

The Impact of Medication Adherence on Quality of Life in Hypertensive Patients: A Cross-Sectional Analysis

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Abstract

Objectives: The main objective of the study is to examine the medication adherence levels of hypertensive patients and to evaluate the effect of adherence on their quality of life.

Materials and Methods: The research was conducted with 341 patients diagnosed with hypertension who visited a family health center in Erzincan between January and April 2025. Data were collected by using demographic information forms, the General Medication Adherence Scale, and WHOQOL-BREF. Descriptive statistics, t-tests, ANOVA, and multiple regression analysis were used for data analysis.

Results: The results of the study revealed the patients' medication adherence level was 1.86, and the quality of life score was 43.62 out of 100. The most problematic area in medication adherence was the patient behavior-related adherence subscale, while the least issues were observed in economic-related non-adherence. The lowest score for quality of life was found in the physical health domain. Statistical analyses indicated that the levels of medication adherence and quality of life significantly differed according to age, educational level, income, disease duration, and the number of comorbidities ($p<0.05$). Especially, individuals in the 45-64 age group had higher levels of both medication adherence and quality of life compared to patients aged 65 and above. According to the regression analysis, medication adherence significantly predicted the quality of life ($p<0.05$).

Conclusion: From this perspective, the findings of this study are guiding for the development of health policies and the planning of personalized healthcare services.

Keywords: hypertension, medication adherence, quality of life, health behaviors

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Introduction

Hypertension is a chronic medical condition characterized by consistently high blood pressure. It is clinically defined as “*having a systolic blood pressure of 140 mmHg or a diastolic blood pressure above 90 mmHg*” (Chobanian et al., 2003; Park, 2019). It is often asymptomatic and progresses without noticeable signs, which is why it is commonly referred to as the “silent killer” (Moore, 2005; Kamble & Srinivas, 2019). However, in rare cases, it may present with some symptoms such as headache, dizziness, chest pain, visual disorder, and shortness of breath (Beevers et al., 2001). Moreover, hypertension is one of the leading causes of numerous health problems, particularly stroke, heart failure, myocardial infarction, and kidney failure (Wright et al., 2011). According to the World Health Organization (WHO) data from 2023, 1.3 billion people aged 30-79 in low and middle-income countries are living with hypertension disease, and approximately 58% of them are not receiving any treatment. The number of individuals unaware of their condition is also in the millions (Mills et al., 2016). Additionally, hypertension accounts for 9.4 million deaths worldwide and represents 7% of the global disease burden (WHO, 2014). In Türkiye, 3.5% of all deaths are attributed to hypertension (Republic of Turkey Ministry of Health, General Directorate of Public Health, 2024). In this context, hypertension is considered a major risk factor among preventable causes of death globally.

The treatment of hypertension generally requires a continuous and systematic approach that includes both medication use and lifestyle changes (Aydın & Öztürk, 2014; Dickinson et al., 2006). However, the effectiveness of this process largely depends on the level of adherence to the treatment (Burnier & Egan, 2019; Dragomir et al., 2010). Treatment adherence is defined as “*the extent to which a patient’s behavior corresponds with agreed recommendations from a healthcare provider*” (Osterberg & Blaschke, 2005; Sabaté, 2003). Adherence encompasses all aspects of the treatment, including medication use and lifestyle modifications. Nevertheless, regular medication use stands out as the primary factor in controlling hypertension (Law et al., 2009). On the other hand, problems with adherence can lead to poor blood pressure control, disease progression, and serious complications such as stroke and heart failure (Krousel-Wood et al., 2011). The asymptomatic nature of the disease makes it more difficult for individuals to accept and follow the treatment, negatively affecting the course of the disease. Studies have shown that a significant proportion of patients with hypertension discontinue treatment within the first year of initiation. The proportion of individuals who maintain treatment regularly is below 50% (Mazzaglia et al., 2009; Vrijens et al., 2008). Moreover, hypertension often coexists with other chronic conditions such as diabetes, heart failure, asthma, and stroke, which further

complicates the treatment process and increases non-adherence (Marcum & Gellad, 2012). Increased non-adherence worsens the disease progression and creates a difficult-to-manage vicious cycle. For this reason, ensuring adherence to treatment in patients with hypertension is of vital importance for clinical success.

