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Social and Health Determinants of Oral Health-Related Quality of Life among Thai Older Adults: A Multidimensional Cross-Sectional Study

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ABSTRACT

BACKGROUND: Oral health-related quality of life (OHRQoL) is an important component of overall well-being in older adults. In the context of Thailand's aging society, problems such as tooth loss and chewing difficulties persist. Simultaneously, research studies on social, health, and psychosocial determinants in the context of Thai older adults remain limited.

OBJECTIVES: To examine the oral health, functional, and psychosocial determinants associated with OHRQoL among Thai older adults.

METHODS: A cross-sectional study investigated 421 Thai older adults aged 60 years and above in Ang Thong Province. Data collection involved structured interviews using questionnaires and oral examinations. Key variables such as demographics, general and oral health status, oral health behaviors, masticatory function (CUMI), and aging perception (Thai AAQ-SF) were analyzed using bivariate and multivariate linear regression techniques to identify the key determinants of OHRQoL (OHIP-14 Thai).

RESULTS: Participants had a mean age of 70.4 years (SD=7.2), and 70.3% were female. The mean OHIP-14 score was 5.5 (SD=7.8). Physical pain was the most frequently reported domain. Three factors showed significant associations with poorer OHRQoL: eating difficulties, avoiding group meals, and lower masticatory function scores (p<0.001), whereas a more positive perception of aging was associated with better OHRQoL. The multiple linear regression model identified the significant determinants of OHRQoL scores (p<0.001) and explained 32.3% of its variance (adjR2=0.323).

CONCLUSIONS: Masticatory function and psychological well-being are important contributors to OHRQoL among Thai older adults. The findings emphasize the need for integrated, multidisciplinary strategies that can promote oral health and enhance quality of life in the aging population.

KEYWORDS: ageing, attitude to health, health–related quality of life, mastication, oral health

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INTRODUCTION

Thailand is rapidly aging, with about 12 million people (18%) aged 60 and above in 2023, which is projected to reach 28% by the early 2030s[1]. This significant shift underscores the need to address older adults' health and quality of life (QoL), including oral health. This study was conducted in Ang Thong Province, a typical semi-urban Thai community. The province has a population structure and proportion of older adults comparable to national patterns, together with socioeconomic characteristics and primary care services similar to those of many provincial areas in Thailand. These features support its suitability as a representative setting for examining oral health and QoL outcomes among community-dwelling older adults.

Oral health is vital to older adults' overall well-being. Oral health-related quality of life (OHRQoL) reflects how oral conditions affect daily function, comfort, and life satisfaction2 . Poor oral health can cause chewing problems, pain, and tooth loss, leading to reduced nutrition, social interaction, and self-esteem[3,4.]

Beyond these clinical and behavioral factors, psychosocial aspects also strongly influence OHRQoL[2,5-6]. In particular, self-perception of aging plays a crucial role in determining health behaviors and QoL in older adults[7-9]. Those who have a positive perception of aging tend to maintain better overall well-being. Although aging perception has been linked to general QoL, evidence for its specific association with OHRQoL remains limited.

This study applied the Wilson and Cleary model of health-related QoL as its conceptual framework[10], linking biological, functional, and psychosocial factors to OHRQoL. Within this framework, impaired masticatory function and negative aging perceptions can lower OHRQoL, whereas a positive view can enhance it. Thus, the aim of this study was to examine the oral health, functional, and psychosocial determinants associated with OHRQoL among Thai older adults using a multidimensional approach.

METHODS

Study Design and Sampling

This cross-sectional study included community-dwelling older adults aged 60 years and above from seven districts in Ang Thong Province, Thailand. Participants were recruited using quota sampling by age group in order to ensure sufficient representation across various age ranges. Although this method may introduce some selection bias, recruitment from all seven districts helped to minimize this limitation.

Eligible participants were older adults aged 60 or older who provided written informed consent. Individuals who were unable to communicate, bedridden, or screened for cognitive impairment using the Mini-Cog Test11 were excluded from the study. Participants were categorized into three age groups: 60–69 years, 70–79 years, and 80 years and above.

The sample size was calculated using G*Power for multiple linear regression with an effect size of 0.09, α=0.05, power=0.90, and 30 predictors, based on a previous study (R^2=0.466)[12]. After adding 15% for potential incomplete data, the required sample size was 414. Ultimately, a total of 421 participants provided complete data and were included in the analysis.

