Systematic measurement of impaired health-related quality of life (HRQoL) entered medicine around 35 years ago. Many factors determine a person’s quality of life and health is only one of them. The same disease will also have a different effect in each individual, so the precise impact (or clinical outcome) of the disease will be unique to each person. This makes it extremely difficult to produce a standardized way of measuring individual HRQoL. For that reason the term ‘health status’ is to be preferred in the context of measurement, it is a measurable marker of the clinical outcome that we are interested in – i.e. HRQoL.

The earliest health status instruments were simple global questions: e.g. ‘how bad is your health?’; but it is unclear what each patient has in mind when answering this question. The first multiple item questionnaires were generic instruments designed to cover all of ill health, but they lack sensitivity to treatment effects, which led to the development of disease-specific questionnaires.

The greatest challenge in health status measurement is the creation of a valid score. Some of the early instruments, such as the SGRQ, addressed each this by applying an empirically determined weight to each item, but most ignored the problem or used a battery of statistical measures in an attempt to validate the score.

Rasch methodology (as used for the CAT) has the creation of a valid total score at its heart. This has had a major impact, particularly, since questionnaires developed using Rasch are much shorter, since they identify the smallest number of items that describe the core effects of the disease and are common to most patients. This methodology lies at the heart of a possible future development – computer adaptive testing, which has the potential to obtain very precise measurements very quickly and efficiently.