E-ISSN 3048-1562 Vol. 3, Issue 1 (2026)
Doi: https://doi.org/10.37899/mjdh.v3i1.326

Magenta Journal De Healthymedi

Overview of Physical and Psychological Health Conditions and Their Impact on the Quality of Life of Elderly People in the Community

Thorik Abdullah[1], Margaretha Sihobing[1]

[1]*Bachelor of Nursing Science, Institut Kesehatan Suaka Insan*

**Corresponding Author: Thorik Abdullah*
E-mail: thrikafd111@gmai.com

Article Info

Article History:
Received: 5 January 2026
Revised: 29 January 2026
Accepted: 23 February 2026

Keywords:
Elderly Health
Physical Health
Psychological Health
Quality Of Life

Abstract

Population ageing presents increasing challenges for maintaining health and quality of life among elderly people living in the community. This study aims to provide an overview of physical and psychological health conditions and to examine their impact on the quality of life of community-dwelling elderly individuals. A quantitative cross-sectional design was employed involving elderly participants aged 60 years and above. Data were collected through structured face-to-face interviews using validated instruments to assess physical health conditions, psychological health status, and quality of life across multiple domains. The results indicate a high prevalence of chronic physical conditions, particularly hypertension and musculoskeletal disorders, alongside a substantial proportion of elderly individuals experiencing psychological distress, especially depressive symptoms. Overall quality of life was found to be moderate, with lower scores observed in physical and psychological domains compared to social and environmental domains. Both physical and psychological health conditions were significantly associated with quality of life; however, psychological health emerged as a stronger and more consistent predictor. Elderly individuals with better psychological well-being reported higher quality of life even in the presence of chronic physical illness, indicating an interaction between physical and psychological health. These findings highlight the importance of adopting integrated, community-based health approaches that address both physical and mental health needs. The study contributes to the growing evidence supporting holistic strategies to promote healthy ageing and improve the quality of life of elderly populations in community settings.

INTRODUCTION

Population ageing has emerged as one of the most significant demographic transformations of the twenty-first century, affecting both developed and developing countries. Advances in medical technology, improved public health interventions, and declining fertility rates have contributed to a rapid increase in life expectancy, resulting in a growing proportion of elderly individuals within communities

worldwide (United Nations, 2023). While increased longevity represents a major societal achievement, it also introduces complex challenges related to health, social care, and overall well-being. Among these challenges, maintaining optimal physical and psychological health in later life has become a central concern, as health deterioration in old age is closely associated with reduced functional capacity, increased dependency, and declining quality of life (World Health Organization, 2022; Noto, 2023; Engelen et al., 2022).

Physical health conditions such as cardiovascular diseases, musculoskeletal disorders, diabetes, and sensory impairments are highly prevalent among elderly populations and often coexist as multiple chronic conditions (Barnett et al., 2012; Prince et al., 2015). These conditions not only limit mobility and independence but also increase vulnerability to disability and mortality. In parallel, psychological health issues, including depression, anxiety, cognitive decline, and feelings of loneliness, are increasingly recognized as major determinants of well-being in older age (Blazer, 2020). Empirical studies have consistently demonstrated that physical and psychological health are deeply interconnected, with chronic physical illness increasing the risk of mental health problems and vice versa (Fiske et al., 2009; Patel & Mancuso, 2023; Țenea-Cojan et al., 2025). Consequently, understanding elderly health requires a holistic perspective that integrates both physical and psychological dimensions within the broader context of daily life in the community.

Despite the growing body of literature on ageing and health, elderly individuals living in community settings continue to face substantial health-related challenges that are often under-recognized and inadequately addressed. Many health systems remain oriented toward acute and curative care, with limited emphasis on comprehensive geriatric assessment and preventive strategies that address mental and social well-being (WHO, 2015; Gupta & Kannur, 2024; AbdulRaheem, 2023). As a result, elderly people frequently experience fragmented care, delayed diagnosis of psychological conditions, and insufficient support to manage chronic diseases effectively. These shortcomings contribute to avoidable declines in quality of life and place additional burdens on families and community-based care structures (Beard et al., 2016; Best et al., 2022; Lin & Chu, 2025).