As a lifelong health condition with serious complications, hypertension affects not only physical health but also psychological and social aspects of patients' lives (Shamsi et al., 2017; Snarska et al., 2020; Stamoulis et al., 2024). The ongoing nature of treatment requires medication use, dietary changes, adjustments to physical activity, and regular health check-up adherence. These demands limit patients' daily lives and adversely impact their quality of life. Individuals with hypertension may also experience psychological issues such as social isolation, anxiety, and stress (Ushakov et al., 2016). Fatigue, loss of motivation, and difficulty adapting to lifestyle changes further deteriorate the individual's quality of life. The presence of comorbid conditions such as diabetes, heart failure, or stroke further reduces physical functionality and weakens individuals' overall perception of their health (Bayliss et al., 2004). In this context, it is essential to focus not only on clinical outcomes but also on aspects related to quality of life in the treatment of hypertension.

Hypertension, treatment adherence, and quality of life have been extensively examined in both national and international literature (Amer et al., 2019; Park et al., 2018; Peacock et al., 2021). But most of these studies tend to investigate these three concepts in isolation, without establishing a clear connection among them. Although treatment adherence is known to play a crucial role in the management of hypertension, studies directly focusing on its impact on patients' quality of life are still relatively scarce. Comprehensive empirical studies that evaluate this relationship in real-life settings and across diverse patient populations are limited. Also, in the specific context of Türkiye, there is a significant gap in field-based research that explores how adherence to antihypertensive treatment regimens influences patients' overall well-being and daily functioning. Understanding this relationship is especially important for improving patient-centered care strategies and health policy development. Therefore, the primary aim of this study is to assess the level of treatment adherence among patients with hypertension and to determine its effects on their quality of life. In addition, the study seeks to explore whether these variables vary significantly across different socio-demographic groups, such as age, gender, educational level, income status, and the presence of comorbidities. Identifying these patterns may help healthcare providers design more targeted interventions and improve health outcomes for hypertensive patients.

Materials and Methods

The aim of this study is to examine the level of treatment adherence in patients with hypertension and to determine the impact of treatment adherence on patients' quality of life. Also, this study aims to assess whether treatment adherence and quality of life significantly differ according to the sociodemographic characteristics of the patients.

To achieve the objectives of the study, individuals who self-reported a diagnosis of hypertension and applied to a family health center located in Erzincan between January and April 2025 were recruited as the study population. According to official records from 2024, the total number of patients diagnosed with hypertension and registered at this health center was 2,975. Given the size of the population and the practical constraints of time and resources, it was deemed unfeasible to conduct a census of the entire patient group. Therefore, a representative sample size was calculated using a 5% margin of error ($\alpha=0.05$), a 95% confidence level, and an assumed response distribution of 0.5, which is commonly used when no prior data are available regarding the population proportions. Based on these parameters, the minimum required sample size was determined to be 341 patients. Data collection was carried out accordingly, and the study was completed with a total of 341 participants who met the inclusion criteria and agreed to participate voluntarily.

During the data collection process, three different questionnaires were used. The first of these is the *demographic information form*, which includes questions regarding the patients' sociodemographic characteristics such as age, gender, education level, and income status. This form also asked patients how long they had been diagnosed with hypertension and how many other chronic diseases they had in addition to hypertension. For assessing the patients' level of treatment adherence, the “*General Medication Adherence Scale*” developed by Naqvi et al. (2018) was used. The scale consists of 11 items and is structured as a 4-point Likert type scale (Always: 0, Often: 1, Rarely: 2, Never: 3). It includes three subdimensions: *non-adherence due to patient behavior (intentional or unintentional)*, *non-adherence related to comorbidity and polypharmacy*, and *non-adherence due to financial constraints*. Higher scores on this scale indicate higher levels of medication (treatment) adherence. The Turkish validity and reliability study of the scale was conducted by Karadamar (2022), and the overall reliability coefficient was reported as 0.81. To measure patients' quality of life, the “*WHOQOL-BREF*,” also known as the *WHO Quality of Life Brief Form*, was used. This instrument includes 26 questions across four domains: physical health, psychological health, social relationships, and environmental factors. In a study conducted by Eser et al. in 1999, the internal consistency coefficient of the

scale was found to be 0.83. In the present study, both scales demonstrated excellent goodness-of-fit indices (TLI, CFI, NFI > 0.80; RMSEA < 0.08) and high internal consistency (Cronbach's alpha > 0.90).

