

Title: The Impact of Chronic Illness on Quality of Life: A Scoping Review of Physical, Psychological and Social Pathways

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Abstract

This scoping review showed evidence (2018 onwards) about the role of chronic illness in determining quality of life (QoL) in the physical, psychological, and social domains. There were ten studies (3 systematic reviews/meta-analyses; 7 cross-sectional). Results were grouped into three themes: (1) physical functioning and symptom burden, in which multimorbidity and pain-related limit were invariably combined with poorer QoL; (2) psychological wellbeing, whereby depression, anxiety and sleep difficulty were consistently related to poorer QoL; and (3) social participation and enabling resources, with health literacy, self-efficacy, self-management and support being constantly correlated to poorer QoL. The review finds the UK practice targets that can be modified such as personalised care, shared decision making, and integrated biopsychosocial support.

1. Introduction

One such term is chronic illness, a health issue that continues to pose a problem throughout life and is often incurable and instead necessitates management (Department of Health and Social Care, 2023). Chronic illness is given priority in the UK since it leads to preventable damage, disparities in health, and long-term burdens on health and care services (Department of Health and Social Care, 2023). In the NHS Long Term Plan, the focus of planning is on long-term conditions since they determine the demand of the workforce, outpatient activity, the use of medicine, and long-term support requirements (NHS England, 2019).

Chronic illness is not a one-time or homogenous experience. Symptom patterns, treatment burden and course of illness vary considerably and influence day to day functioning differently (NHS England, 2019). To take the case of individuals experiencing chronic pain as an example, there may exist significant participation constraints when clinical studies are inconclusive, whereas patients with chronic kidney disease undergoing haemodialysis have to organise the daily existence around rigorous treatment routines (Zambelli et al., 2022; Ramesh et al., 2024).

Quality of life (QoL) is the experience of life of people in areas of health, relationships, purpose, and financial security, and health-related quality of life (HRQoL) is much narrower, paying more attention to health-related functioning (Office for National Statistics, 2022). The significance of QoL outcomes is that they can capture the effects that may not be reflected in clinical measures such as emotional distress, sleep disruption, and loss of independence (Office for National Statistics, 2022). QoL can be measured on a population scale: in Quarter 2 of 2022, 32.28% of adults said that they were very happy, which is against 30.47% in Quarter 1 (Office for National Statistics, 2022).

Acute illness is prevalent in England, one in every four people over 16 years old reported that they had been living with a long-term condition, and loneliness is more common among those who were in bad or very bad health (62%), compared to those in good or very good health (18%), (NHS Digital, 2023). It is likely that the need will grow in the future: the number of people living with major illness is expected to increase to 9.1 million by 2040 (a total of 2.5 million more than in 2019) (Health Foundation, 2023).

Review Question: *How does chronic illness affect the quality of life, and what physical, psychological, and social variables affect this correlation?*

2. Background and Context

2.1 UK Context: Chronic Illness, Services, and Strategic Priorities

The UK health policy positions chronic illness as a priority area due to the long-term condition that creates a sustained demand and makes systems unsustainable (NHS England, 2019). The NHS Long Term Plan puts stronger focus on prevention, earlier intervention and redesigned pathways because episodic care is not yet effective in meeting the needs over an extended period (NHS England, 2019). Nevertheless, the intent of policy may prove challenging to achieve; the King Fund finds the limitations in the form of workforce resources, disjointed solutions, and the necessity to eliminate inequalities (Kings Fund, 2019).

The Department of Health and Social Care major conditions system aims to support clusters like cardiovascular disease, cancer and mental ill-health since it stands for a considerable proportion of poor health and service use (Department of Health and Social Care, 2023). One of the weaknesses of clustering is its ability to decrease the importance of comorbidity; multimorbidity is widespread and siloed pathways may not suit individuals with multiple needs (Department of Health and Social Care, 2023). Predictions serve to create urgency: By 2040, there will be 9.1 million people with major illness in England, with a rise in numbers of 2.5 million compared to 2019 (Health Foundation, 2023). It also increases complexity, where the elderly aged 85 and above are estimated to have 5.7 long-term conditions in 2040 (compared to 5.2 in 2019), and which would demand more coordination (Health Foundation, 2023).

