163/5. 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 in particular in Portugal. Within the European Union the number of people considering their health "very good" or "very good" is reported by as much as 55% 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-assessment 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 health, days in bed due to disease, number of visits to a physician. 2357 outpatients and non patients, 42.72% males, aged between 15 and 69 years of age, participated in the study. Health status was assessed with SF-36 which includes one item on that form. Correlations between the one item self assessed health and dimensions of SF-36 were: Physical Functioning (.50); Role Physical (.50); Bodily Pain (.50); General Health (.45); vitality (.50); Social Functioning (.42); Role-emotional (.34); Mental Health (.45); age (.51); schooling level (.02). All the correlations were statistically significant. A sample of 440 non disabled individuals showed a correlation between the one item self assessed health measure and disease behavior between r=.23 and r=.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 assessment health can be a satisfactory measure of perceived health status in general.

163/6. 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 impair patients' quality of life remains unclear. We select a sample composed of 235 individuals divided into 2 groups: a control sample of 118 healthy individuals from the community and a sample of 114 in and outpatient from our university hospital. Instruments used were: a) WHOQOL-100, b) BDI-14, c) BHS and d) The scales of importance degree given for the 4 facets used for the field trial of the WHOQOL-BREF. Patients had higher BDI means than controls. BHS means also were higher in the patient's group when compared with the control group. Significant depression levels were measured in 46.3% of patients and 18% 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 health status was -.43 (p=0.0021) and -.41 (p=0.0001) for depression symptoms; in the psychological domain, beta for depression symptoms was -.36 (p=0.05); in the independence domain, beta for health status was -.32 (p=0.0021) and -.31 (p=0.0001) for depression symptoms; in the social relations domain yielded beta of .19 (p=0.013) for socioeconomic level and -.43 (p=0.0001) for depression symptoms; in the environment domain, beta was .19 (p=0.002) for age, .33 (p=0.0002) for socioeconomic level, -.40 (p=0.0001) for depression symptoms and -.15 (p=0.022) for health condition; finally, the aspects of physicality domain yielded beta of .14 (p=0.03) for age and -.36 (p=0.0001) for depression symptoms. Although depression condition is correlated with the quality of life of people in poor health and that depression seems to be more strongly correlated with quality of life than health status.

164/5. SENSITIVITY TO CHANGE OF THE SF-36 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 of 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 Nordic Function Activity Questionnaire for Osteoarthritis (HAFQ). Responses to the SF-36 were used to calculate the index SF-6D. Patients' health improved over their stay and remained best 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 NHP, SF-36-2 and SF-36. The SRM of the SF-36 sub-scales fell in between 0.13 (Role Emotional, T1-T2) and 0.84 (Body pain, T1-T2), those of the other instruments ranged from 0.05 (NHP Emotional Reaction, T1-T3) to 0.71 (HAFQ, T1-T3). In this sense 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 in health in patients with osteoarthritis of the hip or knee. The results of our study support that the SF-6D is at least as sensitive to change as the SF-36 or sub-scales of other established Ool. measures. More research will be needed to confirm these findings in other patient and population samples.

165/5. 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 metabolic properties become also, reduced. SF-36 is a short-form questionnaire for the General Health Rating Index, used to evaluate health status. However, the differences are higher when assessing QOL. The aims of the present study are to compare two reduced forms of SF-36, the SF-12 and the SF-12. The sample includes population outside the health care system (N=1434), 46,4% males, aged between 15 and 69 years of age, and patients with different chronic diseases (N=2965), 58,9% males, aged between 15 and 68 years of age, outpatients linked through their diseases to the health care system. We used the Portuguese SF-36 form and after formal authorization by 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 .92 between dimensions of SF-36 and SF-36, .52 to .85 between dimensions of SF-12 and SF-8. 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 .98 (physical), .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 with SF-36 and SF-12 are higher. The use of the SF-36 the use of reduced forms is an interesting alternative.