The data collected in the study were analyzed using the Statistical Package for Social Sciences (SPSS) version 23.0 and the Analysis of Moment Structures (AMOS) version 23.0. Initially, descriptive statistics (means, standard deviations, frequencies, and percentages) were calculated to assess the overall levels of treatment adherence and quality of life among the participants. To determine whether treatment adherence and quality of life differed significantly based on patients' sociodemographic characteristics (such as age, gender, education level, and income), duration of hypertension, and the number of co-existing diseases, inferential statistical tests were conducted. Specifically, independent samples t-tests were used for binary categorical variables, and one-way analysis of variance (ANOVA) was applied for variables with more than two categories. Subsequently, multiple linear regression analysis was employed to identify the predictors of quality of life and to evaluate how treatment adherence influences quality of life. Importantly, only the variables that showed statistically significant differences in the t-tests and ANOVA were included in the regression to ensure parsimony and avoid multicollinearity. All statistical analyses were conducted at a 95% confidence level, with a significant threshold set at $p < 0.05$.

Finally, the ethical approval was obtained from the Committee of Scientific Research and Publication Ethics of Mus Alparslan University, with the decision dated 13.11.2024 and numbered 71. Institutional permission was granted by the Erzincan Governorate Provincial Health Directorate, with the official letter dated 17.12.2024 with number E-15872173-604.01-262679418. However, this study has several limitations. First, as the data were collected from a single family health center, the findings may not be generalizable to all hypertensive patients in Türkiye. Second, the study relied on self-reported information for both hypertension diagnosis and medication adherence, which may be subject to recall or social desirability bias. It was also assumed that participants provided accurate and honest responses during the data collection process.

Results

Descriptive statistics for the 341 patients diagnosed with hypertension who participated in the study are presented in Table 1. As shown in the table, 47.5% of the respondents were female, while 52.5% were male, indicating a relatively balanced gender distribution. In terms

of age, a significant proportion of the sample, 57.5%, were aged 65 years or older, reflecting the prevalence of hypertension among older adults. Regarding educational attainment, most participants (73.0%) were primary school graduates, suggesting a relatively low level of formal education in the study population. In contrast, only 13.5% of the participants completed high school education. These sociodemographic characteristics are important contextual factors that may influence patients' health behaviors, treatment adherence, and perceptions of quality of life, and they are therefore considered in the subsequent analyses.

Tablo 1. Descriptive Statistics

Variables		Frequency	Percent
Gender	Female	162	47.5
	Male	179	52.5
Age	45-64	145	45.5
	65+	196	57.5
Education	Primary school	249	73.0
	Middle school	46	13.5
	High school	46	13.5
Monthly income	12500-30000 ₺	121	35.5
	30001-60000 ₺	118	34.6
	60001 ₺ +	102	29.9
Duration of disease	1-5 years	122	35.8
	6-10 years	138	40.5
	11-15 years	53	15.5
	16 years +	28	8.2
Comorbidity (Number of comorbidities)	None	45	13.2
	1	34	10.0
	2	47	13.8
	3	46	13.5
	4	52	15.2
	5	117	34.3

In terms of economic status, 29.9% of the participants were in the highest income group (monthly household income above 60.000 TL), while the remaining 70.1% belonged to lower- and middle-income categories, indicating that most patients had relatively limited financial resources. This economic profile may have implications for healthcare access, medication affordability, and adherence to treatment regimens. Regarding the duration of hypertension diagnosis, 35.8% of the patients were diagnosed within the past five years, suggesting a substantial number of relatively recent cases. In contrast, 8.2% of the participants reported living with hypertension for 16 years or longer, indicating a small group with long-term disease experience. Furthermore, the comorbidity profile of the sample reveals that 86.8% of patients had at least one additional chronic condition alongside hypertension. 34.3% of the respondents reported having five or more chronic diseases, excluding hypertension, which highlights the

complexity of managing multiple chronic conditions in this population and may further influence treatment adherence and perceived quality of life.

Table 2 presents statistics related to patients' levels of treatment adherence and quality of life. Upon examining Table 2, it is observed that the patients' overall treatment adherence score is 1.86, which is above the scale average of 1.5. However, among the subdimensions of the scale, the “non-adherence due to patient behavior” dimension shows the greatest issues, with an average score of 1.65. This is followed by the “non-adherence due to comorbidity and polypharmacy” dimension, with an average of 1.86 (± 0.92). The dimension with the fewest problems related to adherence is “non-adherence due to financial constraints,” with a relatively higher score of 2.37 (± 0.86).