2.2 Why QoL Matters in Healthcare Decision-Making

The concept of QoL is in the Centre of patient-centred care since individuals tend to focus on daily functioning, independence, and emotional stability in relation to clinical outcomes (National Institute for Health and Care Excellence, 2021b). NICE guidance on shared decision making emphasises the correspondence between care and outcomes that are important to the individual,

such as acceptable burden of treatment and role in life (National Institute for Health and Care Excellence, 2021b). NHS personalised care also encourages joint planning that helps individuals to deal with health in a manner that suits their goals and situations (NHS England, 2019b). QoL can be obtained at population level; 32.28% responded extremely high at Quarter 2 of 2022 (30.47% in Quarter 1) (Office for National Statistics, 2022). Importantly, QoL may not be profusely utilized in practice where services focus on disease targets and activity measures instead of functioning and participation outcomes (NHS England, 2019; Kings Fund, 2019).

2.3 Biopsychosocial Impacts and Variation in Outcomes

There is an indication that chronic illness influences QoL by their interaction via physical, psychological, and social pathways (Makovski et al., 2019). The association between multimorbidity and worse QoL confirms the argument that burden increases with the number of accumulated conditions, and functioning gets limited (Makovski et al., 2019). In primary care multimorbidity, self-efficacy is linked with HRQoL, which means that confidence and capability can buffer the loss of QoL (Peters et al., 2019). Sleep, pain and literacy also have an influence: sleep imbalance might mediate the impact of chronic disease on HRQoL, and chronic pain may be better addressed through functional and psychological interventions instead of medications only (Wu et al., 2025; National Institute for Health and Care Excellence, 2021a). Health literacy impacts navigation and self-management, and literacy interventions might promote improved results, which implies that there are changeable pathways through which QoL can be enhanced (Zhang et al., 2025; Shao et al., 2023).

2.4 Gap and Rationale for a Scoping Review

The evidence is scattered in conditions, mechanisms, and study designs, and the practitioner can hardly see the general pattern (Aromataris and Munn, 2020). The scoping review would be appropriate to the extent of mapping the breadth, finding consistent themes, and gaps without the limitation to a specific question of intervention (Aromataris and Munn, 2020). This promotes practice as it helps to understand where the targeted interventions (including sleep support, self-management programmes and health literacy initiatives) can be applied to improve QoL (Aromataris and Munn, 2020; NHS England, 2019b). Furthermore, figure 1 below shows the biopsychosocial mechanisms under which chronic illness affects the quality of life, a factor that informed the thematic format of this review.



Figure 1: Conceptual Infographic Showing How Chronic Illness Affects Quality of Life.

3. Methods

3.1 Review Design

The scoping review design employed in this study was to map the range of evidence on the topic of the impact of chronic illness on quality of life (QoL) (Aromataris and Munn, 2020). A scoping review suits the topic since the conditions, outcomes, and study designs are multiple, and the aim is to figure out patterns, themes and knowledge gaps instead of estimating one pooled effect (Aromataris and Munn, 2020). This method helps to support a systematic and adaptable synthesis that can guide practice summarising what is known on physical, psychological, and social levels of QoL (Aromataris and Munn, 2020).