Data Collection and Fieldwork

Data collection was conducted from April to May 2024 through interviews at subdistrict health-promoting hospitals, community halls, and participants' homes. A trained and calibrated team

was responsible for collecting data so as to ensure consistency and minimize bias. The interview-based data included demographic, health, behavioral, functional, and psychosocial variables, while the clinical data on natural teeth and posterior occluding pairs were obtained through oral examinations.

Face-to-face interviews were conducted using a standardized script, with interviewers maintaining a neutral tone to limit interviewer bias. Twelve dental health personnel participated: nine interviewers (one dentist, eight dental nurses) and three examiners (one dentist, two dental nurses). All team members were trained and calibrated under the supervision of the principal investigator, who specialized in geriatric dentistry.

Before the data collection, a theoretical training and clinical practice session was conducted with 30 older adults in order to standardize the assessment criteria and achieve inter-examiner reliability. Excellent inter-examiner reliability was established through calibration of oral examinations with an Intraclass Correlation Coefficient (ICC) of 0.969 for teeth and 0.990 for occluding pairs ($p<0.001$). This confirmed the accuracy and uniformity of the measurements. Additionally, all interviewers completed pre-survey training sessions and received periodic monitoring to reduce measurement bias. To maintain data quality, the completed questionnaires were checked on-site and reviewed by the investigator before data entry was conducted.

Instruments and Measurements

Standardized instruments were utilized to gather demographic, health, behavioral, and oral data. Demographic and general health information included factors such as age, gender, marital status, living arrangement, and education level. General health was assessed by examining the presence of systemic diseases, self-care abilities, and health behaviors, including exercise and smoking habits. The questionnaire was pilot tested among a small group of older adults to ensure clarity and comprehension, with no modifications required, indicating good understanding and minimal potential response bias.

Oral examinations were employed to record the total number of natural teeth (excluding retained roots and severely mobile teeth) and the number of posterior occluding pairs. To evaluate oral health behaviors, participants were asked about tooth brushing frequency, use of cleaning aids, denture wearing, and dental visits during the past year.

Masticatory function was measured using the Chulalongkorn University Masticatory Index (CUMI)[13,14]. which assesses difficulties in chewing 20 different food items on a 3-point scale (2=can chew well, 1=can chew with difficulty, 0=cannot chew). Higher scores indicate better chewing ability. Additionally, two questions regarding “difficulty in eating: Do you have any problems eating or chewing food?” and “avoiding group meals: Do dental problems make you try to avoid eating with others?” were included and also pilot tested for clarity together with the main questionnaire.

Perceptions of aging were evaluated using the Thai AAQ-SF15. This 12-item tool consists of three subscales: Physical Change (PC), Psychological Growth (PG), and Psychosocial Loss (PL) (with reversed scoring). Higher total scores reflect more positive perceptions of aging.

The general questionnaire was based on items adapted from the Thai National Oral Health Survey to ensure relevance to community-dwelling older adults. All other instruments used in this study were previously validated Thai versions that

have demonstrated good reliability and validity. The Chulalongkorn University Masticatory Index (CUMI) exhibited strong reliability, with a Cronbach's alpha of 0.89 and ICC of 0.95 (95% CI=0.88–0.98)[13,14]. The Thai version of the Attitudes to Ageing Questionnaire–Short Form (Thai AAQ-SF) showed high internal consistency, with Cronbach's alpha values of 0.764 for PG, 0.704 for PL, and 0.760 for PC. It also demonstrated excellent test–retest reliability, with an ICC of 0.9115. The Oral Health Impact Profile-14 (OHIP-14 Thai) exhibited Cronbach's alpha values ranging from 0.70 to 0.77, along with ICC values ranging from 0.76 to 0.94[16].

The OHIP-14 Thai[16] was used to assess OHRQoL. Participants rated how often they had experienced impacts during the previous four weeks using a 5-point Likert scale (0=never to 4=very often). Higher scores indicate poorer OHRQoL[16].

