HEALTH VULNERABILITIES AMONG ADULTS AND CHILDREN WITHIN HOUSEHOLDS

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ABSTRACT: *The article analyzes the health vulnerabilities of adults and children within the surveyed households. The results highlight functional difficulties and chronic diseases across the two age groups, as well as the associations between these conditions and the different structural patterns of health vulnerabilities specific to these categories.*

KEY WORDS: *health vulnerability, functional difficulties, chronic diseases, household, socio-economic inequalities, family context.*

JEL CLASSIFICATIONS: *I10, I12, I14, D13, J13.*

1. INTRODUCTION

Although the article does not directly address the concept of quality of life, by examining the health vulnerabilities of adults and children within households it falls within the broader scope of this concept. From a methodological perspective, considering the operationalization of this concept, health vulnerability may be regarded as one of its dimensions. Since the boundary between a concept and a dimension is relatively flexible, addressing the dimension of vulnerability individually could also allow it to be understood as a concept, with health vulnerability itself becoming a dimension in turn. Therefore, from both perspectives, health vulnerability can be considered a dimension of the broader concept of quality of life. This also explains its specific treatment within the family context.

The study did not aim to measure levels of satisfaction with quality of life or with health status; rather, it was limited to a descriptive approach to medically documented chronic diseases and functional difficulties observed among children, drawing a parallel with those identified among adults in the same households. The

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analytical approach was not causal but associational, seeking to highlight whether these diseases and functional difficulties occur simultaneously within the two family groups.

2. THEORETICAL CONTEXT

Strictly speaking, quality of life is an evaluative concept, representing the outcome of a global assessment, from a personal perspective, of various aspects of life (Zamfir, 1998, p. 79). According to Zamfir and Milicenco, theories concerning quality of life are numerous, but they can essentially be summarized into two main approaches. The first is the universalist perspective, according to which the set of criteria underlying the evaluation of quality of life is immutable, regardless of people, time, or geographical context. The second is the particularist perspective, according to which evaluation criteria vary depending on socio-historical conditions (apud Oșvat, 2010, p. 183).

In order to emphasize the breadth and importance of the concept of quality of life, as well as the magnitude of research in this field, it should be noted that no fewer than 30 indicators are commonly used in such studies: personal health status, family relationships, housing conditions, environmental quality, working conditions, relations with neighbors, medical care, the quality of education, the quality of mass media, the quality of public transport, opportunities for recreation, the activity of the local administration, national governance, opportunities for self-realization, accessibility of education, opportunities for obtaining employment, safety on the streets, respect for individual rights, participation in decision-making at the workplace, participation in decision-making at the local level, participation in decision-making at the national level, assessment of everyday life, satisfaction with one's profession, satisfaction with one's workplace, satisfaction with leisure time, satisfaction with family life, satisfaction with income, satisfaction with political life, satisfaction with interpersonal relations, and satisfaction with personal achievements in life (Mărginean, 1997, p. 20).

These indicators can be grouped into broader dimensions. For example, the health dimension may include indicators such as personal health status and access to medical care, while the subjective satisfaction dimension may include indicators related to profession, family life, or leisure time.

It may not be coincidental that within the system of indicators used in such research, health status occupies the first position, as it represents one of the three essential components of human capital, alongside educational level and professional training (Voicu, 2007, p. 97). Health status is influenced by mode of life and lifestyle, concepts that require further clarification. According to A. Roth, the mode of life refers to the objective conditions of living, including work, housing, education, leisure time, access to services, as well as hygiene conditions and healthcare. In contrast, lifestyle has a deeply subjective character, varying from one individual to another, and represents the individual's life strategy. According to Cătălin Zamfir, this strategy can lead to success or failure, as each individual adopts behaviors shaped by particular beliefs and representations about the world. Since lifestyle represents a series of decisions that influence health status (apud Lupu & Zanc, 1999, pp. 143–144), it plays an important role in shaping health outcomes.

Within this framework, health vulnerability can be understood as the result of the interaction between objective living conditions and individual and family life strategies.