3.2 Search Strategy

PubMed/Medline, CINAHL, Scopus, and Google Scholar were thoroughly searched to filter out medical, nursing, and multidisciplinary studies (Aromataris and Munn, 2020). The search was restricted to the past 2018 because of the necessity to uphold evidence of current policy, services, and treatment methods (Aromataris and Munn, 2020). The main terms were chronic illness, chronic disease, and long-term condition in combination with quality of life and health-related quality of life (HRQoL) (Aromataris and Munn, 2020). Precision and transparency were enhanced with the help of the use of binary operators, e.g., (chronic disease) OR (chronic illness) OR (long-term condition) AND (quality of life) OR (HRQoL) (Aromataris and Munn, 2020). Relevance filters have been used to increase the relevance: English language, peer-reviewed sources, and human adult populations when database tools had such (Aromataris and Munn, 2020). To enhance the

rigour of scoping review designs, even with search strategy, the search strategy was documented to enable auditability and reproducibility (Aromataris and Munn, 2020).

3.3 Inclusion and Exclusion Criteria

Inclusion criteria were used to make sure that the studies would answer the review question directly and could be used to generate thematic synthesis (Aromataris and Munn, 2020). The included articles were peer-reviewed, published not older than 2018, and addressed chronic illness/chronic disease and provided QoL/HRQoL outcomes in an adult or general population (Aromataris and Munn, 2020). Studies (quantitative, qualitative, and mixed) were not restricted to a particular design since scoping reviews tend to map evidence across all designs and not just trials (Aromataris and Munn, 2020). Only studies that had considered acute-only conditions and had not reported a QoL-related outcome were excluded along with non-peer-reviewed (e.g., blogs) or irrelevant to the focus of this review (Aromataris and Munn, 2020). With this eligibility method, breadth is enhanced, yet relevance is preserved, minimising the chances of narrative topic drift (Aromataris and Munn, 2020).

Table 1: Inclusion and Exclusion Criteria (Aromataris and Munn, 2020)

Criteria	Include	Exclude
Publication type	Peer-reviewed journal articles	Non-peer-reviewed sources (e.g., blogs, opinion pieces)
Year	2018 onwards	Before 2018
Population	Adults / general population with chronic illness	Acute-only populations; irrelevant groups
Focus	Chronic illness and QoL/HRQoL outcomes	No QoL/HRQoL outcome reported
Study design	Quantitative, qualitative, mixed methods	Not empirical research / not relevant

3.4 Study Selection Process

The selection of studies was done after a two-stage screening process, which involved screening by title/abstract and, subsequently, screening by full-text (Tricco et al., 2018). Doubtful studies were also re-evaluated in relation to the criteria to minimize the undeserving exclusions and enhance uniformity in the decision process (Tricco et al., 2018). A PRISMA-like flow method was used to record the selection process and demonstrate the number of records that were identified, screened, excluded, and included (Tricco et al., 2018).

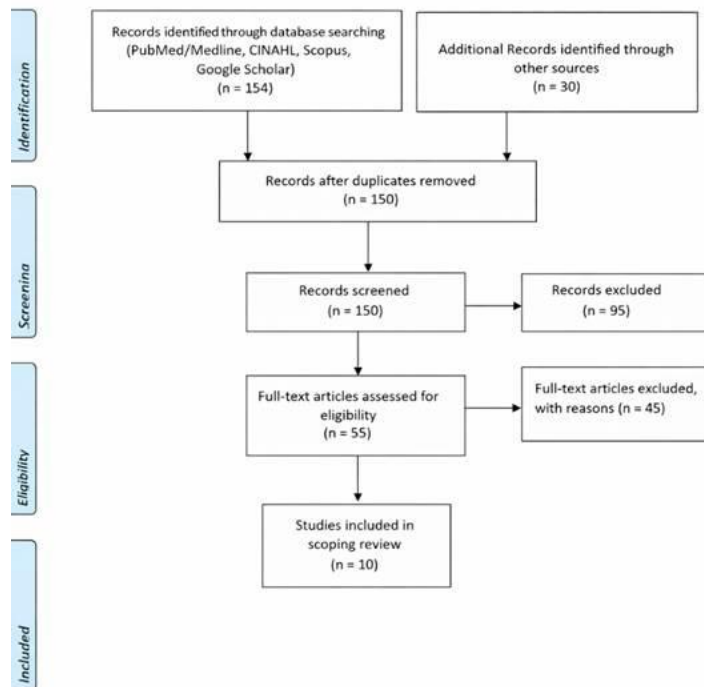


Figure 2: PRISMA Flow Diagram (Tricco et al., 2018).