Statistical Analysis

Data were analyzed using IBM SPSS Statistics version 29.0. Descriptive statistics summarized the participant characteristics. Independent t-tests and one-way ANOVA were used for bivariate analyses, and multiple linear regression (enter method) was performed to identify the key determinants of OHRQoL. Statistical significance was set at $p<0.05$. Before interpreting the regression models, key assumptions, including linearity, homoscedasticity, normality of residuals, and multicollinearity, were evaluated. Residual and normal probability plots indicated no major violations, and variance inflation factor values showed no evidence of multicollinearity.

Ethical Considerations

This study adhered to the Declaration of Helsinki and was approved by the Human Research Ethics Committee of the Faculty of Dentistry, Chulalongkorn University (HREC-DCU 2023-133, valid from February 9, 2024 to February 8, 2026). All participants received information about the study and provided written informed consent before the data collection.

RESULTS

A total of 421 participants (mean age 70.4±7.2 years; 70.3% female) were included. Most were married (54.9%), functionally independent (97.9%), and reported systemic diseases (75.1%). Regular tooth brushing was common (94.5%), though 72.9% did not use additional cleaning aids. Two-thirds (66.7%) had twenty or more teeth, but only 22.8% had four or more natural occluding pairs. Eating difficulties were reported by 44.7%, and 11.3% avoided group meals (Table 1 and Table 2).

Table 1 Sociodemographic and General Health Characteristics with OHIP-14 Scores.

Variables	n	%	OHIP-14 Score		*F/t*	*p*-value
			Mean	SD		
Total	421	100	5.46	7.8		
Age (years): mean±S.D.=70.4±7.2						
60–69 years	215	51	5.3	8.0	0.743	0.48[a]
70–79 years	145	34	5.3	7.6		
80 years or above	61	15	6.6	8.1		
Gender						
Male[ref]	125	30	5.4	7.4	0.099	0.92[b]
Female	296	70	5.5	8.0		

Table 1 Sociodemographic and General Health Characteristics with OHIP-14 Scores.(Continue)

Variables	n	%	OHIP-14 Score		*F/t*	*p*-value
			Mean	SD		
Marital status						
Married[ref]	231	55	5.3	8.2	0.446	0.64[a]
Single	55	13	4.9	6.9		
Previously married	135	32	5.9	7.6		
Living arrangement						
With spouse[ref]	69	17	6.5	8.9	0.761	0.47[a]
Alone	48	11	5.5	7.8		
With family	304	72	5.2	7.6		
Highest education level						
Elementary school or lower[ref]	310	74	5.6	7.7	1.516	0.22[a]
Secondary school or higher	102	24	4.6	7.8		
No education	9	2	8.9	12.2		
Presence of systemic disease						
No[ref]	105	25	4.7	6.8	1.229	0.22[b]
Yes	316	75	5.7	8.2		
Exercise						
No[ref]	94	22	7.1	8.2	2.295	0.02[b]
Yes	327	78	5.0	7.7		
Smoking						
Non-smokers[ref]	366	87	5.3	7.7	1.493	0.23[a]
Ex-smokers	36	9	5.8	7.1		
Current smokers	19	4	8.4	10.9		
Self-care ability						
Independent[ref]	412	98	5.3	7.8	2.900	<0.001[b]
Semi-dependent or Dependent	9	2	12.9	8.1		

[ref]Reference category of dummy variable in multiple linear regression analysis, [a]One-way ANOVA, [b]Independent samples t–test

Table 2 Oral Health Behaviors and Oral Status with OHIP-14 Scores.

Variables	n	%	OHIP-14 Score		*F/t*	*p*-value
			Mean	SD		
Brushing						
No[ref]	23	6	9.0	9.4	2.212	0.03[b]
Yes	398	94	5.7	7.7		
Use of extra cleaning instruments						
No[ref]	307	73	5.9	8.1	1.911	0.06[b]
Yes	114	27	4.4	6.9		
Denture wear						
No denture wear[ref]	311	74	5.8	8.3	5.742	0.003[a]
Wearing dentures and functioning well	86	20	3.4	5.2		
Wearing dentures but not functioning well	24	6	9.0	8.5		

Table 2 Oral Health Behaviors and Oral Status with OHIP-14 Scores. (Continue)