Table 2. Quality of Life and Treatment Adherence Statistics

Variables		Mean	S. D.
Medication adherence	Patient behavior	1.65	1.01
	Comorbidity and polypharmacy	1.86	0.92
	Financial constraints	2.37	0.86
	Overall treatment adherence	1.86	0.88
Quality of life	Physical health	43.17	22.85
	Psychological health	49.74	20.97
	Social relationships	45.58	20.43
	Environmental factors	44.28	21.37
	Overall quality of life	43.62	30.10

An analysis of the participants' quality of life levels revealed that the mean score for health-related quality of life was 43.62 (± 30.1), which falls below the theoretical scale midpoint of 50. This indicates that, overall, the patients in the study experience a relatively low perceived quality of life in relation to their health status. When the subdomains of quality of life are examined, the lowest mean score was observed in the domain of physical health (43.17 $\pm$ 22.85), suggesting that patients face the most significant difficulties in managing physical limitations and symptoms associated with hypertension and possible comorbidities. The physical health domain was followed by environmental factors, social relationships, and psychological health, respectively. Although the mean score for psychological health also remained below the scale midpoint, it was relatively higher compared to the other domains, indicating that patients may perceive their emotional and cognitive well-being as less impaired than their physical or environmental conditions. These findings underscore the multidimensional impact of hypertension on patients' quality of life and highlight the need for holistic approaches in patient care and support interventions.

Whether patients' levels of treatment adherence and quality of life differed according to individual and demographic characteristics, duration of illness, and number of comorbidities were tested using t-test and ANOVA. The results of these tests are presented in Table 3.

Table 3. Quality of Life and Treatment Adherence Statistics

Variables		Medication adherence			Quality of life		
		Mean	S. D.	t/F	Mean	S. D.	t/F
Age	45-64	2.53	0.67	15.80*	65.34	24.51	14.61*
	65+	1.37	0.67		27.55	22.92	
Gender	Female	1.89	0.88	-0.54	44.29	29.79	0.039
	Male	1.84	0.88		43.02	30.45	
Education	Primary school	1.59	0.81	66.94 *	34.84	26.35	62.51*
	Middle school	2.33	0.69		55.98	27.98	
	High school	2.86	0.24		78.80	19.70	
Monthly income	12500-30000 ₺	1.47	0.73	46.71*	31.82	25.62	28.84*
	30001-60000 ₺	1.75	0.89		41.53	30.87	
	60001 ₺ +	2.46	0.69		60.05	26.85	
Duration of disease	1-5 years	2.57	0.61	80.08*	66.60	25.43	63.66*
	6-10 years	1.64	0.79		35.87	24.72	
	11-15 years	1.30	0.58		25.47	22.19	
	16 years +	0.92	0.43		16.07	18.28	
Comorbidity	0 (none)	2.91	0.15	254.66*	76.67	19.51	105.39*
	1	2.81	0.20		73.53	23.79	
	2	2.68	0.24		64.89	17.80	
	3	2.02	0.63		48.91	18.22	
	4	1.32	0.53		27.88	18.29	
	5+	1.03	0.38		18.59	18.03	

* $p < 0,05$

Upon examining Table 3, it is observed that treatment adherence and quality of life levels significantly differ according to age, education level, monthly income, duration of illness, and number of comorbidities ($p < 0.05$). When analyzed by age groups, patients aged 45–64 showed significantly higher levels of treatment adherence ($\bar{x} = 2.53 \pm 0.67$) and quality of life level ($\bar{x} = 65.34 \pm 24.51$) compared to those aged 65 and above ($\bar{x} = 1.37 \pm 0.67$; $\bar{x} = 27.55 \pm 22.92$). In terms of gender, there was no statistically significant difference between male and female patients in treatment adherence and quality of life levels ($p > 0.05$). It was found that as education level increased, scores for both treatment adherence and quality of life also increased. The analysis based on income revealed that individuals with higher income had better treatment adherence and higher quality of life. Furthermore, as the duration of illness increased, patients' levels of both treatment adherence and quality of life levels significantly decreased. Like, as the number of comorbidities increased, a significant decline in treatment adherence and quality of life was observed.