3.5 Data Extraction and Thematic Analysis

The extracted data included: author/year, setting, sample, chronic condition(s), design, QoL outcome/tool, and main findings of interest concerning QoL (Aromataris and Munn, 2020). The thematic analysis was used to synthesise the findings through familiarisation to coding and the grouping of codes and the refinement of three final themes (Aromataris and Munn, 2020). This helps to create depth in analysis since it provides links between the study results and common mechanisms (e.g., symptom burden, psychological distress, social support) instead of describing studies individually (Aromataris and Munn, 2020).

3.6 Ethics

Since it was a secondary review of published studies, there was no direct involvement of a participant, and formal NHS ethics knowledge was not needed (Nursing and Midwifery Council, 2018). The ethical practice was aimed at being accurate, fair in presentation of the evidence, and proper referencing, which is, as per professional standards (Nursing and Midwifery Council, 2018).

4. Results

4.1 Overview of Included Studies (n = 10)

Ten articles passed the inclusion criteria and were subjected to thematic synthesis (Aaron et al., 2025; Hu et al., 2024). The evidence base included 3 systematic reviews/meta-analyses and 7

cross-sectional observational studies, which provide a wide but weak causal inference (Makovski et al., 2019; Huang et al., 2024). The primary care populations and community were predominantly used as settings, as well as a particular clinical group of patients (haemodialysis) and a sample of community chronic pain (Ramesh et al., 2024; Zambelli et al., 2022). In terms of geography, a number of studies were mainly carried out in Asia (especially China and India), and evidence syntheses helped to sum up findings in many contexts (Lei et al., 2025; Ramesh et al., 2024). The categories of conditions were general chronic disease groups, multimorbidity, chronic pain, and chronic kidney disease under haemodialysis (Makovski et al., 2019; Zambelli et al., 2022). One of the main quality concerns is the fact that the majority of primary studies were cross-sectional, and therefore, correlations with QoL could be based on correlation, not on the direction of effect (Peters et al., 2019; Wu et al., 2025).

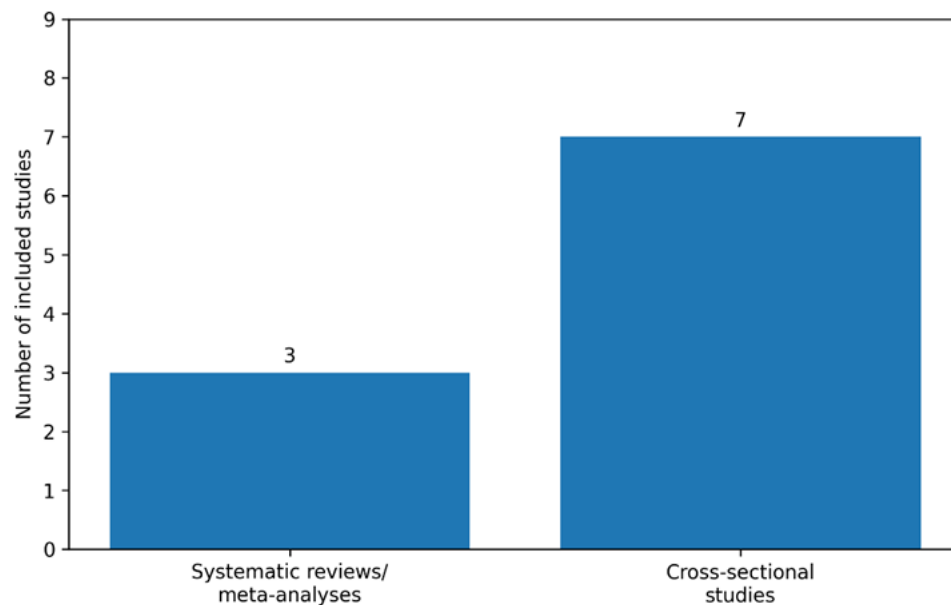


Figure 3: Study Designs (3 Reviews Vs 7 Cross-Sectional) (Derived from Table 2) (Makovski et al., 2019).