Variables	n	%	OHIP-14 Score		*F/t*	*p*-value
			Mean	SD		
Dental visit within 1 previous year						
No[ref]	275	65	4.9	7.4	2.073	0.04[b]
Yes	146	35	6.5	8.6		
Number of remaining teeth						
0–19 teeth[ref]	140	33	3.7	6.6	3.575	<0.001[b]
20 teeth or more	281	67	6.3	8.5		
Number of natural occluding tooth pairs						
0–3[ref]	325	77	5.9	8.4	2.982	0.003[b]
4 or more	96	23	3.8	5.3		
Total occluding pairs						
0-3[ref]	266	63	6.4	8.8	3.823	<0.001[b]
4 or more	155	37	3.8	5.4		
Avoid group eating						
No[ref]	372	88	4.7	7.2	4.188	<0.001[b]
Yes	49	12	11.0	10.2		
Eating difficulties						
No[ref]	233	55	3.2	6.2	6.558	<0.001[b]
Yes	188	45	8.2	8.7		

[ref]Reference category of dummy variable in multiple linear regression analysis, [a]One-way ANOVA, [b]Independent samples t–test

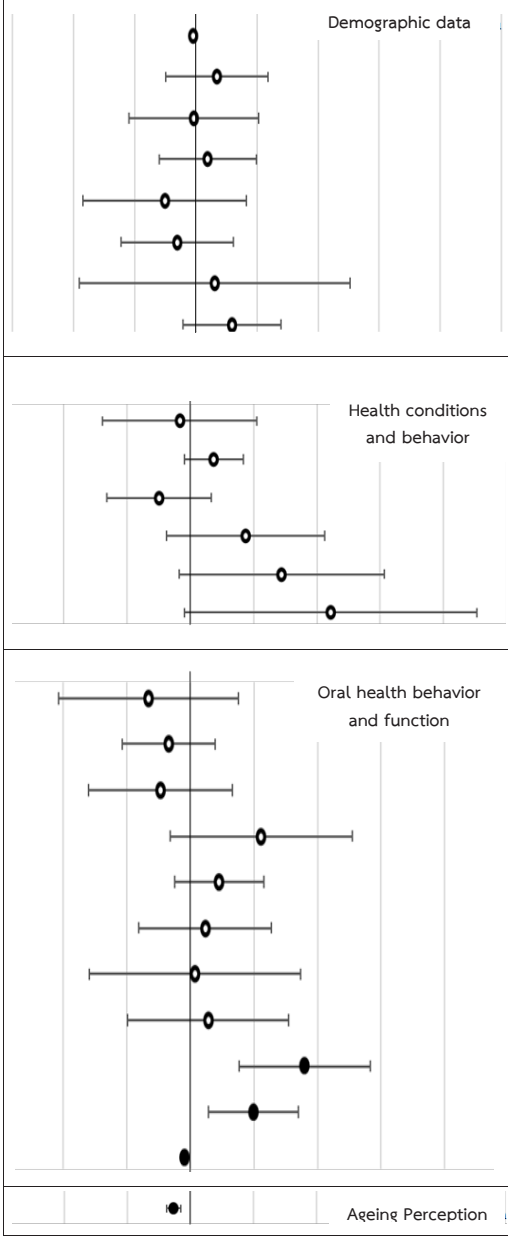
The mean OHIP-14 score was 5.5±7.8, with the highest domain score in physical pain (1.6±1.9) and the lowest in social disability (0.3±0.9) (Table 3). The mean CUMI score was 81.4±16.9, and the Thai AAQ-SF mean was 13.1±2.9.

Table 3 Oral Health Impact Profile Scores (OHIP-14) among Thai Older Adults. (n=421)

Dimension	Mean	Median	Mode	SD	Min	Max
Functional limitation	1.2	0.0	0	1.9	0	8
Physical pain	1.6	1.0	0	1.9	0	8
Psychological discomfort	0.8	0.0	0	1.5	0	8
Physical disability	0.8	0.0	0	1.5	0	8
Psychological disability	0.4	0.0	0	1.1	0	7
Social disability	0.3	0.0	0	0.9	0	7
Handicap	0.4	0.0	0	1.1	0	8
OHIP-14 total score	5.5	2.0	0	7.8	0	48

