
10 Oral Quality of Life

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Although oral disease is a common problem affecting many people throughout the world, it is rarely life-threatening. As a result, governments and health policy-makers tend to give oral health a relatively low priority. Many oral health researchers argue, however, that the prevention and control of oral disease deserves greater attention because the adverse impact of poor oral health on the individual is underestimated (Sheiham & Croog, 1981; Nikias, 1985; Reisine, 1985; Ettinger, 1987; Locker, 1988; Reisine, 1988a; Locker, 1992a). Many consequences of oral disease affect not only physical but also social and psychological well-being. These researchers contend that oral health experts must develop adequate indicators for measuring and demonstrating the comprehensive impact of oral disease on the individual.

Traditional oral health measures such as the number of decayed, missing and filled teeth, and periodontal status are related to physical status alone (Cushing, Sheiham & Maizels, 1986; Sheiham, Maizels & Maizels, 1987; Locker, 1988) and represent only an objective clinical assessment of oral health. They exclude self-assessment of health status in terms of personal, social and psychological impact (Cushing, Sheiham & Maizels, 1986; Locker, 1988).

Oral quality of life is a concept that captures both the social and psychological impact of oral disease on well-being (Gift & Redford, 1992). Many oral health researchers have demonstrated the direct correlation between oral health and quality of life (Cohen & Jago, 1976; Giddon, 1978; Ettinger, 1987; Giddon, 1987; Shumaker & Giddon, 1989). Quality of life relates to the satisfaction of human needs for growth, well-being, self-esteem, freedom and the pleasures of meaningful relationships and meaningful work (US Panel on the Quality of American Life, 1980). The quality of life indicators were first introduced to the health field in the 1970s by health researchers and policy-makers who needed a method for assessing the impact of chronic disease that went beyond the limited measures of mortality and morbidity (Krupinski, 1980; Mosteller, 1981; Chambers & Macdonald, 1982; Kaplan & Bush, 1982; Selby et al. 1984; Bulpitt & Fletcher, 1985; Croog et al., 1986).

The definition of health-related quality of life varies, but the emerging consensus in the literature identifies three major dimensions that should be included: physical symptoms, perception of well-being, and functional capacity (Levine & Croog, 1984; Wenger et al., 1984). ICS II used the same dimensions in defining oral quality of life: the number of oral health symptoms, perception of oral well-being, and social and physical functioning as affected by oral health problems.

Previous studies have investigated each of the three dimensions of oral quality of life. For example, some have examined pain and impairment due to oral health problems (Croog