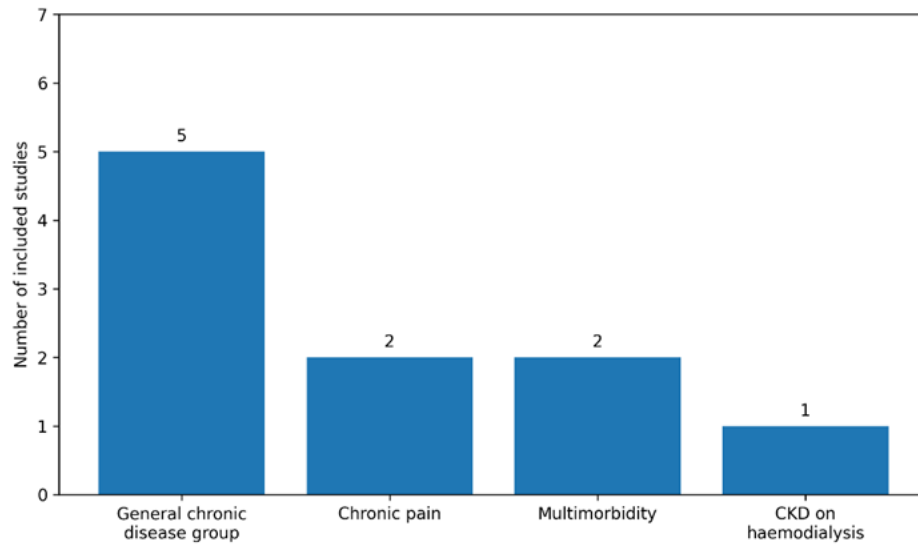


Figure 4: Conditions Represented (e.g., Chronic Pain, Multimorbidity, and CKD) (Derived from Table 2) (Zambelli et al., 2022).

4.2 Theme 1: Physical Functioning and Symptom Burden

In all research, low QoL was always associated with physical constraints and symptomatic load, such as treatment load and multimorbidity (Hu et al., 2024; Makovski et al., 2019). The meta-analysis of multimorbidity shows that the worse the long-term conditions, the less the QoL, which confirms the hypothesis of the burden (Makovski et al., 2019). This tendency is probable as several factors may cause conflicting self-care activities (appointments, medicines, monitoring) and limit everyday activities (Lei et al., 2025; Makovski et al., 2019). QoL in general chronic disease samples was attributed to functional capacity and lifestyle-related factors, implying that physical activity is a workable tool that enhances QoL (Hu et al., 2024; Lei et al., 2025). Hu et al. mention physical activity and the degree of digitisation as applicable to HRQoL, which means that access to digital tools can be used to aid self-management behaviors (Hu et al., 2024).

Nevertheless, this also carries the risk of increasing inequality in case of uneven access to digital opportunities, i.e., in the situation when some groups can improve more than others (Hu et al., 2024; Lei et al., 2025). The literature on chronic pain shows that even with a lack of measurement of lived impact by standard biomedical indices, symptom interference has the potential to decrease QoL (Zambelli et al., 2022). A major weakness is the impossibility of using cross-sectional results to establish the cause between low activity and worse QoL or vice versa pain or exhaustion, and therefore inactivity (Hu et al., 2024; Zambelli et al., 2022).