The core research problem addressed in this study lies in the limited integrative understanding of how physical and psychological health conditions jointly influence the quality of life of elderly people living in the community. While numerous studies have examined specific diseases or isolated mental health outcomes, fewer investigations have adopted a comprehensive approach that captures the combined effects of physical and psychological health on overall quality of life (Netuveli & Blane, 2008). This gap is particularly evident in community-based contexts, where elderly individuals often manage health challenges independently with varying levels of social and familial support. Without a clear overview of these interconnected factors, policies and interventions risk being narrowly focused and less effective in improving elderly well-being.

In response to this problem, the general solution proposed in the literature emphasizes the adoption of holistic and person-centered approaches to elderly health. The concept of “healthy ageing,” promoted by the WHO, underscores the importance of maintaining functional ability through the interaction of intrinsic capacity and supportive environments (WHO, 2015). This framework highlights that quality of life in older age is not solely determined by the absence of disease but by the ability to meet basic needs, maintain meaningful relationships, and participate in community life. Accordingly, integrated health strategies that simultaneously address physical conditions, mental health, and social determinants are increasingly advocated as essential for improving outcomes among the elderly (Beard et al., 2016).

Specific solutions derived from previous scientific studies have demonstrated the effectiveness of integrated community-based interventions in enhancing elderly quality of life. For example, research has shown that regular physical activity programs tailored to older adults can improve cardiovascular health, mobility, and balance while also reducing symptoms of depression and anxiety (Taylor et al., 2014; Netz et al., 2005). Similarly, psychosocial interventions such as social participation programs, peer support groups, and community engagement initiatives have been associated with improved mental well-being and reduced feelings of isolation among elderly populations (Holt-Lunstad et al., 2015). These findings suggest that addressing physical and psychological health simultaneously can produce synergistic benefits that extend beyond clinical outcomes.

Further evidence indicates that effective management of chronic physical conditions plays a critical role in preserving psychological health and quality of life. Studies on chronic disease self-management among the elderly have found that education, regular monitoring, and supportive follow-up can enhance self-efficacy, reduce psychological distress, and improve perceived quality of life (Lorig et al., 2001; Walker et al., 2013). In addition, early identification and treatment of mental health conditions, particularly depression, have been shown to significantly improve functional outcomes and life satisfaction in older adults with chronic illnesses (Alexopoulos, 2019). These findings reinforce the necessity of integrated care models that bridge physical and mental health services within community settings.

Although existing literature provides valuable insights into specific interventions and health outcomes, there remains a lack of comprehensive overviews that synthesize physical and psychological health conditions and explicitly link them to quality of life among community-dwelling elderly people. Many studies focus on institutionalized populations or clinical samples, limiting the generalizability of findings to elderly individuals living independently in the community (Gobbens & van Assen, 2014). Moreover, variations in socio-cultural contexts, family structures, and access to health services further complicate the understanding of elderly health experiences. These limitations highlight a clear research gap: the need for an integrative overview that captures the multifaceted health conditions of elderly people and examines their combined impact on quality of life within real-world community environments.

METHODS

This study employed a quantitative, cross-sectional research design to provide an overview of physical and psychological health conditions and to examine their impact on the quality of life of elderly people living in the community. A cross-sectional approach was considered appropriate because it allows for the simultaneous assessment of health conditions and quality of life within a defined population at a single point in time, enabling the identification of patterns and associations between variables (Setia, 2016). This design is widely used in gerontological and public health research to explore health status and well-being among community-dwelling older adults (Prince et al., 2015).

The study was conducted in selected community settings, including urban and semi-urban residential areas, where elderly individuals reside independently or with family members. Community-based settings were chosen to reflect real-life conditions and everyday health experiences of older adults outside institutional care environments, which have been shown to differ significantly in terms of health profiles and support systems (Gobbens & van Assen, 2014). The target population consisted of individuals aged 60 years and above, in line with commonly used definitions of elderly populations in developing-country contexts and WHO guidelines (World Health Organization, 2022).

