

Oral Health related Quality of Life: Clinical applications of the concept and its measurement



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“Philosophical standpoint”

- A clinical dentist
- An occasional and not very good patient
- A taxpayers’ representative

“Philosophical standpoint”

- A clinical dentist
 - One of about 24000 in UK
 - Perhaps a quarter of a million in Europe
- An occasional and not very good patient
 - One of 60M in UK
 - One of 725M in Europe
- A taxpayers' representative

“Philosophical standpoint”



What are we all trying to achieve?

So what are dentists trying to achieve?

- Trying to earn money?
- Trying to prolong life?
- Trying to maintain quality of life for our patients?
- Trying to improve quality of life for our patients?

A hundred billion Euros spent annually on doing things ostensibly to maintain or improve oral health related quality of life

It might be an idea if we could work out whether any of this activity does anything for QoL

Clinical applications of OHRQoL data: Where are we now?

1. As a way of developing the agenda for good practice
2. As an outcome measure for clinical interventions
3. As a way to help policy makers decide on a system that might stand a chance of delivering an endpoint that is appropriate for the public.

2. Developing an agenda for good practice (bottom up) using a QoL framework



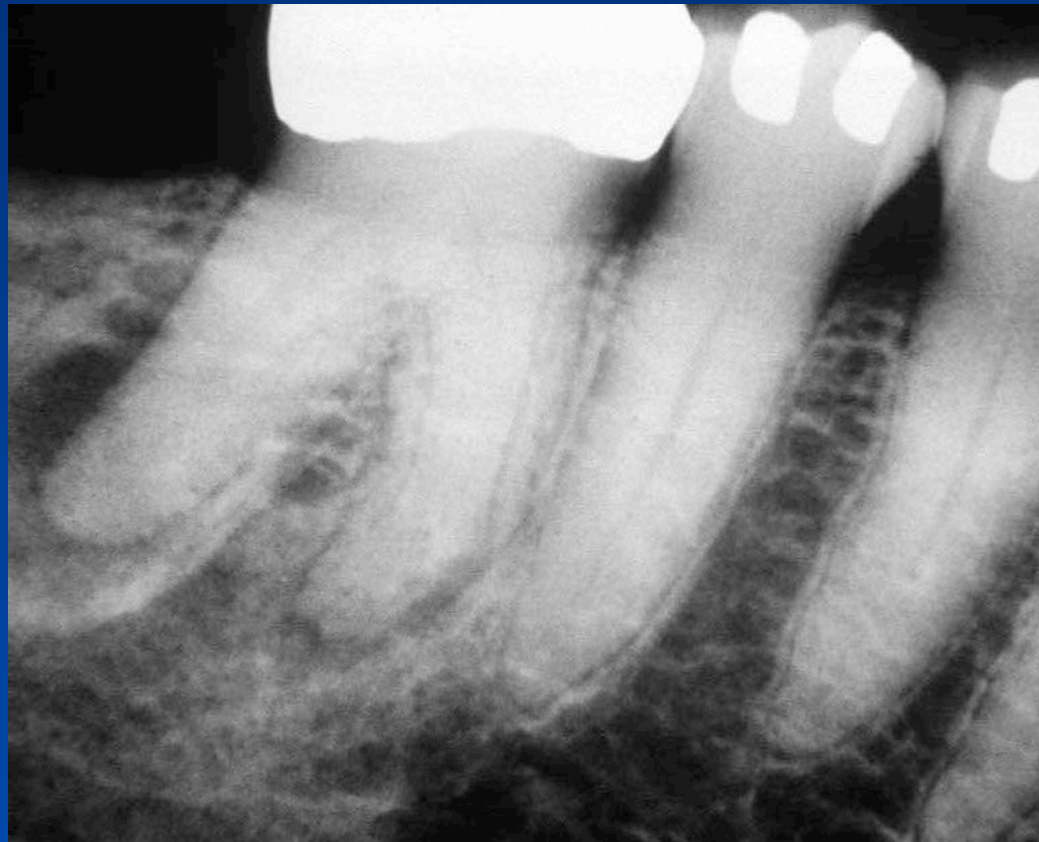
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Example: Disease = treatment paradigm