3. RESEARCH AREA AND METHODOLOGY

The research was conducted in the city of Petroșani in May 2017. Petroșani is known not only as the most representative administrative unit of the former Jiu Valley coal basin but also for the economic and demographic processes that have affected it. These include the restructuring of mining and the deindustrialization of the entire area through the disappearance of related activities. The lack of employment opportunities generated occupational vulnerability across various socio-demographic groups, while selective migration had a decisive impact on the city's population. Layoffs and prolonged unemployment, in the absence of alternative job opportunities, led to the deprofessionalization of former mining workers, and poverty became persistent among large segments of the population.

These socio-economic transformations produced multiple and ongoing forms of social vulnerability, with potential effects on living conditions reflected in health status, including that of children and youth within households.

Methodologically, the study employed a sociological survey based on a questionnaire, administered by specially trained operators at the respondents' homes. The survey was quantitative and descriptive, with a sample constructed using a multi-layered quota method (based on sex, age, residential area, and street), ensuring structural representativeness at the population level. Although the initial planned sample size was 1,000 individuals, due to circumstances beyond the researchers' control, the final sample comprised 931 individuals. Deviations from the planned sample size were minor, primarily occurring in densely populated areas, and did not negatively affect the structural representativeness of the sample. Data processing was carried out using SPSS after the questionnaires were checked for validity, reliability, and completeness and organized into an electronic database.

4. DATA ANALYSIS AND INTERPRETATION

This chapter is structured in several stages corresponding to the dimensions under investigation. We have aimed for a logical presentation of the analyzed aspects, beginning with the health status of adults, the household structure, and the presence of children within households, followed by the health status of children and its association with that of adults.

4.1 Health Status of Adults: Functional Difficulties and Chronic Diseases

The health status of adults within the analyzed households was assessed using two items. One focused on functional difficulties across various domains of daily activities, while the other addressed the presence of medically documented chronic

diseases. The collected data (see Table 1 in the Appendix) were summarized into an aggregated indicator (see Table 2 in the Appendix) and are presented in Figure 1.

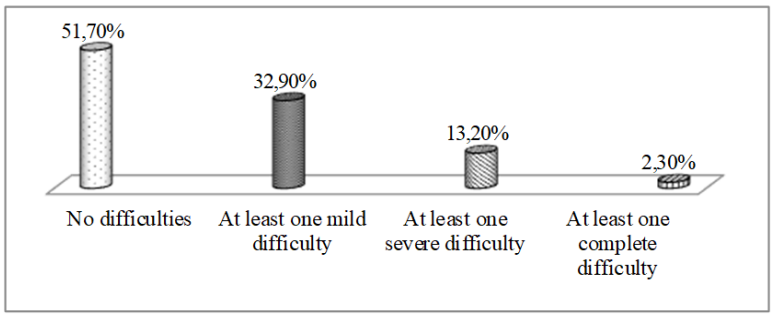

Figure 1. Level of Functional Difficulties among Adults (N = 931)

The distribution of the aggregated indicator shows that over half of adults (51.7%) do not experience any functional difficulties in any of the analyzed domains, whereas the proportion of those exhibiting severe functional limitations is considerably low (2.3%).

Table 1. Hierarchy of Adults' Functional Difficulties, Summarized by Domains (%) (N=450)

Domain	*Mild Difficulty (%)*	*Severe Difficulty (%)*	*Complete Difficulty (%)*
Vision	31.8	9.2	1.0
Walking / Climbing Stairs	10.1	4.6	1.2
Hearing	8.9	4.1	0.3
Memory / Concentration	7.1	1.7	0.5
Personal Care	2.7	0.5	0.1
Communication	2.1	0.5	0.1

