162/IS ONE ITEM ENOUGH TO MEASURE HEALTH STATUS?

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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 53% 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 one item self-perception question with the answers to the SF-36 and with measures of disease behavior like number of sick days, days out of work due to disease, days in bed due to disease, number of visits to a physician. 2357 outpatient and non patients, 42,72% males, aged between 15 and 98 years of age, participated in the study. Health status was assessed with SF-36 which includes one item with that form. Correlations between the one item self assessed health and dimensions of SF-36 were: Physical Functioning (.60); Role Physical (.50); Bodily Pain (.53); General Health (.65) (corrected for overlap); Vitality (.50); Social Functioning (.42); Role-Emotional (.34); Mental Health (.48); age (-.51); schooling level (0.23). All the correlations were statistically significant. A sample of 449 non diseased individuals showed a correlation between the one item self assessed health measure and disease behavior between r=-0.23 and r=-0.36. All the correlations were 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 item self assessed health can be a satisfactory measure of perceived health status in general.

163/HEALTH STATUS AND QUALITY OF LIFE- THE EFFECT OF DEPRESSIVE SYMPTOMS

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The occurrence of depressive symptoms in sick people has been extensively demonstrated. The extent to which depressive symptoms can impair patients' quality of life remains unclear. We select a sample composed of 253 individuals divided into 2 groups: a control sample of 118 healthy individuals from the community and sample with 134 in and out-patients from our university hospital. Instruments used were: a) WHOQOL-100, b) BDI c) BHS and d) The scale of importance degree given for the facets used for the field trial of the Spirituality, Religiosity and Personal Beliefs module of the WHOQOL (WHOQOL-SRPBi). 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 46.3% 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 WHOQOL-100 domains we found that in the physical domain the beta for the health state was -0,32 (p=0,0001) and -0.41 (p=0,0001) for depression symptoms; in the psychological domain, beta for depression symptoms was -0,58 (p=0,0001); in the independence level domain, beta for health state was -0,43 (p=0,0001) and -0,41 for depression symptoms; the social relations domain yielded beta of 0.19 (p=0,01) for socioeconomic 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=0,00001) for socioeconomic level, -0,30 (p=0,00001) for depression symptoms and -0,15 (p=0,02) for health condition; finally, the aspects of spirituality domain yielded beta of 0,14 (p=0,03) for age and -0,36 (p=0,00001) for depression symptoms. Although health condition is correlated negatively to quality of life in the physical, independence level and social relation domains, depression symptoms are in all domains with stronger betas. We therefore conclude that health condition have a negative influence on patients' quality of life, but depression seems to be more strongly correlated with quality of life than health status.

164/SENSITIVITY TO CHANGE OF THE SF-6D IN PATIENTS WITH OSTEOARTHRITIS OF HIP OR KNEE

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The SF-6D (Brazier 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 two months 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 Osteoarthritis (HFAQ). Responses to the SF-36 were used to calculate the index SF-6D. Patients' health improved over their stay and remained almost stable for the next two months. Standardized response means (SRM) were calculated to investigate the measures' sensitivity to change. The SF-6D showed to be more sensitive to change than most of the subscales of the SF-36, and the other instruments, respectively. For the SF-6D SRMs of 0.64 (T1-T2) and 0.34 (T1-T3) were found. The SRMs of the SF-36 subscales fell in between 0.13 (Role Emotional, T1-T3) and 0.84 (Bodily Pain, T1-T2), those of the other instruments ranged from 0.05 (NHP Emotional Reaction, T1-T3) to 0.71 (HFAQ, T1-T3). In this sample correlation analysis showed higher associations of the SF-6D with psychosocial dimensions of health than with physical dimensions. It can be concluded that the SF-6D is capable of measuring changes of health in patients with osteoarthritis 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 subscales or other established QoL measures. More research will be needed to confirm these findings in other patient and population samples.

165/STUDY OF REDUCED FORMS OF SF-36 IN A PORTUGUESE SAMPLE

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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 which hinders their use in everyday clinical practice. That is one of the reasons why health care units impose the utilization of shorter forms that take up a small amount of time. When we reduce a questionnaire its metric properties become, also, reduced. Sf-36 is a short-form questionnaire from the General Health Rating Index, used to evaluate health status. However its main use is to assess QOL. The aims of the present study are to compare two reduced forms of SF-36, the SF-12 and the SF-8. The sample includes population outside the health care system (N= 1434), 46.44% males, aged between 15 and 95 years of age, and patients with different chronic diseases (N=923), 36.9% males, aged between 15 and 98 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 MOT. SF-36 includes eight dimensions plus one health transition item. The eight dimensions can be grouped in two major dimensions or components, 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 .82 between dimensions of SF-12 and SF-36. Factorial structure of both forms are identical to the SF-36 structure, with the same dimension by component (physical versus mental) and identical magnitude. Correlations between the two components of SF-36 and SF 12 are .93 (mental) and .96 (physical), and .88 and .91 between the same components of SF-8 and SF-36. Comparing the differences between patients and non-patients for the two components, the differences are higher with SF-36, lower with SF-12 and lower with SF-8. We can say that if taking up time is a limitation for the use of the SF-36 the use of reduced forms is an interesting alternative.