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EDITORIAL

What Is Health Related Quality Of Life (HRQOL)?

The ultimate goal of health care is to maintain or improve the quality of life of people. Health is an important determinant of a person's quality of life although it is not the only one. Other factors such as culture, religion, environment, education and finance can also affect quality of life but they are often beyond the scope of health care. Health related quality of life (HRQOL) is the main concern for health care professionals and is becoming an important health outcome indicator.[1-3]

Why is HRQOL an important health outcome indicator? The by-product of advances in medical science and technology is an increasing number of people living with chronic diseases and disabilities. The change in our population's morbidity pattern has called for a paradigm shift in how we should evaluate outcomes of illnesses and care. Is it worthwhile to keep a comatose person alive on a respirator? Is renal transplant a better treatment than haemodialysis for patients with renal failure? Why is palliative treatment important for a terminally ill patient? Is rehabilitation after a stroke or myocardial infarct really useful? Is one particular health care delivery system better for patients with chronic diseases than another? Traditional indicators like mortality rates and objective clinical parameters are no longer adequate to answer these questions.

Self-evaluated HRQOL is most valid for patients seen in family practice, whose illnesses are rarely lethal but often dysfunctional. It has been used as a screening instrument for physical, psychological, role functioning and social problems in patients with chronic diseases so that appropriate interventions can be given. It can assess the quality of our care from the patients' point of view. It has been shown to be more sensitive than objective indicators in predicting mortality,[4] detecting functional impairment,[5] determining consultation rates[6,7] and showing the effectiveness of treatment in patients with chronic diseases.[8]

The main barrier to the use of HRQOL as an outcome indicator is the lack of a common definition and measuring standard. Major breakthroughs in the conceptualization of HRQOL and standardization of measures have resulted from works by Lohr *et al*[1], Bergner *et al*[9] and the Medical Outcome Study by Ware *et al*[10] in the last two decades. Function is the most essential dimension of HRQOL and it should include physical, social and role functioning. The other essential dimensions are mental health and general health perception. Vitality, pain and cognitive function are also important

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domains of HRQOL.[3] Evaluation of HRQOL should be subjective, that is the person being assessed rates his/her own status.

HRQOL measuring instruments can be generic or disease specific. Generic instruments have the advantage of being applicable to all persons irrespective of their type or number of illnesses but they may not be sensitive to some problems unique to particular diseases. Instruments specific to a particular disease, e.g. AIDS, are more specific and sensitive but they make comparison between different patient groups difficult. Furthermore, the results of disease specific instruments are difficult to interpret in persons with multiple diseases. The current trend favours the use of generic instruments for most patients, and if necessary, supplementing the assessment by disease specific instruments.

Many HRQOL instruments have been developed in the last decade but most of them are in English and few are available in Chinese. Application of such instruments to our local Chinese population requires careful translation and cross-cultural validation. One needs to evaluate whether the content, concept, construct and scoring method of an instrument are valid and whether it is acceptable to our population. The International Quality of Life Assessment (IQOLA) Project has developed a standard method for cross-cultural applications of a HRQOL instrument.[11] It consists of three stages:

1) rigorous translation, which should be evaluated for conceptual equivalence and respondent acceptance, this is to ensure content validity;

2) formal psychometric tests of item and scale concept and construct validity;

3) validation and norming studies evaluating the equivalence of interpretation across countries, a measure of criterion validity.[11]

The first two stages are essential before the instrument can be applied to the population concerned and the third is for developing a reference norm for meaningful interpretation of data obtained from specific patient groups.

The MOS 36 item Short Form Health Survey (SF-36)[10,11] and the Dartmouth COOP functional health assessment Charts/WONCA (COOP/WONCA Charts)[12] are two popular generic HRQOL instruments for people living in the community. Both of them include most of the essential concepts of HRQOL and have been shown to be suitable for cross-cultural applications.[11,12] The SF-36 is more comprehensive than the COOP/WONCA Charts and its scores can be analyzed by parametric statistical tests, but it may be too long for routine clinical use and its scoring method is more complicated. On the other hand, the COOP/WONCA Charts are ideal for routine use in general practice because it takes less than 5 minutes to complete and the scoring method is very straight forward. The scores of the COOP/WONCA Charts are non-parametric which limits the scope of statistical analysis.

Both the SF-36 and COOP/WONCA Charts have been translated into Chinese* and validated on our local population by the first two stages of the standard method of the IQOLA Project. Population norming studies are underway, so we will soon be able to use HRQOL as an outcome indicator of illnesses and care for our Chinese population. This will bring our health care closer to its ultimate goal of improving the quality of life of people. ■

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* Please contact the author if you want to obtain a copy of the English or Chinese version of these HRQOL measures.

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