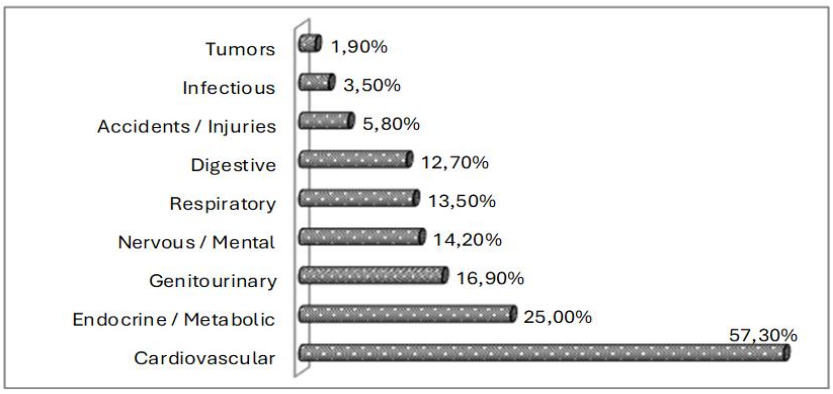

Figure 2. Types of Medically Documented Chronic Diseases among Adults (N = 260)

Following the filtering of the questionnaire data, the most frequent functional difficulties among adults are those related to vision and mobility, whereas difficulties

in personal care and communication occur at much lower rates. In addition to assessing functional limitations, the presence of medically documented chronic diseases (lasting more than three months) was also examined to evaluate the health status of adults. The data indicate that a significant portion of the population (29.7%) reports the presence of such conditions (see Table 4 in the Appendix), highlighting the potential for health vulnerability within the analyzed households.

According to Figure 2 (see Table 5 in the Appendix), the highest proportion is represented by cardiovascular diseases, followed by endocrine and metabolic diseases, as well as genitourinary diseases and nervous system disorders. At a roughly similar level, with slight variations, are respiratory diseases, digestive diseases, injuries caused by accidents, infectious diseases, and tumors, all occurring in considerably lower proportions.

In the case of highly prevalent chronic diseases, it can be noted that they are largely consistent with factors associated with lifestyle, sedentary behavior, and aging.

4.2 Household Structure and Presence of Children

Continuing the analysis, we examine the household dimension, which represents the physical and psychosocial space where adults, children, and youth included in the study live. The family is important because various forms of vulnerability, including health vulnerability, manifest within it, and the size and income of the household influence how the health problems of its members are addressed.

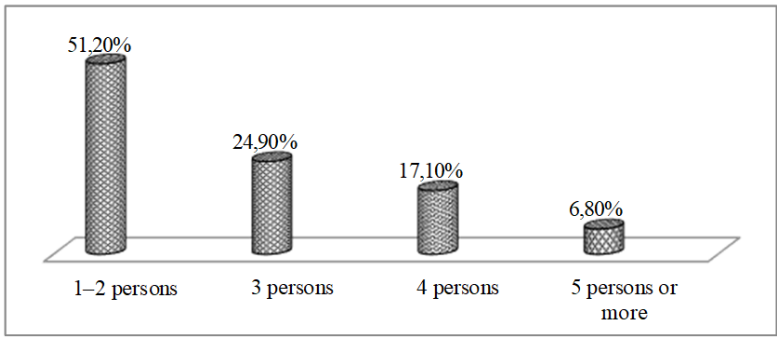

Figure 3. Household Size (N = 931)

After recoding the variable concerning the number of household members (see Table 6 in the Appendix), their distribution, as shown in Figure 3, indicates a predominance of small-sized households (51.2%). Medium-sized households (3–4 persons) are relatively less common, while large households (5 persons or more) are even rarer (6.8%), reflecting the structural shift in family models in urban areas, especially in post-industrial regions.

The analysis of household structure is completed by examining the presence of children. Only households composed of two or more persons (including single-parent families) were asked about the presence of children and youth under 18 years. From

the total of 931 households, 136 single-person households were excluded. The new reference base consisted of 795 households, of which only 295 reported having children under 18, a proportion close to two-fifths (37.1%) (see Table 7 in the Appendix). The total number of children identified in these families (451) was obtained by summing the number of children corresponding to each household category (see Table 8 in the Appendix).