4.3 Theme 2: Psychological Wellbeing and Mental Health

Psychological distress became one of the significant QoL drivers, especially by way of depression, anxiety and sleep disruption (Aaron et al., 2025; Wu et al., 2025). Aaron et al. synthesised evidence that proves depression and anxiety are prevalent among adults with chronic pain, and there are explicit implications of HRQoL (Aaron et al., 2025). It is important since mental health symptoms have the potential to increase perceived symptom burden, decrease incentives to self-care, and exacerbate social withdrawal (Aaron et al., 2025; Zambelli et al., 2022).

According to Wu et al., the relationship between chronic disease and HRQoL was mediated by sleep difficulty, which shows that sleep is a mechanism and not an inconvenient side effect (Wu et al., 2025). This is clinically significant: even in the stable and not necessarily reversible underlying condition, an increase in sleep can have QoL outcomes (Wu et al., 2025; Zambelli et al., 2022). This multi-domain perspective is also shared by Zambelli et al. because they focus on the idea that chronic pain management shall be approached with broader methodologies which consider the function and wellbeing (Zambelli et al., 2022). One of the main criticisms is that most of them use self-reported measures, which predisposes them to shared-method bias (e.g., low mood affecting both the symptom ratings and QoL scoring) (Aaron et al., 2025; Wu et al., 2025). Nevertheless, uniformity among a meta-analysis and observational results will increase the assurance that mental component is materially connected to QoL in chronic disease (Aaron et al., 2025; Wu et al., 2025)

4.4 Theme 3: Social Life, Support, Participation and Enabling Resources

It was repeatedly linked with improved QoL by social support and other enabling resources (self-efficacy, health literacy, and self-management) (Ramesh et al., 2024; Zhang et al., 2025). Zhang et al. determined that health literacy is correlated with QoL in patients with chronic diseases and showed that health literacy might help daily coping (Zhang et al., 2025). The persistence of self-management was also important: Huang et al. judged that self-management interventions could help people with chronic diseases to improve their results, which apply to QoL (Huang et al., 2024). QoL in a haemodialysis population was found to be correlated with self-management and social support, proving the dependence of treatment-intensive conditions on the family/community resources (Ramesh et al., 2024).

Peters et al. proved that self-efficacy was interrelated with HRQoL in multimorbidity, which said that confidence and capability could offset the adverse effects of a complex illness (Peters et al., 2019). Most importantly, these resource variables are realistic targets of interventions, although most of the evidence in this area is still correlational, as opposed to proving what improves QoL

overall (Peters et al., 2019; Zhang et al., 2025). Another issue is transferability: information on certain health systems might not be easily transferred onto the UK service framework without taking access, continuity and customised care delivery into account (Ramesh et al., 2024; Zhang et al., 2025).

Table 2: Study Characteristics and Headline QoL-Relevant Findings

Study	Design	Population/setting	QoL-relevant headline finding (high level)
Aaron et al., 2025	Systematic review + meta-analysis	Adults with chronic pain (multiple studies)	Depression/anxiety are common and linked to poorer wellbeing/QoL
Hu et al., 2024	Cross-sectional	Middle-aged/older adults with chronic disease	Physical activity and digitisation factors associated with HRQoL
Huang et al., 2024	Systematic review + meta-analysis	Chronic disease populations (multiple studies)	Self-management interventions improve outcomes relevant to QoL
Lei et al., 2025	Cross-sectional	People with chronic diseases	QoL associated with functional/lifestyle and related factors
Makovski et al., 2019	Systematic review + meta-analysis	Multimorbidity populations (multiple studies)	Multimorbidity associated with lower QoL/HRQoL
Peters et al., 2019	Cross-sectional	Primary care multimorbidity	Higher self-efficacy associated with better HRQoL
Ramesh et al., 2024	Cross-sectional	CKD haemodialysis patients	Social support + self-management correlated with QoL
Wu et al., 2025	Cross-sectional	Middle-aged/older adults with chronic disease	Sleep difficulty mediates chronic disease–HRQoL relationship
Zambelli et al., 2022	Cross-sectional (mapping in community sample)	Chronic pain/community context	Chronic pain management aligns with multi-domain QoL impacts
Zhang et al., 2025	Cross-sectional	Chronic disease patients	Health literacy associated with QoL