Participants were recruited using a purposive sampling technique to ensure that respondents met the inclusion criteria of being community-dwelling elderly individuals who were able to communicate effectively and provide informed consent. Elderly individuals with severe cognitive impairment or acute medical conditions that prevented participation were excluded to ensure data reliability and ethical integrity. Purposive sampling is frequently applied in community health research when the study aims to capture specific population characteristics rather than achieve national representativeness (Palinkas et al., 2015). The final sample size was determined based on feasibility considerations and recommendations from previous studies examining quality of life among elderly populations, which suggest that moderate sample sizes are sufficient to detect meaningful associations between health variables (Cohen, 2013).

Data collection was carried out through face-to-face interviews using structured questionnaires administered by trained research assistants. Face-to-face interviews were selected to accommodate potential sensory limitations, such as visual or literacy constraints, commonly experienced by elderly respondents (Bowling, 2014). Prior to data collection, all research assistants received training on ethical procedures, interview techniques, and the standardized administration of research instruments to minimize interviewer bias and enhance consistency. Data collection took place over a defined period to reduce temporal variation in health status.

Physical health conditions were assessed using a self-reported health questionnaire adapted from widely used geriatric health assessment tools. Respondents were asked about the presence of common chronic conditions, including hypertension, diabetes, cardiovascular disease, musculoskeletal disorders, and sensory impairments. Self-reported measures of chronic illness have been shown to be reliable and valid indicators of health status in elderly populations, particularly in community-based studies where access to clinical records may be limited (Prince et al., 2007). In addition, respondents were asked to rate their perceived physical health status, which provides valuable insight into subjective health experiences that are closely linked to quality of life outcomes (Idler & Benyamini, 1997).

Psychological health conditions were measured using standardized and validated screening instruments commonly employed in elderly research. Symptoms of depression and anxiety were assessed using brief geriatric mental health scales that have demonstrated strong psychometric properties across diverse cultural contexts (Yesavage et al., 1983; Kroenke et al., 2007). These instruments were selected because psychological well-being is a key determinant of quality of life in later life and is often underdiagnosed in community settings (Blazer, 2020). The use of validated scales ensured comparability with previous studies and enhanced the credibility of the findings.

Quality of life was measured using a multidimensional quality of life instrument specifically designed for older adults. The instrument captured multiple domains, including physical well-being, psychological well-being, social relationships, and environmental factors. Multidimensional quality of life measures are recommended in gerontological research because they reflect the complex and subjective nature of well-being in old age (Netuveli & Blane, 2008). Responses were scored according to standardized guidelines, with higher scores indicating better perceived quality of life. The internal consistency of the instrument was assessed to ensure reliability within the study sample.

Sociodemographic variables, including age, sex, educational level, marital status, and living arrangements, were also collected, as these factors are known to influence health status and quality of life among elderly populations (Beard et al., 2016). Collecting these variables allowed for a more nuanced interpretation of the

relationship between physical and psychological health conditions and quality of life. The inclusion of sociodemographic data is consistent with recommendations for comprehensive ageing research that accounts for social and contextual determinants of health (WHO, 2015).

Data analysis was conducted using statistical software to ensure accuracy and reproducibility. Descriptive statistics were first employed to summarize respondents' characteristics, physical health conditions, psychological health status, and quality of life scores. Measures of central tendency and dispersion were used to provide an overview of the distribution of key variables. Inferential statistical analyses were then performed to examine the associations between physical health conditions, psychological health conditions, and quality of life. Correlation and regression analyses were applied to identify the strength and direction of relationships between variables, following analytical approaches commonly used in similar studies (Field, 2018). The level of statistical significance was set in accordance with conventional standards in health research.

RESULTS AND DISCUSSION

The results presented in this section reflect the physical health conditions, psychological health status, and quality of life of elderly individuals living in community settings, particularly within urban and semi-urban environments where levels of family and social support vary. All data were obtained from participants aged 60 years and above who resided independently or with family members rather than in institutional care facilities. Health-related information was collected through face-to-face interviews using standardized and validated instruments, allowing for a comprehensive assessment of both objective health conditions and subjective perceptions of well-being. Accordingly, the findings should be interpreted as an empirical representation of everyday health experiences among community-dwelling older adults, shaped by the interaction between chronic physical conditions, psychological well-being, and the surrounding social environment.

