take up a small amount of time. When we reduce a questionnaire to its metric properties becomes, also, reduced. SF-36 forms the clinical intervention. The aim of the present study is to compare the two reduced forms of SF-36, the SF-12, the SF-36, and the QOL. The sample includes population outside the health care system (N=1403), 46.4% males, aged between 15 and 85 years of age, patients with different chronic diseases (N=220), 30.9% females, aged between 15 and 85 years of age, outpatients linked through their diseases to the health care system. We used the Portuguese SF-36 form after formal authorization from the MO. SF-36 includes eight dimensions plus one health transition item. The eight dimensions can be grouped into dimensions: the physical and the mental component. The reduced forms maintain the eight dimensions. Results show correlations ranging from .52 to .93 between dimensions of SF-12 and SF-36, and .52 to .61 between dimensions of SF-12 and SF-36. Factorial structure of both forms are identical. The SF-36 structure, with the same dimension by component (physical versus mental) and identical magnitude. Correlation between the two components of SF-36 and SF-12 are .93 (mentals) and .56 (physical). The SF-36 and SF-12 components of SF-36 and SF-12. Comparing the differences between patients with OAFDs. In major two components, the differences are higher with SF-36, lower with SF-12 and lower with SF-36. SF-12 and SF-36. The use of the reduced forms is an interesting alternative.