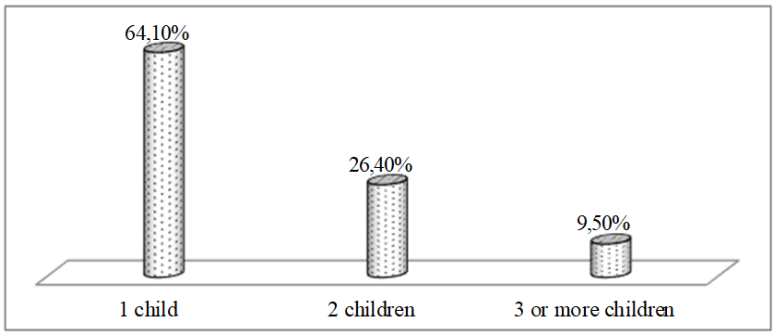

Figure 4. Number of Children per Household (N = 295)

To provide a clearer view of the distribution of families with children according to their number, the variable was recoded into several synthetic categories (see Table 9 in the Appendix). The results, presented in Figure 4, show a predominance of families with one child (64.1%) or two children (26.4%), whereas families with three or more children are much less frequent (9.5%). The distribution of the number of children per household aligns with the previously presented household structure model (Figure 3), which is dominated by small-sized households. Within this context, we will now examine the health status of children in the surveyed households.

4.3 Health Status of Children

As in the analysis of adults, the health status of children and youth was assessed by identifying functional difficulties reported by respondents in daily activities (see Table 10 in the Appendix). Table 2 presents a hierarchy of these difficulties by domain.

Table 2. Hierarchy of Functional Difficulties among Children/Youth, Summarized by Domains (%) (N = 295)

Domain	*Mild Difficulty (%)*	*Severe Difficulty (%)*	*Complete Difficulty (%)*
Vision	3.7	0.0	0.0
Walking / Climbing Stairs	0.3	0.3	0.3
Hearing	0.0	0.0	0.0
Memory / Concentration	1.7	0.0	0.0
Personal Care	0.3	0.3	0.3
Communication	0.3	0.0	0.3

Compared to adults (Table 1), functional difficulties among children and youth occur at very low proportions, with the most frequent issues related to vision, memory, and concentration, but generally at a mild level of difficulty.

To provide a clearer overview of the functional difficulties observed in children and youth, an aggregated indicator was constructed (see Table 11 in the Appendix), with the resulting distribution presented in Figure 5.

The overwhelming majority of children and youth (93.2%) do not exhibit any functional difficulties in the analyzed domains, with the proportion of limitations being very low and most of them classified as minor functional difficulties. This indicates a much more favorable health profile among children and youth, with only 6.8% affected by some restrictions in daily activities (see Table 12 in the Appendix), compared to 48.3% of adults (see Table 3 in the Appendix).

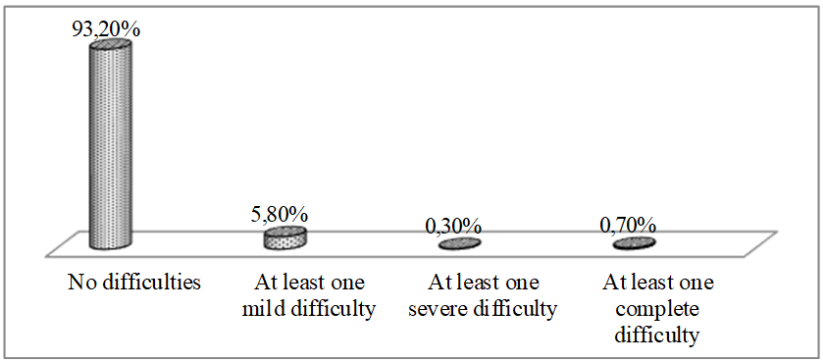

Figure 5. Level of Functional Difficulties among Children (N = 295)

Following the same approach used for adults, the assessment of children's and youth's health was continued by examining medically documented chronic diseases. Only 2.4% of the children in the sample had a certified medical condition (see Table 13 in the Appendix). There is a small number of children with medically documented chronic diseases (N = 7), with the majority being nervous system disorders and mental disorders (57.1%), followed by respiratory diseases (28.6%) and endocrine or metabolic diseases (14.3%) (see Table 14 in the Appendix).

The comparison of documented diseases suggests that these patterns are compatible across the two age groups. For adults, they correspond to processes associated with aging and lifestyle, whereas for children, due to the small number of cases, we limit ourselves to a descriptive presentation (see Table 18 in the Appendix). This comparison supports the idea that there are two types of health vulnerabilities, each with characteristics associated with the respective age group.