Factors affecting quality of life and the impact of treatment adherence on quality of life were tested using multiple linear regression analysis (Table 4). Upon examining Table 4, it is observed the established model is statistically significant ($p < 0.05$) and explains approximately 63% of the total variance in quality of life.

Table 4. Factors Affecting Quality of Life

Variables		Beta	S. Beta	S. Error	t	p	VIF
Age	45-64	5.17	0.17	3.23	1.60	0.110	0.62
	65+	Ref					
Education	Primary school	Ref					
	Middle school	2.05	0.07	3.16	0.65	0.518	
	High school	11.32	0.38	4.11	2.76	0.006	0.83
Monthly income	12500-30000 ₺	4.04	0.13	3.04	1.33	0.185	0.88
	30001-60000 ₺	4.99	0.17	2.85	1.75	0.081	
	61000 ₺+	Ref					
Duration of disease	1-5 years	4.81	0.16	4.97	0.97	0.334	0.85
	6-10 years	1.52	0.05	4.17	0.36	0.716	
	11-15 years	1.22	0.04	4.40	0.28	0.781	
	16 years+	Ref					
Comorbidity	0 (none)	25.61	0.85	6.74	3.80	<0.001	0.79
	1	25.70	0.85	6.58	3.91	<0.001	
	2	22.90	0.76	5.69	4.02	<0.001	
	3	17.54	0.58	4.24	4.14	<0.001	
	4	5.04	0.17	3.36	1.50	0.135	
	5+	Ref					
Medication adherence		10.66	0.31	2.51	4.25	<0.001	0.45
Constant	C	-8.79		6.67	-1.32	0.188	
Model	Durbin-Watson	2.03					
	F	42.9					
	Adjusted R ²	0.63					
	p	<0.001					

Ref: Referans

According to the analysis results, the variables that have a significant effect on quality of life include education level, comorbidity status, and treatment adherence. It was found that individuals with a high school education or above have significantly higher quality of life levels compared to those with primary education ($\beta=11.32$; $p=0.006$). On the other hand, although an increase in income level was associated with higher quality of life scores, this difference was not found to be statistically significant ($p>0.05$). Like, no statistically significant effect was observed in terms of the duration of illness.

Comorbidity status was identified as one of the strongest predictors of quality of life. Individuals with no comorbid conditions ($\beta=25.61$; $p<0.001$), as well as patients with one ($\beta=25.70$; $p<0.001$), two ($\beta=22.90$; $p<0.001$), or three ($\beta=17.54$; $p<0.001$) comorbidities, had significantly higher quality of life levels compared to those with five or more comorbidities. In

addition, an increase in treatment adherence significantly improves quality of life ($\beta=10.66$; $p<0.001$). Treatment adherence was found to be the most influential variable affecting quality of life.

Discussion and Conclusion

The main objective of this study is to examine the level of treatment adherence among patients with hypertension and to reveal its effects on their quality of life. Using the General Medication Adherence Scale and the WHOQOL-BREF Quality of Life Scale, the study found that the patients' treatment adherence level was 1.86, which is above the scale average of 1.50. The area in which patients experienced the most difficulty was behavioral adherence, while the least problematic area was non-adherence due to financial reasons. Furthermore, treatment adherence was found to vary significantly by age, education level, income status, duration of illness, and number of comorbidities ($p<0.05$). A similar pattern was observed in quality of life scores. However, unlike adherence scores, patients' quality of life scores was below the scale average of 50, with a mean of 43.62 (± 30.10). Additionally, both treatment adherence and quality of life showed a declining trend with increasing age. As the duration of illness and the number of comorbid conditions increased, significant decreases were observed in treatment adherence and quality of life. In contrast, higher levels of education and income were associated with increased adherence and quality of life. These findings are consistent with the existing literature. Studies have shown that treatment adherence and quality of life in patients with hypertension significantly differ according to socio-demographic variables like age, education, and income (Azar et al., 2020; Burnier & Egan, 2019; Ruksakulpiwat et al., 2024; Rupakheti et al., 2024; Uchmanowicz et al., 2019; Zheng et al., 2021), as well as duration of illness (Topik et al., 2023) and number of chronic conditions (Algabbani et al., 2020; Priatna et al., 2024). These studies have reported lower adherence and quality of life among older individuals, those with low income, and those with multiple diseases. They also suggest that improvements in education and income levels are associated with better outcomes in these measures. Therefore, policies and interventions aimed at improving treatment adherence and quality of life in hypertensive patients should adopt a holistic approach that considers factors such as age, education, income, duration of illness, and number of comorbidities. In this context, expanding awareness-raising educational programs targeting disadvantaged groups, strengthening patient-physician communication, offering counseling services to support behavioral adherence, and individualizing treatment processes to meet patients' needs would be important steps toward

enhancing treatment success and overall quality of life. This may be partly explained by the fact that a large portion of the participants were older adults who are likely to be retired and benefit from the comprehensive coverage of the national health insurance system in Türkiye, which reduces out-of-pocket costs and co-payments.