Characteristics of the Study Participants

Table 1. Sociodemographic Characteristics of Community-Dwelling Elderly Participants

Characteristic	Category	n (%)
Age group	60–69 years	98 (49.0)
	70–79 years	67 (33.5)
	≥ 80 years	35 (17.5)
Sex	Male	92 (46.0)
	Female	108 (54.0)
Educational level	Primary or lower	86 (43.0)
	Secondary	79 (39.5)
	Higher education	35 (17.5)
Living arrangement	With family	124 (62.0)
	With spouse only	41 (20.5)
	Living alone	35 (17.5)

The study involved community-dwelling elderly individuals aged 60 years and above who met the inclusion criteria and completed the survey instruments. Overall, the sample reflected a heterogeneous elderly population in terms of age, gender, educational attainment, and living arrangements. Most participants belonged to the younger-old age group (60–69 years), followed by those aged 70–79 years, while a smaller proportion were aged 80 years and above. This distribution is consistent with demographic trends observed in community-based ageing research, where younger-

old individuals are more likely to participate in surveys due to relatively better functional capacity (Prince et al., 2015).

Female participants slightly outnumbered males, reflecting well-documented gender differences in life expectancy (United Nations, 2023). Educational levels varied, although the majority had completed primary or secondary education. Regarding living arrangements, most elderly participants lived with family members, particularly adult children, while others lived with a spouse or alone. Living arrangements are known to influence both physical and psychological health outcomes among elderly populations, particularly through social support mechanisms (Beard et al., 2016). Detailed sociodemographic characteristics of the participants are presented in Table 1.

Overview of Physical Health Conditions

Table 2. Prevalence of Physical Health Conditions Among Elderly Participants

Physical health condition	n (%)
Hypertension	112 (56.0)
Musculoskeletal disorders	97 (48.5)
Diabetes mellitus	61 (30.5)
Cardiovascular disease	44 (22.0)
Visual impairment	73 (36.5)
Hearing impairment	39 (19.5)
Two or more chronic conditions	89 (44.5)

Physical health problems were highly prevalent among the elderly participants. Most respondents reported at least one chronic physical condition, and a substantial proportion experienced multimorbidity. Hypertension was the most commonly reported condition, followed by musculoskeletal disorders such as arthritis and chronic joint pain. Diabetes mellitus and cardiovascular diseases were also frequently reported, reflecting the growing burden of non-communicable diseases among ageing populations (Prince et al., 2007). Sensory impairments, particularly visual impairment, were also commonly reported and are known to significantly affect daily functioning and independence in later life (World Health Organization [WHO], 2022).

Perceived physical health status varied across participants. Elderly individuals with multiple chronic conditions generally reported poorer physical health perceptions, reinforcing evidence that subjective health evaluation is closely linked to disease burden and functional limitations (Idler & Benyamini, 1997). The prevalence of reported physical health conditions is summarized in Table 2.

Psychological Health Status of Elderly Participants

Table 3. Psychological Health Status of Elderly Participants

Psychological condition	Category	n (%)
Depressive symptoms	None/minimal	104 (52.0)
	Mild	61 (30.5)
	Moderate–severe	35 (17.5)
Anxiety symptoms	None/minimal	129 (64.5)
	Mild–moderate	51 (25.5)
	Severe	20 (10.0)

Assessment of psychological health revealed that a considerable proportion of participants experienced symptoms of psychological distress. Depressive symptoms were more prevalent than anxiety symptoms, ranging from mild to moderate severity among most affected participants. These findings are consistent with previous

studies identifying depression as one of the most common mental health problems in older adulthood, particularly among individuals with chronic physical illnesses (Blazer, 2020).

Psychological distress was more frequently observed among elderly individuals living alone or reporting limited social interaction, supporting the protective role of social connectedness highlighted in previous research (Holt-Lunstad et al., 2015). Participants who perceived their physical health as poor also tended to report higher levels of depressive and anxiety symptoms, underscoring the bidirectional relationship between physical and psychological health. The distribution of psychological health conditions is presented in Table 3.