Table 3: Theme-By-Study Mapping

Study	Theme 1 Physical	Theme 2 Psychological	Theme 3 Social/resources	One-line contribution
Aaron <i>et al.</i> , 2025		✓		Distress is common in chronic pain and relates to poorer QoL
Hu <i>et al.</i> , 2024	✓		✓	Activity/digital factors relate to HRQoL in chronic disease
Huang <i>et al.</i> , 2024			✓	Self-management interventions support QoL-related outcomes
Lei <i>et al.</i> , 2025	✓			QoL varies with health and lifestyle-related factors
Makovski <i>et al.</i> , 2019	✓			Multimorbidity is linked to poorer QoL/HRQoL
Peters <i>et al.</i> , 2019			✓	Self-efficacy is associated with better HRQoL
Ramesh <i>et al.</i> , 2024			✓	Support + self-management correlate with QoL (dialysis)
Wu <i>et al.</i> , 2025		✓		Sleep difficulty mediates chronic disease impact on HRQoL
Zambelli <i>et al.</i> , 2022	✓	✓		Chronic pain affects function and wellbeing; multi-domain needs
Zhang <i>et al.</i> , 2025			✓	Health literacy relates to QoL in chronic disease

5. Discussion

5.1 Summary of Main Findings

This scoping review determined three themes that explained the impact of chronic illness on the quality of life (QoL) (Makovski *et al.*, 2019). To begin with, the QoL was lower due to physical functioning and symptom burden, which caused restriction and pain interference and workload to deal with various conditions (Makovski *et al.*, 2019; Hu *et al.*, 2024). Second, they served as psychological wellbeing and sleep, which were found to be associated with worse QoL, especially in chronic pain (Aaron *et al.*, 2025; Wu *et al.*, 2025). Third, social support, and enabling resources (health literacy, self-efficacy and self-management) were found to be protective factors, which positively contributed to adaptation and participation (Zhang *et al.*, 2025; Peters *et al.*, 2019).

5.2 Interpretation by Theme

5.2.1 Physical Functioning and Symptom Burden

The results indicate that there is a burden pathway: the more symptoms increase and the more conditions a person has, the worse functioning is, and the lower is the quality of life (Makovski *et al.*, 2019). The significance of multimorbidity is especially high as it raises the symptom load and treatment workload and makes work, relations and independence limited (Makovski *et al.*, 2019; Lei *et al.*, 2025). Hu *et al.* show that physical activity is connected to HRQoL, meaning movement can prevent the negative impact on functioning and wellbeing in groups with chronic diseases (Hu *et al.*, 2024). But it is not clear where it is going: the low QoL can cause inactivity due to fatigue or pain, not the other way around (Hu *et al.*, 2024; Lei *et al.*, 2025). In practice, the interventions

must be realistic (pacing, graded activity, symptom-sensitive plans) and should not suggest individual failure in a case where the restriction is primarily based on the clinical reasons (Makovski et al., 2019).

5.2.2 Psychological Wellbeing, Sleep, and Chronic Pain

Psychological reasons probably act as consequences and magnifiers of burden of sickness (Aaron et al., 2025). Depression and anxiety are more frequent and associated with worse wellbeing in chronic pain, which is an indicator of pain being a higher-risk subgroup of QoL loss (Aaron et al., 2025). According to Wu et al., sleep provides a possible mediator between chronic disease and HRQoL, and therefore, sleep is a potential source of intervention to enhance QoL (Wu et al., 2025). It helps holistic care: symptom therapy does not always bring significant benefits to QoL as important mechanisms are still active (Zambelli et al., 2022; Wu et al., 2025). The NICE chronic pain guidance emphasises the evaluation and non-pharmacological management of pain, which is consistent with the requirement to combine function and wellbeing (National Institute for Health and Care Excellence, 2021a).