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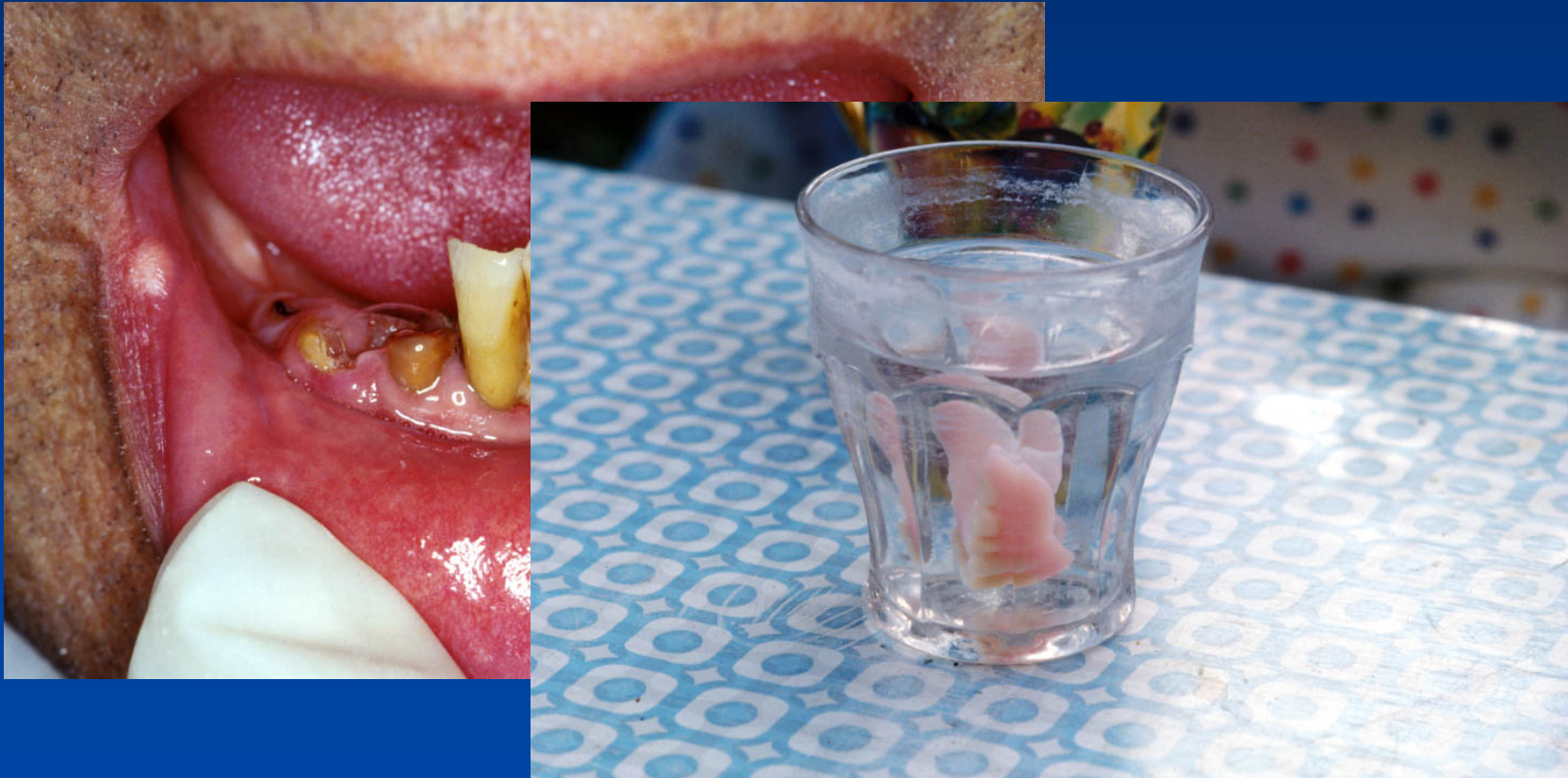


2. Developing an agenda for good practice (bottom up) using a QoL framework

Where disease does not translate to treatment, how can we decide strategy?

What pattern or state of teeth is associated with “quality of life” or loss of “quality of life” and what is the impact of getting there?

2. Developing an agenda for good practice (bottom up) using a QoL framework



If we do not think in terms what we need to do strategically to maintain or improve QoL, dentistry will continue to be disease or product driven, not patient driven.



2. Developing an agenda for good practice (bottom up) using a QoL framework

Impact on QoL could be at the heart of every treatment plan

QoL data from:

- Epidemiology (esp. longitudinal)
- Clinical trials (of big questions)

2. Clinical trials

Should every clinical trial use some measure of “QoL”?



You have to



Might want to

2. Clinical trials

Are there special conditions for use of existing measures as outcome measures in trials?

Can the index or profile measure change?

- floor effects?
- sensitive to the condition of interest?

Is it brief enough to use repeatedly amongst a bunch of clinical measures?

OHIP 14 (UK 1998)

“Prevalence” using an oral status measure of any problem	51%
of some kind of pain/discomfort	40%
of “handicap”	7%
of total inability to function	1%

Mean problems (of 14)	1.6
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More where partial dentures were used

2. Clinical trials – measuring OHQoL

Major impact interventions where starting impairment or disability is severe?



Trials even attempting to measure OHrQoL as an outcome are still quite rare

2. Clinical trials

Can they be used as or translated into a measurement of utility in an economic evaluation?

What is one point change worth?

Heydecke et al (2005)

Brennan and Spencer (2006)

2. Clinical trials – economic value

Heydecke et al 2005

Cost comparison of implants versus conventional treatment

- Can \$14.41 per OHIP point
- No indication of the utility

2. Clinical trials – economic value

Brennan and Spencer 2006

“QoL” measures profiles not single index of utility

- Mapped OHIP-14 to EuroQoL
- Correlation but complex and a bit messy
- Some way yet from being able to do this

Clinical applications of OHRQoL data

1. As an outcome measure for clinical interventions
2. As a way of developing the agenda for good practice
3. As a way to help policy makers decide on a system that might stand a chance of delivering an endpoint that is appropriate for the public.

3. Helping policy makers

What policy makers decide affects clinical outcomes.

Decisions on:

- Assumption (50 years in NHS)
- Prevalence
- History
- Expedience
- Impact on quality of life

Conclusions

1. Clinical applications of QoL encompass all of clinical dentistry because maintaining or improving QoL is the ultimate purpose of clinical work
2. Until we start to provide clinical evidence, measured in terms of QoL, clinicians and health planners will base their practice or policy on something else
3. Using what we have is a priority, and so is improving what we have

Conclusions