Better masticatory function correlated with better OHRQoL (r=–0.492, p<0.001), and a more positive aging perception correlated with better OHRQoL (r=–0.209, p<0.001). Poorer OHRQoL was significantly associated with lack of exercise (p=0.02), dependence in self-care (p=0.004), infrequent brushing (p=0.03), non-functioning dentures (p=0.003), fewer than twenty teeth (p<0.001), fewer than four

occluding pairs (p=0.003), avoiding group meals (p<0.001), and eating difficulties (p<0.001). Multiple linear regression (adjusted R^2=0.323, p<0.001) identified the key predictors of poorer OHRQoL: avoiding group eating (ß=0.147, p<0.001), eating difficulties (ß=0.126, p=0.006), and lower masticatory function (ß=–0.391, p<0.001). A more positive aging perception was independently associated with better OHRQoL. (ß=–0.196, p<0.001) (Figure 1).



Variable	B	SE(B)	β	*p*-value
Constant	32.173	5.115		<0.001
Age (years)	-0.094	0.052	-0.086	0.07
Gender (Female)	0.688	0.848	0.040	0.42
Marital status (Single)	-0.058	1.078	-0.003	0.96
Marital status (Previously married)	0.392	0.805	0.023	0.63
Living arrangement (Alone)	-1.02	1.357	-0.041	0.45
Living arrangement (Family)	-0.604	0.935	-0.035	0.52
Highest education (No)	0.605	2.253	0.011	0.79
Highest education (Secondary high)	1.182	0.810	0.065	0.15
Presence of systemic disease	-0.336	1.236	-0.019	0.79
Number of systemic diseases	0.746	0.472	0.111	0.12
Exercise	-0.991	0.837	-0.053	0.24
Smoking (Ex-smokers)	1.747	1.269	0.062	0.17
Smoking (Current smokers)	2.882	1.649	0.076	0.08
Self-care ability (Semi/dependent)	4.440	2.353	0.082	0.06
Brushing	-1.314	1.434	-0.038	0.36
Use of extra cleaning instruments	-0.678	0.741	-0.038	0.36
Dentures: Wearing + well-functioning	-0.933	1.149	-0.048	0.42
Dentures: Wearing + not functioning well	2.224	1.455	0.066	0.13
Dental visit in 1 year	0.908	0.715	0.055	0.21
Remaining teeth 20+	0.465	1.064	0.028	0.66
Natural occluding pairs ≥ 4	0.139	1.691	0.007	0.93
Total occluding pairs ≥ 4	0.558	1.293	0.034	0.67
Avoid group eating	3.593	1.051	0.147	<0.001
Eating problems	1.989	0.721	0.126	0.006
Masticatory function (CUMI)	-0.182	0.022	-0.391	<0.001
Perception of Ageing (Thai-AAQ SF)	-0.525	0.113	-0.196	<0.001

Figure 1 Forest Plot Illustrating Associations (B) between Demographic, Health, Oral Health and Aging Perception and Oral Health–Related Quality of Life (OHIP-14).

DISCUSSION

This study explored the factors associated with OHRQoL among Thai older adults using the OHIP-14. The average score indicated a relatively low level of oral health impacts. The highest score was in the physical pain domain, while the lowest was in social disability, consistent with previous findings showing that older adults often report pain-related impacts, such as eating discomfort, while minimizing social disability[17].

From the multiple linear regression analysis, the Mean Square Error (MSE) reflected the model's average prediction deviations, with masticatory function (CUMI) showing the most precise estimate (SE(ß)=0.022). The relatively large SE(ß) for some variables and the moderate R^2 suggest that, although the model offers useful insights, additional unmeasured factors may influence OHRQoL. Key determinants identified were eating difficulties, avoidance of group meals, masticatory ability and aging perception. Eating problems arising from oral diseases, chewing or swallowing difficulties, and tooth loss were associated with poorer OHRQoL.

Regarding oral functions, eating problems such as chewing difficulties, swallowing issues, and tooth loss often occur alongside oral disease and are linked to lower OHRQoL. Many studies have shown that the majority of oral symptoms, including chewing difficulties, swallowing problems, and dry mouth, are associated with poorer OHRQoL[18,19]. These conditions may interfere with chewing ability and daily activities, potentially reducing overall QoL among older adults.

Participants who had a tendency to avoid eating with others reported worse OHRQoL. This aligns with earlier findings indicating that less frequent communal meals are associated with a reduced overall QoL. Older adults who stated that they habitually dine alone were found to have the lowest QoL scores[20].

