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Research Article

Quality of Life among Older Patients with Chronic Diseases Attending a Tertiary Care Hospital in Greater Noida, India: A Cross-sectional Study

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A B S T R A C T

Background: Chronic diseases are common in later life and affect far more than clinical values. How patients themselves rate their daily lives is seldom recorded in busy outpatient clinics in India. Objectives: To assess the quality of life of older patients with chronic diseases across four domains, to grade it as good, average, or poor, and to examine its association with socio-demographic variables. Methods: A descriptive cross-sectional study was conducted among 100 patients aged ≥ 40 years living with one or more chronic conditions, recruited by convenience sampling from the outpatient departments of a tertiary care teaching hospital in Greater Noida. A 20-item structured rating scale covering physical, psychological, social, and environmental domains (score 20–80) was administered by interview. Levels were set at mean ± 1 SD, and associations were tested with the chi-square test ($p < 0.05$).

Results: The mean score was 48.22 ± 8.13 (60.3% of the maximum). Quality of life was average in 70%, poor in 17%, and good in 13% of patients. The physical domain scored lowest (54.4%) and the environmental domain highest (67.1%). Mobility was the weakest item, rated poor or very poor by 79%. Quality of life level did not differ significantly by any of the nine socio-demographic characteristics.

Conclusion: Most patients lived with an average quality of life, limited mainly by physical and emotional difficulties that cut across social groups. Routine quality of life screening, with nursing support for mobility, pain, sleep, and emotional well-being, should be offered to all such patients.

Keywords: Quality Of Life; Chronic Disease; Older Adults; Multimorbidity; Geriatric Nursing

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Introduction

India is ageing quickly. About 149 million Indians, 10.5% of the population, were aged 60 years or more in 2022, a proportion expected to approach one-fifth (20.8%) by mid-century [14]. According to the first wave of the national ageing survey, about three of every four older adults have one or more long-term conditions [6]. Conditions such as hypertension, diabetes, cardiac and respiratory disease, and arthritis are controlled rather than cured, so patients live with them and with their treatment for many years. Chronic disease and multimorbidity also often appear before 60 years of age, especially in less advantaged populations [2].

Control of blood pressure or blood glucose says little about how a patient is actually living. The World Health Organization defines quality of life as a person's perception of his or her position in life in relation to culture, values, goals and concerns [16], which makes the patient, not the clinician, the judge. The WHO Decade of Healthy Ageing likewise asks health systems to protect functional ability and well-being, not merely to treat individual diseases [18].

Evidence consistently shows that chronic illness lowers quality of life and that the physical domain suffers most. Quality of life declines as the number of conditions rises [4], and a meta-analysis found that each additional disease reduces physical well-being more than any other aspect [9]. In India, analyses of national and state data have linked multimorbidity with poorer health-related quality of life among older adults [5–1], and community studies report mostly moderate scores, with income, education and dependence often related to the result [12–8–11].

Most of this evidence comes from community surveys, and hospital patients may differ from the general older population. Nurses see these patients repeatedly during follow-up, but a structured picture of how they rate their own lives is rarely available. This study, guided by the input–process–output model of General System Theory [15], therefore aimed to (a) assess quality of life across physical, psychological, social and environmental domains among patients with chronic diseases, (b) grade it as good, average or poor, and (c) examine its association with socio-demographic variables.

Materials And Methods

Design, setting and participants

A quantitative, descriptive cross-sectional design was adopted. The study took place in the medicine, cardiology, endocrinology, nephrology, pulmonology and orthopaedic out-patient departments of Sharda Hospital, a university-affiliated tertiary teaching hospital offering multiple specialities in Greater Noida, Uttar Pradesh, in 2026. Eligible patients were 40 years or older, had lived with one or more long-term conditions for at least six months, could communicate in Hindi or English and agreed to take part. Patients who were acutely ill, had cognitive or hearing problems that prevented reliable answers, or did not complete the interview were excluded. The lower age limit of 40 years was chosen so that patients approaching old age with a long-standing illness could also be included. One hundred patients were recruited by non-probability convenience sampling from those present on the days of data collection.

Instrument

The tool had two parts. Part A recorded nine socio-demographic variables. Part B was a structured 20-item quality of life rating scale developed by the investigators with reference to the WHOQOL framework [13]. It contained five items in each of the physical, psychological, social and environmental domains. Each item was rated 1 (very poor), 2 (poor), 3 (good) or 4 (very good), giving domain scores of 5–20 and a total score of 20–80, with higher scores indicating better quality of life. Total scores were graded using the sample mean ± 1 SD: 57–80 as good, 41–56 as average and 20–40 as poor. Nursing faculty reviewed the content of the tool, and a pilot study on patients outside the final sample led to minor changes in wording.