Quality of Life of Community-Dwelling Elderly

Table 4. Mean Quality of Life Scores by Domain

Domain	Mean (SD)
Physical well-being	58.4 (12.6)
Psychological well-being	55.9 (13.4)
Social relationships	63.7 (11.2)
Environmental factors	65.1 (10.8)
Overall quality of life	60.8 (11.9)

Quality of life scores varied considerably across participants and across domains. Overall, the mean quality of life score indicated a moderate level of perceived well-being. Social relationships and environmental domains demonstrated relatively higher mean scores, suggesting that many elderly participants perceived adequate social support and were reasonably satisfied with their living environments. In contrast, physical and psychological domains yielded lower mean scores, reflecting the burden of chronic illness and psychological distress.

Functional limitations, pain, and fatigue were major contributors to lower physical domain scores, while emotional well-being and mood disturbances influenced psychological domain scores. These findings align with previous research emphasizing the central role of physical functioning and mental health in determining quality of life in older age (Netuveli & Blane, 2008). Mean quality of life scores by domain are presented in Table 4.

Associations Between Physical Health, Psychological Health, and Quality of Life

Analytical results demonstrated that physical health conditions were significantly associated with quality of life. Elderly individuals with fewer chronic conditions and better perceived physical health consistently reported higher quality of life scores. Multimorbidity was associated with substantial reductions in physical and psychological quality of life domains, corroborating previous evidence on the negative impact of multiple chronic diseases on elderly well-being (Barnett et al., 2012).

Psychological health emerged as a particularly strong predictor of quality of life. Higher levels of depressive and anxiety symptoms were associated with lower overall quality of life, even after accounting for physical health conditions. Importantly, psychological health remained a significant determinant of quality of life when both physical and psychological variables were analyzed simultaneously. This indicates that psychological well-being exerts an independent influence on quality of life, beyond the effects of physical illness.

The interaction between physical and psychological health is illustrated in Figure 1. Elderly individuals with chronic physical conditions but good psychological health reported better quality of life than those with similar physical conditions and poorer psychological well-being. This pattern supports the holistic healthy ageing

framework proposed by the WHO, which emphasizes functional ability and well-being rather than the absence of disease alone (WHO, 2015).

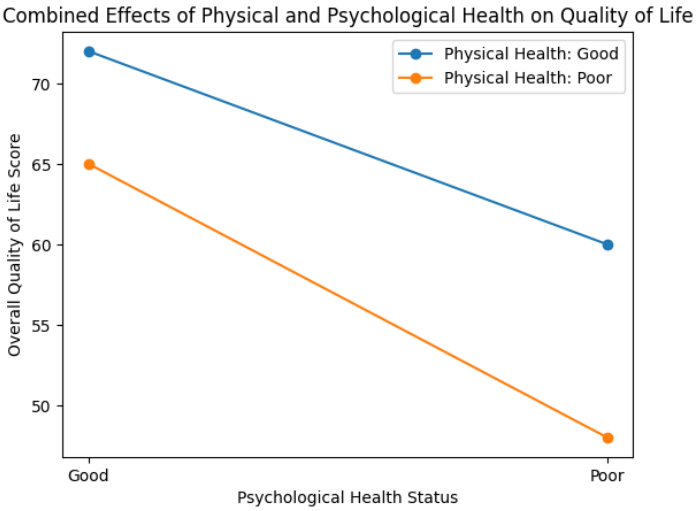

Figure 1. Combined Effects of Physical and Psychological Health on Quality of Life

This study provides an integrated overview of physical and psychological health conditions among community-dwelling elderly people and examines how these conditions shape their quality of life. The findings demonstrate that ageing in the community is characterized by a high burden of chronic physical conditions accompanied by a substantial prevalence of psychological distress, particularly depressive symptoms. More importantly, the results indicate that physical and psychological health are not independent determinants of quality of life but interact in complex ways to influence elderly well-being. This discussion interprets these findings in relation to existing literature, highlights their theoretical and practical implications, and situates the study within the broader discourse on healthy ageing.

The high prevalence of chronic physical conditions observed in this study is consistent with previous epidemiological research on ageing populations. Conditions such as hypertension, musculoskeletal disorders, diabetes, and cardiovascular disease have been widely reported as dominant contributors to morbidity among older adults, particularly in community settings where long-term disease management often replaces acute care (Prince et al., 2007; Barnett et al., 2012). The finding that nearly half of the participants experienced multimorbidity reinforces concerns raised in earlier studies that multiple chronic conditions have become the norm rather than the exception in later life. Multimorbidity has been repeatedly associated with functional decline, increased health service utilization, and reduced quality of life, underscoring its significance as a public health challenge in ageing societies.