Regarding the CUMI scores, which reflect masticatory function, participants with higher scores generally experienced better OHRQoL. This suggests that efficient chewing is important for maintaining or improving OHRQoL among older adults, consistent with previous research that identified masticatory ability as a key factor influencing OHRQoL[19]. Maintaining good masticatory function may also promote greater participation in daily activities, contributing positively to QoL.

Better masticatory function may enhance OHRQoL because efficient chewing supports adequate nutrition, reduces eating-related discomfort, and promotes confidence during meals, which together reduces the perceived oral health impacts in daily life. Likewise, a more positive perception of aging may contribute to better OHRQoL by promoting healthier coping strategies, increasing motivation for oral self-care, and fostering more adaptive emotional responses to functional limitations. Accordingly, this positive attitude can result in fewer perceived disruptions to daily functioning.

In addition, this study found an association between OHRQoL and perceptions of aging, suggesting that the ways that individuals view aging can significantly influence their OHRQoL. Although previous research has not directly examined this relationship, oral health remains a vital component of general health. These findings align with broader evidence that emphasizes the strong impact of psychological and social factors on QoL.[9,21] Furthermore, studies have shown that fostering a positive perception of aging can enhance older adults' well-being and should thus be incorporated

into future health promotion strategies and interventions[7].

A more positive perception of aging may also influence OHRQoL through both psychological and behavioral pathways. Older adults with positive views of aging are more likely to maintain oral hygiene behaviors, adopt constructive coping strategies, and interpret oral symptoms less negatively, thereby reducing their perceived impact on daily life.

These findings are consistent with the Wilson and Cleary model, which links biological functions, symptoms, functional status, and health perceptions to QoL[10]. In this study, masticatory function reflects biological and functional status, while eating difficulties and avoidance of group meals correspond to symptom and functional levels, and perception of aging represents health perceptions. These associations align with the model's framework, thereby indicating that both oral function and psychosocial appraisal jointly shape OHRQoL in older adults.

As a result, this study underscores the importance of a multidimensional approach in dental public health, revealing that both clinical aspects, such as tooth loss and chewing ability, as well as psychological aspects, including aging perception, are related to OHRQoL. These results advocate for increased use of comprehensive health promotion strategies for older adults. However, several limitations should be acknowledged.

First, due to the cross-sectional design, the study does not allow for conclusions regarding cause and effect, which limits the ability to establish causal relationships between the identified factors and OHRQoL, as the data represent a single point in time. Thus, further longitudinal research is recommended to explore these variables over time and inform future interventions.

Second, since the participants were recruited only from Ang Thong Province, the findings largely reflect a local context and may not be generalizable to older adults in other regions of Thailand. Future longitudinal and multi-site studies with broader sampling are therefore needed to confirm these associations and strengthen the external validity of the results.

Practical suggestion: To improve OHRQoL among Thai older adults, regular dental check-ups and preventive education should be promoted in order to detect and manage oral problems early. Community meal programs can enhance their social engagement and reduce loneliness while improving access to dental prosthetics and treatments for tooth loss. In addition, strengthening mobile dental services in rural areas and encouraging good oral hygiene can further enhance oral health and QoL.

Policy suggestion: Comprehensive oral health programs should be implemented to address both the clinical and psychological aspects of care, as ensuring accessibility to affordable dental services through subsidies and mobile clinics is essential, particularly in rural communities. For this reason, it is suggested that oral health concerns be integrated into national health policies, including the implementation of campaigns to promote positive aging and community engagement that are supported by continued government investment in preventive and research initiatives.

Academic suggestion: Future studies should include qualitative methods that can explore the perceptions and experiences of older adults related to oral health and aging. Both longitudinal and intervention research approaches are needed

to clarify the causal relationships among masticatory function, aging perception, and OHRQoL, and to evaluate strategies such as prosthetic rehabilitation and orofacial exercises for aging in order to assess their impacts on OHRQoL.