4.4 Statistical Relationships between Adult Health, Children's Health, and Monthly Net Family Income

The presentation of health vulnerabilities for the two age groups allowed for an analysis aimed at identifying their co-occurrence within the same households. We also

explored whether there were differences according to monthly net family income. Associations between variables were tested using the chi-square test, with their strength measured by Cramer's V coefficient. In cases where expected frequencies were low, the Fisher exact test was applied, and Odds Ratios were calculated to estimate relative risk.

The association between functional difficulties in adults and those in children within the sampled households is statistically significant ($\chi^2(1) = 10.85$; $p = 0.001$), but of low strength ($V = 0.192$). The Odds Ratio indicates that the likelihood of functional difficulties in children is approximately 4.5 times higher in households where adults experience such difficulties (Odds Ratio = 4.48; 95% CI: 1.712 – 11.556) (Coman, 2011, pp. 244–245). This highlights the potential existence of a family context for functional vulnerabilities, even though the relationship is relatively weak (see Table 15 in the Appendix).

Further analysis of the association between adults' and children's functional difficulties, considering different levels of intensity, shows that as the level of adults' functional difficulties increases, there is a tendency for the proportion of children with functional difficulties to also rise within the household. This association is statistically significant ($\chi^2(9) = 29.114$; $p = 0.001$) but of low strength ($V = 0.181$). The direction of the relationship between these ordinal variables is confirmed by the Gamma coefficient, which shows a positive and moderately strong association between adults' and children's functional difficulties (Gamma = 0.585; $p = 0.006$) (Coman, 2011, pp. 250–251; see Table 16 in the Appendix). This supports the possibility of a family context for functional vulnerabilities.

The association between medically documented chronic diseases in children and the presence of functional difficulties is statistically significant ($\chi^2(1) = 14.767$; $p < 0.001$), also confirmed by the Fisher exact test ($p = 0.008$). Approximately two-fifths of children with a chronic disease (42.9%) also exhibit functional difficulties, compared to 5.9% of children without chronic disease. The Odds Ratio further indicates a strong association between chronic disease and functional difficulties in children, with the likelihood of co-occurrence being over seven times higher among children with chronic disease (Odds Ratio = 7.261; 95% CI: 2.747–19.187) (see Table 17 in the Appendix).

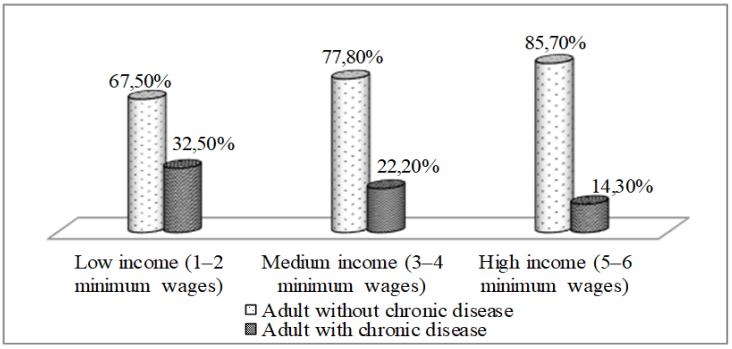

Figure 6. Monthly Family Income and Presence of Chronic Diseases in Adults (N = 931)

The analysis then examined the relationship between monthly net family income and health indicators of household members (presence of functional difficulties and chronic diseases) to determine whether income level produces differences. For children, due to the small number of chronic disease cases, the analysis focused on functional difficulties. The data distribution showed relatively minor variation across income categories (ranging from 88.9% to 95.6%), suggesting the absence of a clear economic gradient, i.e., monthly net family income is not evidently associated with the presence of functional difficulties among children (see Table 19 in the Appendix).

Finally, the association between adults' chronic diseases and monthly net family income was tested, revealing a statistically significant relationship ($\chi^2(2) = 15.102$; $p = 0.001$), although of low strength ($V = 0.127$) (see Table 20 in the Appendix).

The data distribution in Figure 6 suggests the presence of a notable economic gradient, with nearly one-third of adults in low-income households experiencing chronic diseases, compared to 14.3% in high-income households. This indicates the possible existence of social inequality in health status.