Beyond the presence of diagnosed conditions, this study highlights the importance of perceived physical health as a key determinant of quality of life. Elderly individuals who rated their physical health poorly consistently reported lower quality of life scores, regardless of the number of chronic conditions. This finding aligns with the work of Idler and Benyamini (1997), who demonstrated that self-rated health is a powerful predictor of mortality and well-being. Subjective health perceptions may capture dimensions of pain, fatigue, and functional limitation that are not fully reflected in clinical diagnoses, suggesting that elderly health assessments should move beyond disease counts toward more person-centered evaluations.

Psychological health emerged as a particularly salient factor influencing quality of life. Depressive symptoms were relatively common among participants and showed a strong negative association with overall quality of life across multiple domains. This

finding is consistent with extensive literature identifying depression as one of the most significant contributors to reduced well-being in older adulthood (Blazer, 2020; Fiske et al., 2009). Importantly, the results indicate that even mild to moderate depressive symptoms were associated with meaningful reductions in quality of life, supporting arguments that subclinical psychological distress should not be overlooked in community-based elderly care.

The association between psychological health and quality of life was not merely additive but appeared to operate independently of physical health status. Multivariate analyses demonstrated that psychological health remained a significant predictor of quality of life after controlling for physical health conditions and sociodemographic factors. This finding corroborates earlier studies suggesting that mental health has a distinct and robust influence on how older adults perceive their lives, their social relationships, and their sense of purpose (Netuveli & Blane, 2008). From a theoretical perspective, this supports biopsychosocial models of ageing, which emphasize that well-being in later life is shaped by the dynamic interplay of biological, psychological, and social factors rather than by physical health alone.

One of the most important contributions of this study lies in its examination of the combined effects of physical and psychological health on quality of life. The interaction analysis illustrated that elderly individuals with chronic physical conditions but good psychological health reported better quality of life than those with similar physical conditions and poorer psychological well-being. This finding suggests that psychological resilience, emotional regulation, and coping capacity may buffer the negative effects of physical illness on daily life. Similar conclusions have been drawn in previous research on successful ageing, which emphasizes adaptability and psychological resources as key elements of well-being despite health limitations (Alexopoulos, 2019).

These results strongly align with the World Health Organization's healthy ageing framework, which defines healthy ageing as the process of developing and maintaining functional ability that enables well-being in older age (WHO, 2015). Within this framework, quality of life is not determined solely by the absence of disease but by the capacity to function, maintain meaningful relationships, and engage with the environment. The present findings provide empirical support for this perspective by demonstrating that psychological health plays a critical role in sustaining quality of life, even in the presence of physical decline.

The domain-specific quality of life findings further enrich this interpretation. Social and environmental domains showed relatively higher scores compared to physical and psychological domains, suggesting that many elderly participants perceived adequate social support and satisfactory living conditions. This may reflect the protective role of family co-residence and community ties, which are common in many cultural contexts and have been shown to mitigate some of the negative effects of ageing (Beard et al., 2016). However, lower scores in physical and psychological domains indicate that health-related challenges continue to constrain daily functioning and emotional well-being, highlighting areas where targeted interventions are most needed.

The empirical evidence provided in this article has a lot of implications on the design of community based interventions of elderly care and development of health policy. The strong impact of psychological health on the overall quality of life implies that the mental health services need to be included as one of the main aspects of gerontological care as opposed to a secondary one. Interventions that are solely interested in the management of the somatic disease might not yield significant improvement in quality of life in case the underlying psychological distress is left untreated. As a result, a periodic screening of depression and anxiety, the presence

of free psychosocial assistance and encouragement of socialization will probably become as imperative as the treatment of established physical symptoms.