Masticatory function is a crucial predictor of oral health experiences. Additionally, a person's psychological attitude towards aging greatly affects their perception of oral health. Behavioral factors, such as difficulties in eating and smoking habits, also play a significant role in overall oral health quality. This research indicates that OHRQoL is primarily influenced by two key factors: masticatory function and perceptions of aging. Furthermore, the study emphasizes the importance of functional and psychological elements beyond the traditional demographic indicators, as these insights can contribute to the development of integrated oral health promotion strategies and guide policy directions for improvement of the well-being of older adults.

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ORIGINAL ARTICLE

ปัจจัยทางสังคมและปัจจัยทางสุขภาพที่กำหนดคุณภาพชีวิตในมิติสุขภาพช่องปากของผู้สูงอายุไทย: แนวทางหลายมิติในงานวิจัยแบบภาคตัดขวาง

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บทคัดย่อ

ที่มาของปัญหา: คุณภาพชีวิตในมิติสุขภาพช่องปากเป็นองค์ประกอบสำคัญของสุขภาวะผู้สูงอายุ ท่ามกลางสังคมผู้สูงอายุของไทย ยังคงมีปัญหาการสูญเสียฟันและการบดเคี้ยว ขณะเดียวกันงานวิจัยที่ศึกษาปัจจัยทางสังคม สุขภาพ และมิติด้านจิตสังคมในบริบทของผู้สูงอายุไทยยังคงมีอยู่อย่างจำกัด

วัตถุประสงค์: เพื่อศึกษาปัจจัยด้านสุขภาพช่องปาก การทำหน้าที่ของช่องปาก และปัจจัยด้านจิตสังคมที่สัมพันธ์กับคุณภาพชีวิตในมิติสุขภาพช่องปากของผู้สูงอายุไทย

วิธีการศึกษา: การศึกษาภาคตัดขวางนี้สำรวจผู้สูงอายุชาวไทย 421 คน อายุ 60 ปีขึ้นไปในจังหวัดอ่างทอง โดยใช้การสัมภาษณ์เชิงโครงสร้างโดยใช้แบบสอบถามและการตรวจช่องปาก ตัวแปรสำคัญ อาทิ ข้อมูลประชากรศาสตร์ สภาวะสุขภาพร่างกายและสุขภาพช่องปาก พฤติกรรมสุขภาพช่องปาก ความสามารถในการบดเคี้ยว (ดัชนี CUMI) การรับรู้ต่อความสูงวัย (Thai AAQ-SF) ได้รับการวิเคราะห์การถดถอยเชิงเส้นแบบทวิและพหุคูณเพื่อระบุปัจจัยสำคัญที่ส่งผลต่อคุณภาพชีวิตในมิติสุขภาพช่องปาก (OHIP-14 ฉบับภาษาไทย)

ผลการศึกษา: ผู้เข้าร่วมการวิจัยมีอายุเฉลี่ย 70.4 ปี (70.4±7.2 ปี) ร้อยละ 70.3 เป็นเพศหญิง ค่าเฉลี่ยคะแนนคุณภาพชีวิตในมิติสุขภาพช่องปาก 5.46 (5.46±7.8) ความเจ็บปวดทางกายเป็นผลกระทบหลัก ปัจจัยที่มีความสัมพันธ์กับคุณภาพชีวิตในมิติสุขภาพช่องปากที่แย่ลง คือ การรับประทานอาหารได้ลำบาก การหลีกเลี่ยงการรับประทานอาหารร่วมกับผู้อื่น และคะแนนบดเคี้ยวต่ำ (p<0.001) การรับรู้การสูงวัยในเชิงบวกช่วยเพิ่มคุณภาพชีวิตในมิติสุขภาพช่องปาก แบบจำลองการถดถอยเชิงเส้นพหุคูณอธิบายความแปรปรวนได้ร้อยละ 32.3 (adjR2=0.323)

สรุป: การทำหน้าที่ของช่องปากและสุขภาพจิตมีส่วนสำคัญที่สัมพันธ์กับคุณภาพชีวิตในมิติสุขภาพช่องปากของผู้สูงอายุไทย มีความจำเป็นต่อกลยุทธ์เชิงบูรณาการและสหวิทยาการเพื่อส่งเสริมสุขภาพช่องปากและคุณภาพชีวิต

คำสำคัญ: ผู้สูงอายุ, ทัศนคติต่อสุขภาพ, คุณภาพชีวิตในมิติสุขภาพ, การบดเคี้ยว, สุขภาพช่องปาก