5. CONCLUSIONS

This article aimed to highlight the health vulnerabilities of adults and children in the surveyed households, focusing on functional difficulties and medically documented chronic diseases. The results show that functional difficulties are much more frequent among adults than children, a pattern that is also observed for chronic diseases. In adults, chronic diseases appear to be largely associated with lifestyle factors and the aging process, whereas in children they are specific to early stages of life.

Statistical analysis reveals an association between adults' and children's functional difficulties, suggesting the existence of a family-level pattern of functional vulnerabilities. Additionally, chronic diseases in children are associated with functional difficulties, indicating a much higher likelihood of co-occurrence among children with chronic conditions. The economic dimension, measured by monthly net family income, does not show a statistically significant relationship with functional difficulties in children. In contrast, among adults, an economic gradient in health status is evident, with chronic diseases being far more prevalent among those in low-income households, suggesting the emergence of a structural pattern of health vulnerability linked to economic disparities.

Overall, the analysis highlights two possible structural patterns of health vulnerabilities: a family-related pattern, affecting functional difficulties across adults and children; an economic pattern, where adults in low-income households are more likely to suffer from chronic diseases compared to those in higher-income households.

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APPENDICES

Table 1. Level of Adults' Functional Difficulties by Domain (%) (N = 931)

Type of Difficulty	*No Difficulty*	*Mild (%)*	*Severe (%)*	*Complete (%)*	*Total*
Vision	540 (58.0%)	296 (31.8%)	86 (9.2%)	9 (1.0%)	931
Hearing	807 (86.7%)	83 (8.9%)	38 (4.1%)	3 (0.3%)	931
Walking / Climbing Stairs	783 (84.1%)	94 (10.1%)	43 (4.6%)	11 (1.2%)	931
Memory / Concentration	844 (90.7%)	66 (7.1%)	16 (1.7%)	5 (0.5%)	931
Personal Care	900 (96.7%)	25 (2.7%)	5 (0.5%)	1 (0.1%)	931
Communication	905 (97.2%)	20 (2.1%)	5 (0.5%)	1 (0.1%)	931

Table 2. Level of Adults' Functional Difficulty (Aggregated Variable) (N = 931)

Level of Functional Difficulty	*N*	*%*
No difficulty in any domain	481	51.7
At least one mild difficulty	306	32.9
At least one severe difficulty	123	13.2
At least one complete difficulty	21	2.3
Total	931	100

Table 3. Presence of at Least One Functional Difficulty in Adults (N = 931)

Situation	*N*	*%*
No difficulty	481	51.7
At least one difficulty	450	48.3
Total	931	100

Table 4. Presence of a Medical Certificate Confirming a Limiting Chronic Disease in Adults (Question 6) (N = 931)

Situation	*N*	*%*
Yes	260	27.9
No	671	72.1
Total	931	100

Table 5. Types of Medically Documented Chronic Diseases in Adults (Multiple Response Item) (N = 260)

Type of Disease	*N*	*% of Cases*
Infectious diseases	9	3.5
Tumors	5	1.9
Endocrine / Metabolic diseases	65	25.0
Nervous system disorders / Mental disorders	37	14.2
Cardiovascular diseases	149	57.3

Respiratory diseases	35	13.5
Digestive diseases	33	12.7
Genitourinary diseases	44	16.9
Accidents / Injuries	15	5.8

Note: The question allowed for multiple responses. Percentages are calculated based on the total number of respondents with a medically documented chronic disease (N = 260). The total number of responses recorded was 392.

Table 6. Household Size (Recoded Variable) (N = 931)

Household Size	***N***	***%***
1–2 persons	477	51.2
3 persons	232	24.9
4 persons	159	17.1
5 persons or more	63	6.8
Total	931	100

Note: The variable was recoded for use in association analyses.

Table 7. Presence of Individuals under 18 in the Household (Question 9) (Total N = 931; Valid N = 795)

Situation	***N***	***% of Total (N = 931)***	***% of Valid (N = 795)***
Yes	295	31.7	37.1
No	500	53.7	62.9
Non-response (filter/not applicable)	136	14.6	–
Total	931	100.0	100.0

Note: The question was asked only to households for which the item was applicable (Valid N = 795) due to the questionnaire's filtering logic; the "% of valid" column reflects the distribution within the actual surveyed population.