The study also found that quality of life in patients with hypertension is significantly affected by their level of education and the number of chronic conditions they have ($p<0.05$). Literature similarly highlights the impact of education level on the quality of life of patients. For example, Azar et al. (2020) reported that increases in education level led to significant improvements across all subdimensions of quality of life. Ose and colleagues (2014) stated that higher education levels help patients better manage disease-specific risks, which in turn positively influences quality of life. Similarly, Barbareschi et al. (2011), in a study conducted with 553 hypertensive patients, found that individuals in lower-income groups had poorer quality of life, but physical and social functioning, as well as overall quality of life, improved with higher education. From this perspective, increasing education levels and reducing chronic disease burden should be key targets for improving the quality of life among individuals with hypertension. Strengthening treatment adherence can meaningfully enhance health outcomes and overall quality of life. Therefore, relevant health policies should be designed not only with a focus on medical interventions but also by considering patients' socioeconomic conditions, and where possible, should be individualized. Through tailored support programs and educational initiatives for at-risk groups, both treatment success and quality of life can be improved. In addition to education level, this study also identified the number of comorbid conditions as a statistically significant factor affecting quality of life ($p<0.005$). This finding is also supported by literature. Priatna et al. (2024), in a study conducted in Indonesia, demonstrated that an increased number of comorbidities significantly reduced quality of life. Similarly, Lee and Lee (2023) found that the presence of comorbid conditions had a statistically significant and negative impact on the quality of life in hypertensive patients aged 19 and older. Consistent results were also reported by Wang et al. (2009) and Lee and So (2012). These findings highlight the vital importance of identifying, effectively managing, and controlling comorbid chronic conditions in patients with hypertension to maintain and improve their quality of life. Accordingly, it is essential to provide comprehensive and integrated healthcare services that take the burden of multiple chronic conditions into account in the care of hypertensive patients.

Another key finding of this study is that improvements in treatment adherence have a positive impact on the quality of life of patients ($p<0.05$). Indeed, various studies in the literature have shown that treatment adherence has a statistically significant effect on quality of life. For example, a study conducted in Indonesia by Sriyati and Latif (2023) found that hypertensive patients with better adherence had higher levels of quality of life. Similarly, in a study involving 1,525 individuals, Peacock et al. (2021) reported that treatment adherence problems negatively affected the quality of life, particularly among those who had been diagnosed with hypertension for more than one year. The researchers emphasized individuals experienced more problems in the mental health dimension of quality of life. Rupakhetti et al. (2024), in a study of 380 hypertensive patients in Nepal, found that patients' quality of life was significantly influenced not only by demographic characteristics such as age and gender, but also by their level of treatment adherence. The authors noted that patients with higher levels of adherence had better quality of life outcomes. Therefore, supporting treatment adherence is of critical importance in interventions aimed at improving patients' quality of life. Strategies such as patient education, regular follow-up, medication reminder systems, and personalized care plans are believed to facilitate disease management and enhance patients' quality of life. Future research should focus on longitudinal and interventional designs to better understand the causal relationship between treatment adherence and quality of life in hypertensive patients. Evaluating the effectiveness of adherence-enhancing strategies such as digital tools, personalized counseling, or community-based programs may provide valuable insights into sustainable improvements in patient outcomes. Additionally, future studies could examine potential mediators and moderators of this relationship, including health literacy, psychological resilience, perceived social support, and patient-physician communication quality.

In conclusion, treatment adherence significantly affects quality of life in patients with hypertension. Particularly, advanced age, low socioeconomic status, and the presence of comorbid conditions negatively impact both treatment adherence and quality of life. Therefore, strengthening approaches such as personalized counseling, patient education, and continuous follow-up in healthcare services is essential for enhancing the effectiveness of the treatment process and improving patients' quality of life.

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Conflict of Interest

The author declares that there is no conflict of interest.

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