Likewise, the interaction between physical and psychological health as observed indicates the need to have integrated and multidisciplinary care strategies to older adults. Synergistic interventions involving physical exercises, self-management of chronic diseases, and psychological aid have shown to have an additive effect on the health of the elderly (Lorig et al., 2001; Taylor et al., 2014). The proposed study supplements that body of evidence by showing that such combined interventions are likely to directly and positively influence the quality of life of community-based older adults.

Although it has its contributions, the current research has a number of limitations, which should be paid close attention to. The cross-sectional nature of the study does not allow drawing conclusive conclusions about causality since the directionality of the interrelationship of health conditions and quality of life is not determined; thus, poor quality of life can be the cause of psychological distress but not the other way around. These temporal dynamics need to be shed light on by longitudinal research. Besides, using self-reported measures can also create bias in the reporting, even though such an approach is rapidly acceptable and acceptable quality in the context of community-based gerontology studies.

Another weakness is related to the generalizability of the findings. The sample included community-based older adults only and did not include those who are in an institutional setting and can have very different health issues and quality of life determinants. Also, the socio-cultural variables that are related to the context of the study could influence the perception of well-being and health, and, therefore, one must take the findings with caution when applying them to other populations. However, it is important to note that despite these limitations, the integrative approach used in the study is not minor and can provide the insights that can be applied to a wide range of the community contexts of ageing.

CONCLUSION

This study concludes that the quality of life of elderly people living in the community is shaped by the combined influence of physical and psychological health conditions. While chronic physical illnesses remain highly prevalent and contribute to functional limitations in later life, psychological health emerges as a particularly strong and independent determinant of overall well-being. Elderly individuals with better psychological health tend to maintain higher quality of life even in the presence of physical health problems, highlighting the buffering role of mental well-being against physical decline. These findings support holistic and biopsychosocial perspectives on ageing and underscore the importance of integrated, community-based health strategies that simultaneously address physical disease management and psychological support to promote healthy ageing and improve the quality of life of older adults.

REFERENCES

AbdulRaheem, Y. (2023). Unveiling the significance and challenges of integrating prevention levels in healthcare practice. *Journal of primary care & community health, 14*, 21501319231186500. https://doi.org/10.1177/21501319231186500

Alexopoulos, G. S. (2019). Mechanisms and treatment of late-life depression. *Translational Psychiatry, 9*(1), 188. https://doi.org/10.1038/s41398-019-0514-6

Barnett, K., Mercer, S. W., Norbury, M., Watt, G., Wyke, S., & Guthrie, B. (2012).

Epidemiology of multimorbidity and implications for health care, research, and medical education: A cross-sectional study. *The Lancet, 380*(9836), 37–43. https://doi.org/10.1016/S0140-6736(12)60240-2

Beard, J. R., Officer, A., de Carvalho, I. A., Sadana, R., Pot, A. M., Michel, J. P., Lloyd-Sherlock, P., Epping-Jordan, J. E., Peeters, G. M. E. E., Mahanani, W. R., Thiyagarajan, J. A., & Chatterji, S. (2016). The World Health Organization's global strategy and action plan on ageing and health. *The Gerontologist, 56*(Suppl_2), S163–S166. https://doi.org/10.1093/geront/gnw124

Best, K. L., Noreau, L., Gagnon, M. A., Barthod, C., Hitzig, S. L., & Routhier, F. (2022). Housing, transportation and quality of life among people with mobility limitations: a critical review of relationships and issues related to access to home-and community-based services. *Disabilities*, *2*(2), 204-218. https://doi.org/10.3390/disabilities2020015

Blazer, D. G. (2020). Depression in late life: Review and commentary. *The Journals of Gerontology: Series A, 75*(2), 307–315. https://doi.org/10.1093/gerona/glz150

Bowling, A. (2014). *Research methods in health: Investigating health and health services* (4th ed.). Open University Press.

Cohen, J. (2013). *Statistical power analysis for the behavioral sciences* (2nd ed.). Routledge.

Declaration of Helsinki. (2013). Ethical principles for medical research involving human subjects. *JAMA, 310*(20), 2191–2194. https://doi.org/10.1001/jama.2013.281053

Engelen, L., Rahmann, M., & de Jong, E. (2022). Design for healthy ageing–the relationship between design, well-being, and quality of life: a review. *Building Research & Information*, *50*(1-2), 19-35. https://doi.org/10.1080/09613218.2021.1984867

Field, A. (2018). *Discovering statistics using IBM SPSS statistics* (5th ed.). SAGE Publications.