Table 8. Number of Individuals under 18 in the Household (Question 10) (Total N = 931; Valid N = 295 households with children)

Number of Children	***Number of Households***	***% of Valid (N = 295)***
1 child	189	64.1
2 children	78	26.4
3 children	19	6.4
4 children	3	1.0
5 children	2	0.7
6 children	2	0.7
7 children	1	0.3
8 or more children	1	0.3
Total	295	100

Note: The question was applied only to households that reported the presence of individuals under 18 (Valid N = 295). In total, 451 children under 18 were identified in the sample, calculated by summing the number of children corresponding to each household category.

Table 9. Number of Children per Household (Recoded Variable) (Valid N = 295)

Number of Children (Recoded)	***N***	***% of Valid (N = 295)***
1 child	189	64.1
2 children	78	26.4
3 or more children	28	9.5
Total	295	100

Note: The variable was recoded for use in association analyses.

Table 10. Level of Functional Difficulties among Children/Youth by Domain (Question 11) (Valid N = 295)

Type of Difficulty	*No Difficulty*	*Mild (%)*	*Severe (%)*	*Complete (%)*	*Total*
Vision	284 (96.3%)	11 (3.7%)	0 (0.0%)	0 (0.0%)	295
Hearing	295 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	295
Walking / Climbing Stairs	292 (99.0%)	1 (0.3%)	1 (0.3%)	1 (0.3%)	295
Memory / Concentration	290 (98.3%)	5 (1.7%)	0 (0.0%)	0 (0.0%)	295
Personal Care	292 (99.0%)	1 (0.3%)	1 (0.3%)	1 (0.3%)	295
Communication	293 (99.3%)	1 (0.3%)	0 (0.0%)	1 (0.3%)	295

Table 11. Aggregated Level of Functional Difficulty in Children (Valid N = 295)

Level of Functional Difficulty	*N*	*% of Valid (N = 295)*
No difficulty in any domain	275	93.2
At least one mild difficulty	17	5.8
At least one severe difficulty	1	0.3
At least one complete difficulty	2	0.7
Total	295	100

Table 12. Presence of at Least One Functional Difficulty in Children (Dichotomous Variable) (Valid N = 295)

Situation	*N*	*% of Valid (N = 295)*
No difficulty	275	93.2
At least one difficulty	20	6.8
Total	295	100

Table 13. Presence of a Medical Certificate Confirming a Limiting Chronic Disease in Children/Youth (Total N = 931; Valid N = 295 Households with Children)

Situation	*N*	*% of Valid (N = 295)*
Yes	7	2.4
No	288	97.6
Total	295	100

Note: The question was applied only to households with children under 18 (Valid N = 295).

Table 14. Types of Medically Documented Chronic Diseases in Children/Youth (Multiple Response Item) (N = 7)

Type of Disease	*N*	*% of Cases (N = 7)*
Endocrine / Metabolic diseases	1	14.3
Nervous system disorders / Mental disorders	4	57.1
Respiratory diseases	2	28.6

Table 15. Relationship Between the Presence of Functional Difficulty in Adults and Children (Valid N = 295)

Adult Difficulty	*Child without Difficulty*	*Child with Difficulty*	*Total*
No difficulty	194 (96.5%)	7 (3.5%)	201
At least one difficulty	81 (86.2%)	13 (13.8%)	94
Total	275	20	295

$\chi^2(1) = 10,85$; $p = 0,001$
V Cramer = 0,192
Odds Ratio = 4,448

IC 95% [1,712 – 11,556]
Note: The analysis was based on variables derived from the relevant adult and child questions. The variables were recoded into a dichotomous format. Test used: Pearson's χ^2. Valid N = 295.