Data collection and ethical considerations

The hospital administration granted permission for the study. Patients were approached in the waiting areas, the purpose of the study was explained in simple language, and informed consent was obtained. Each was told that declining would have no bearing on their care and that responses would be kept confidential. The scale was administered orally in the patient's preferred language (Hindi or English), and each interview took 15–20 minutes.

Statistical analysis

Data were entered in Microsoft Excel. Socio-demographic variables and item responses are reported as frequency and percentage, and total and domain scores as mean, standard deviation and mean percentage of the maximum. Pearson's chi-square test was used.

To examine whether the level of quality of life varied with each socio-demographic characteristic, with $p < 0.05$ taken as significant.

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Results

Characteristics of the participants

The participants were aged 43–77 years (mean 58.4 years); 65% were in their fifties, and 25% were 60 or older (Table 1). Nearly three-quarters were men. Forty-three per cent had no formal education, half came from rural areas, 61% lived in nuclear families and 58% were widowed, separated or single.

Table 1. Socio-demographic Characteristics of the Participants (N = 100)

Variable	Category	n (%)
Age (years)	40–49	10 (10.0)
	50–59	65 (65.0)
	60–69	24 (24.0)
	≥ 70	1 (1.0)
Gender	Male	74 (74.0)
	Female	26 (26.0)
Marital status	Married	42 (42.0)
	Widowed / separated / single	58 (58.0)
Religion	Hindu	48 (48.0)
	Muslim	19 (19.0)
	Sikh	16 (16.0)
	Christian / others	17 (17.0)
Education	No formal education	43 (43.0)
	Primary	21 (21.0)
	Secondary / higher secondary	15 (15.0)
	Graduate and above	21 (21.0)
Occupation	Unemployed / homemaker	38 (38.0)
	Self-employed / business	20 (20.0)
	Private / government service	20 (20.0)
	Retired	22 (22.0)
Monthly family income (INR)	≤ 10,000	24 (24.0)
	10,001–20,000	19 (19.0)
	20,001–30,000	23 (23.0)
	> 30,000	34 (34.0)
Type of family	Nuclear	61 (61.0)
	Joint	39 (39.0)
Area of residence	Rural	50 (50.0)
	Urban	35 (35.0)
	Semi-urban	15 (15.0)

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Overall and domain-wise quality of life

Total scores ranged from 28 to 65, with a mean of 48.22 ± 8.13 and a median of 48.5. Seventy percent of patients had an average quality of life, 17% a poor one, and only 13% a good one. Across domains, environment scored highest and physical health lowest (Table 2). Psychological well-being showed the widest spread of scores (SD 4.18), a sign that emotional adjustment varied considerably from one patient to another.

Table 2.Domain-wise Quality of Life Scores (N = 100)

Domain	Possible range	Mean	SD	Mean %	Rank
Physical health	5–20	10.88	3.14	54.4	4
Psycho-logical well-being	5–20	11.54	4.18	57.7	3
Social rela-tionships	5–20	12.38	2.93	61.9	2
Environ-ment	5–20	13.42	3.89	67.1	1
Total	20–80	48.22	8.13	60.3	–

Note. Mean % = mean score as a percentage of the maximum possible score.

Item-wise responses

Eleven of the 20 items had a mean below 2.5, the midpoint of the scale, and nine of these came from the physical or psychological domain (Table 3). Ability to move around was rated lowest, followed by freedom from worry, sadness, and anxiety. Within the social domain, closeness and support within the family scored lower than contact with the wider community and the respect patients received. A sense of meaning and purpose in life, and all environmental items, received comparatively favorable ratings.

Table 3.Item-wise Ratings on the Quality of Life Scale (N = 100)

Domain	Item	Poor or very poor, %	Mean (1–4)
Physical	Ability to move around	79	1.97
	Freedom from pain and discomfort	62	2.20
	Quality of sleep	60	2.23
	Energy for everyday activities	59	2.25
	Self-care without help	59	2.23
Psycho logical	Ability to enjoy life	58	2.26
	Concentration and memory	59	2.23
	Satisfaction with self	60	2.20
	Freedom from worry, sadness and anxiety	61	2.19
	Meaning and purpose in life	45	2.66
Social	Relationship with family members	59	2.24
	Support from family and friends	60	2.22
	Opportunity to meet friends and relatives	47	2.60
	Participation in social and religious activities	44	2.66
	Respect in family and community	44	2.66
Environ ment	Feeling of safety in daily life	45	2.67
	Enough money to meet needs	44	2.68
	Access to health services	48	2.60
	Availability of health and daily-life information	44	2.74
	Living conditions and access to transport	43	2.73

Association with socio-demographic variables

The level of quality of life was independent of every socio-demographic characteristic tested (Table 4). Average quality of life was the commonest level in every category. Women were less likely than men to have a good quality of life (3.8% vs 16.2%) and more likely to have a poor one (23.1% vs 14.9%), but the difference was not significant (p = 0.215).