5.2.3 Social Support and Enabling Resources

The evidence implies that there is a pathway of resources, in which health literacy, self-efficacy, and self-management allow people to navigate care and maintain daily living to support QoL (Zhang et al., 2025). Health literacy is related to QoL, which means that a person copes and engages in treatment because of their understanding and use of health information (Zhang et al., 2025). The outcomes of chronic disease can be enhanced by health literacy interventions, which means that they have modifiable drivers but not immutable disadvantages (Shao et al., 2023). Self-management interventions are also associated with positive outcomes, and structured programmes in lieu of a short-term advice have positive outcomes (Huang et al., 2024). NHS personalised care and support planning is consistent with these results, while disparities in access to the so-called resources can create disparities in case of the lack of targeted support (NHS England, 2019b; NHS England, 2026).

5.3 Wider UK Policy Context and Limitations

The results are consistent with the UK priorities on living well with long-term conditions of prevention, integration, and person-centred care (NHS England, 2019; Kings Fund, 2019). NICE, shared decision making helps integrate QoL trade-offs into care planning, particularly whereby treatment can impact fatigue, sleep or participation (National Institute for Health and Care Excellence, 2021b). Limitations of the evidence are a cross-sectional design, the absence of

consistent measures of QoL, and poor longitudinal analysis (Aromataris and Munn, 2020; Wu et al., 2025). Despite structured reporting, review limitations have database coverage, English-only constraint and screening risk of a single reviewer (Tricco et al., 2018; Aromataris and Munn, 2020).

5.4 Implications for Practice and Policy

Put more emphasis on integrated biopsychosocial care, shared decision making, personalised planning, and self-management and health literacy support (Nursing and Midwifery Council, 2018; National Institute for Health and Care Excellence, 2021b; NHS England, 2026).

6. Conclusion and Recommendations

6.1 Conclusion

According to this scoping review, three pathways of chronic illness decreasing quality of life (QoL) occur that are interacting: physical burden, psychological distress, and decreased social participation (Makovski et al., 2019). Among the physical effects are functional limitation, interference with symptoms, and workload of having several conditions which, jointly, undermines day-to-day wellbeing (Makovski et al., 2019). Perceived burden is further aggravated by psychological processes, such as low mood and sleep disturbance, which may limit self-care and relationship involvement (Makovski et al., 2019). The outcomes depend on social resources: individuals who have stronger support and can cope with the disease better tend to report higher QoL despite the persistence of symptoms (Makovski et al., 2019). This is important to the UK given that wellbeing is a quantifiable social outcome; 32.28% of adults in Quarter 2, 2022, were extremely happy, showing that population QoL is changeable and can be employed in policy-making (Office for National Statistics, 2022).

6.2 Recommendations

Practice (Service Level): Incorporate shared decision making into regular reviews; combine pain, mood and sleep review; and reinforce self-management support (National Institute of Health and Care Excellence, 2021b; National Institute of Health and Care Excellence, 2021a). Introduce personalised care and support planning to ensure that goals are based on functioning and participation instead of by biomedical outcomes alone (NHS England, 2019b; Nursing and Midwifery Council, 2018).

Policy/System: Coordinate QoL improvement with long-term planning and prevention and enhance the provision of personalised care across services (NHS England, 2019; Department of Health and Social Care, 2023). Get ready to increase demand: it is estimated that major illness

will affect 9.1 million individuals in England by 2040 and will need more sustainable patterns of care (Health Foundation, 2023; NHS England, 2026).

Research: Consistency of QoL instruments, longitudinal designs and the effect of health literacy and self-management intervention on QoL (Shao et al., 2023; Aromataris and Munn, 2020).

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