Table 16. Relationship Between the Level of Functional Difficulty in Adults and Children (Analysis by Intensity) (Valid N = 295)

Adult Difficulty Level \ Child Difficulty Level	*No Difficulty*	*At Least One Mild Difficulty*	*At Least One Severe Difficulty*	*At Least One Complete Difficulty*	*Total*
No difficulty	194 (96.5%)	7 (3.5%)	0 (0.0%)	0 (0.0%)	201
At least one mild difficulty	58 (89.2%)	5 (7.7%)	0 (0.0%)	2 (3.1%)	65
At least one severe difficulty	20 (76.9%)	5 (19.2%)	1 (3.8%)	0 (0.0%)	26
At least one complete difficulty	3 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3
Total	275	17	1	2	295

$\chi^2(9) = 29,114$; $p = 0,001$
V Cramer = 0,181; p = 0,001
Gamma = 0,585; p = 0,006

Table 17. Relationship Between the Presence of a Medically Documented Chronic Disease in Children and the Presence of a Functional Difficulty (Valid N = 295)

Documented Chronic Disease	*Child without Difficulty*	*Child with Difficulty*	*Total*
Yes	4 (57.1%)	3 (42.9%)	7
No	271 (94.1%)	17 (5.9%)	288
Total	275	20	295

$\chi^2(1) = 14,767$; $p < 0,001$
Fisher exact (2-sided) = 0,008
Odds Ratio = 7,261
IC 95% [2,747 – 19,187]
Note: The variables are derived from the question on documented chronic disease and the dichotomous variable constructed from the question on the presence of at least one functional difficulty. Due to low frequencies in some cells (25% of cells had expected counts below 5), the Fisher's exact test is also reported. Valid N = 295.

Table 18. Comparative Distribution of Types of Chronic Diseases in Adults and Children (Descriptive Data)

Type of Disease	*Adults (N = 260) N (%)*	*Children (N = 7) N (%)*
Endocrine / Metabolic diseases	65 (25.0%)	1 (14.3%)
Nervous system disorders / Mental disorders	37 (14.2%)	4 (57.1%)
Respiratory diseases	35 (13.5%)	2 (28.6%)
Cardiovascular (heart) diseases	149 (57.3%)	0 (0%)
Digestive diseases	33 (12.7%)	0 (0%)
Genitourinary diseases	44 (16.9%)	0 (0%)
Infectious diseases	9 (3.5%)	0 (0%)
Tumors	5 (1.9%)	0 (0%)
Accidents / Traumas	15 (5.8%)	0 (0%)

Note: Percentages are calculated from the total cases with medically documented chronic disease (Adults N = 260; Children N = 7). Multiple-response questions; percentages are not mutually exclusive and may therefore exceed 100%.

Table 19. Relationship Between Monthly Net Family Income (Recoded into 3 Categories) and the Presence of a Functional Difficulty in Children (Valid N = 295)

Monthly Net Income	*Child without Difficulty*	*Child with Difficulty*	*Total*
Low income (1–2 minimum wages)	152 (95.6%)	7 (4.4%)	159
Medium income (3–4 minimum wages)	107 (90.7%)	11 (9.3%)	118
High income (5–6 minimum wages)	16 (88.9%)	2 (11.1%)	18
Total	275	20	295

$\chi^2(2) = 3,163$; $p = 0,206$ (nesemnificativ)
V Cramer = 0,104 (effect neglijabil)
Note: The variable "monthly net income" was recoded from Question 31, based on intervals relative to the minimum net wage (1,065 RON in 2017). Percentages are calculated by row. One cell (16.7%) had an expected frequency below 5. No statistically significant association was observed. Valid N = 295.

Table 20. Relationship Between Monthly Net Family Income (Recoded into 3 Categories) and the Presence of a Medically Documented Chronic Disease in Adults (Valid N = 931)

Monthly Net Income	*Adult without Chronic Disease*	*Adult with Chronic Disease*	*Total*
Low income (1–2 minimum wages)	372 (67.5%)	179 (32.5%)	551
Medium income (3–4 minimum wages)	263 (77.8%)	75 (22.2%)	338
High income (5–6 minimum wages)	36 (85.7%)	6 (14.3%)	42
Total	671	260	931

Chi-square (χ^2): 15.102, $p = 0.001$ (statistically significant)
Cramer's V: 0.127 (indicating a weak association)