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Table 4.Association between Level of Quality of Life and Socio-demographic Variables (N = 100)

Variable	Category	Good	Average	Poor	χ^2 (df)	p
Age (years)	< 50	1	6	3	1.76 (4)	0.779
	50–59	9	45	11		
	≥ 60	3	19	3		
Gender	Male	12	51	11	3.08 (2)	0.215
	Female	1	19	6		
Marital status	Married	5	29	8	0.26 (2)	0.880
	Widowed / separated / single	8	41	9		
Religion	Hindu	7	35	6	2.11 (6)	0.909
	Muslim	2	14	3		
	Sikh	2	10	4		
	Christian / others	2	11	4		
Education	No formal education	6	27	10	5.55 (6)	0.475
	Primary	4	14	3		
	Secondary / higher secondary	0	13	2		
	Graduate and above	3	16	2		
Occupation	Unemployed / homemaker	6	25	7	5.85 (6)	0.441
	Self-employed / business	1	16	3		
	Private / government service	1	14	5		
	Retired	5	15	2		
Monthly family income (INR)	≤ 10,000	5	18	1	5.74 (6)	0.453
	10,001–20,000	1	14	4		
	20,001–30,000	2	16	5		
	> 30,000	5	22	7		
Type of family	Nuclear	7	44	10	0.42 (2)	0.813
	Joint	6	26	7		
Area of residence	Rural	6	37	7	1.54 (4)	0.820
	Urban	4	24	7		
	Semi-urban	3	9	3		

Note. Several cells had expected frequencies below five; results should be interpreted with caution.

Discussion

Seven in ten patients in this hospital sample reported an average quality of life, and the mean score lay just above the middle of the possible range. This agrees with the predominance of moderate quality of life among older people in Tirupati [11] and with earlier Indian community studies [12–8], and it is consistent with the lower scores reported among multimorbid older residents of Uttar Pradesh [5]. The findings suggest that most patients were coping with their illness but were not living as well as they might.

Physical health emerged as the weakest domain, with mobility the lowest-rated item of all. The same pattern appeared among 310 older patients in a Mangalore hospital,

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where physical health had the lowest domain score [7], and in the meta-analytic evidence that additional diseases depress physical well-being more than other domains [9–4]. Pain, poor sleep, low energy, and limited self-care were each rated poor or very poor by about six patients in ten. These are precisely the problems that nursing care, through pain assessment and guidance on safe activity, better sleep habits, and preventing falls, can address directly.

The psychological domain ranked second lowest, with the items on worry, sadness, and anxiety rated lowest. Concerns about complications, cost, and dependence are often left unspoken in a short clinic visit. Yet many patients still reported a clear sense of purpose in life, a strength on which counselling can build. In the social domain, family closeness and support scored lower than wider social participation, which echoes concerns about how family support for older people is changing [10]. The relatively high environmental scores probably reflect the fact that the participants were already attending a tertiary hospital with ready access to services and information.

Quality of life was not significantly associated with any socio-demographic variable. Punabaka et al. (2023) likewise found no difference by age, gender, or education, whereas community studies have related quality of life to income, education, and dependence [12–1]. Because every participant had at least one chronic disease, the illness itself may have narrowed differences between social groups; the modest sample and sparse cells also limited statistical power. The lower share of women with a good quality of life, though not significant, matches reports of poorer quality of life among older Indian women [7–1] and deserves attention in larger studies.

Strengths and limitations

The study provides hospital-based, patient-reported data across four domains and identifies specific items that nurses can target. Several limitations apply. Three-quarters of the participants were younger than 60 years, so the findings describe patients in late middle age as much as older adults. Convenience sampling at a single center limits generalization. Disease-specific information, such as diagnosis, number of conditions, and illness duration, was not included in the analysis. The rating scale was developed for this study rather than a validated measure like the WHOQOL-BREF, and its cut-off points were derived from the sample itself. Because data were collected at a single point in time, causal relationships cannot be inferred.

Implications for nursing

A brief quality of life check can be built into routine outpatient nursing assessment. Patients with low physical scores may benefit from structured advice on pain relief, exercise, sleep, and fall prevention, and those with low psychological scores from counselling or referral. Nurse-led integrated and telehealth self-care programs for older adults have been evaluated in systematic reviews [3–17], and similar approaches could be tested in Indian hospital clinics.

Conclusion

Most patients with chronic diseases attending this hospital had an average quality of life, and only a small minority reached a good level. Physical limitations, particularly reduced mobility, and emotional strain were the main problems, and they affected patients across all socio-demographic groups. Regular assessment of quality of life, together with physical and emotional support, should form part of routine nursing care for all patients with long-term illness rather than for particular subgroups.

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Author Contributions

TA, US, and A designed the study, collected and analyzed the data, and drafted the manuscript. KS supervised the study and critically revised the manuscript. All authors approved the final version.

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