EDITORIAL

Assessing health status with the SF-36

The word 'health' may mean something different to a person with cancer than to a person who is free of illness or disability. Nevertheless, the concept of health can be usefully operationalized and measured. By looking at the instruments of measurement, 'health' can be defined by a matrix of (i) independence in the activities of daily living, (ii) mental well-being (including the equally nebulous concept of 'energy'), (iii) social function and (iv) the absence of symptoms (e.g. pain). Similar approaches have been taken in the measurement of another concept currently in vogue, that of 'quality of life'. Since both concepts are hard to define, it is hardly surprising that there is no consensus about what they are and how they differ: some authors use the concepts almost interchangeably (e.g. [1]) whereas others consider them to be quite distinct (e.g. [2]).

If one accepts that health is a reasonable thing to quantify, measures of health might be used to screen populations (although these non-specific measures may give little insight into the cause of the health problem). If carefully constructed, they might be able to take account of the trade-off between the beneficial and harmful effects of interventions and therefore be suitable as global outcome measures in evaluative studies.

The Medical Outcomes Study short form 36-item questionnaire (SF-36) is widely used to measure health status. There was a volley of literature describing its careful psychometric development from longer versions [3] and then a further wave of articles exploring the use of an anglicized version [4, 5]. These early reports were encouraging. However, concerns are emerging about its use in older people, particularly in its self-report form. This is obviously a problem given the age structure of many clinical populations and given that self-report forms are preferred because they eliminate observer bias. Two papers published in this issue of Age and Ageing add to these concerns [1, 6].

O'Mahony and colleagues used the SF-36 as a postal measure in older stroke patients [6]. They found that patients have difficulty with questions asking about 'work or other activities' and 'vigorous activities'. This leads to incomplete scores and questions its relevance to this group. Parker and colleagues [1] have shown that the self-completion version of SF-36 does not work well in hospital inpatients, but an interview can improve response rates.

In the absence of a demonstrably better scale, the SF-36 probably remains the best bet as a measure of health, if that is what is wanted. Reports of studies in which it is used must be read carefully to check the response rates among the older patients in the sample and to see whether older patients have been excluded to produce a better response rate. We need to solve the conundrum of how to measure health (and other outcomes) in our most damaged patients, including those who are confused, blind or deaf as well as many of those in nursing homes.

In 1993, Ware wrote that the SF-36 was being used in over 200 clinical trials [7], so presumably we will see more published studies which have used this measure. Only when we have seen how this instrument performs in randomized controlled trials when compared with other outcome measures (such as disability or mood measures) will we know if the SF-36 is sensitive enough to pass the acid test of an outcome measure—to be feasible enough and sensitive enough to detect the difference in effectiveness between two different interventions.

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References
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