Fiske, A., Wetherell, J. L., & Gatz, M. (2009). Depression in older adults. *Annual Review of Clinical Psychology, 5*, 363–389. https://doi.org/10.1146/annurev.clinpsy.032408.153621

Gobbens, R. J. J., & van Assen, M. A. L. M. (2014). Psychometric properties of the Tilburg Frailty Indicator (TFI) among community-dwelling older people. *Archives of Gerontology and Geriatrics, 59*(1), 115–122. https://doi.org/10.1016/j.archger.2014.03.003

Gupta, M., & Kannur, D. (2024). Management Strategies for Advancing Rural Elderly Well-Being: A Holistic Approach to. *Improving Healthcare Quality and Patient Engagement: Management and Technology Insights: Management and Technology Insights*, 209. https://doi.org/10.4018/979-8-3693-8552-4.ch007

Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: A meta-analytic review. *Perspectives on Psychological Science, 10*(2), 227–237. https://doi.org/10.1177/1745691614568352

Idler, E. L., & Benyamini, Y. (1997). Self-rated health and mortality: A review of twenty-seven community studies. *Journal of Health and Social Behavior, 38*(1), 21–37. https://doi.org/10.2307/2955359

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2007). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Lin, C. P., & Chu, W. M. (2025). Home-based palliative care: benefits, challenges, opportunities and future directions in a super-aged society. *Journal of Hospice and Palliative Care*, *28*(3), 81. https://doi.org/10.14475/jhpc.2025.28.3.81

Lorig, K. R., Ritter, P., Stewart, A. L., Sobel, D. S., Brown, B. W., Bandura, A., Gonzalez, V. M., Laurent, D. D., & Holman, H. R. (2001). Chronic disease self-management program: 2-year health status and health care utilization outcomes. *Medical Care, 39*(11), 1217–1223. https://doi.org/10.1097/00005650-200111000-00008

Netuveli, G., & Blane, D. (2008). Quality of life in older ages. *British Medical Bulletin, 85*(1), 113–126. https://doi.org/10.1093/bmb/ldn003

Noto, S. (2023, July). Perspectives on aging and quality of life. In *Healthcare* (Vol. 11, No. 15, p. 2131). MDPI. https://doi.org/10.3390/healthcare11152131

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health, 42*(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Patel, P., & Mancuso, A. (2023). A holistic approach to physical and mental health: associations between chronic disease and psychiatric conditions. *Psychology, Health & Medicine*, *28*(6), 1421-1429. https://doi.org/10.1080/13548506.2022.2088815

Prince, M. J., Wu, F., Guo, Y., Gutierrez Robledo, L. M., O'Donnell, M., Sullivan, R., & Yusuf, S. (2015). The burden of disease in older people and implications for health policy and practice. *The Lancet, 385*(9967), 549–562. https://doi.org/10.1016/S0140-6736(14)61347-7

Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., & Rahman, A. (2007). No health without mental health. *The Lancet, 370*(9590), 859–877. https://doi.org/10.1016/S0140-6736(07)61238-0

Setia, M. S. (2016). Methodology series module 3: Cross-sectional studies. *Indian Journal of Dermatology, 61*(3), 261–264. https://doi.org/10.4103/0019-5154.182410

Taylor, D., Physical Activity and Mental Health. (2014). *The Lancet Psychiatry, 1*(3), 234–238. https://doi.org/10.1016/S2215-0366(14)70338-2

Țenea-Cojan, Ş. T., Dinescu, V. C., Gheorman, V., Dragne, I. G., Gheorman, V., Forţofoiu, M. C., ... & Dobrinescu, A. G. (2025). Exploring multidisciplinary approaches to comorbid psychiatric and medical disorders: A scoping review. *Life, 15*(2), 251. https://doi.org/10.3390/life15020251

United Nations. (2023). *World population ageing 2023*. United Nations Department of Economic and Social Affairs.

World Health Organization. (2015). *World report on ageing and health*. World Health Organization.

World Health Organization. (2022). *Mental health of older adults*. World Health Organization.