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THE MEANING OF ILLNESS IN ESTONIA AND IN FINLAND

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Abstract. The basis of the analysis of the individual meanings of illness are the negative consequences of illness in a person's life. Illness is discussed as insecurity, a generator of existential loneliness and ontological crisis, a weakening unity with the surrounding world, an opposition of the body to the "ego", etc.

The danger of death acquires a significant role in the factor containing the Estonians' individual meanings of illness. In the meanings of illness of the Finnish, death is not a separate factor, it spreads between other fears. In the answers of Estonian respondents the social meanings of illness form two complexes, in one of them work is emphasised, in the other social roles are stressed. In the case of Finnish respondents the social meanings of illness join into one factor. Taken by the age groups the differences in illness interpretations between the respondents of different countries are not statistically significant.

1. The meaning of health in well-being

Health can be discussed as the resource of an individual as well as the society and as the main precondition of welfare. Health is a social resource as far as working capacity and increase in population are concerned. Approaching from an individual level, health enables work, social communication and self-development and is often considered to be a resource associated with power, wealth and reputation. Being healthy can be treated as being secure (Tuominen 1994:94, Turner 1990:82, Karisto 1984:48, Allardt 1976:134)

Health is the central determining factor of the quality and possibilities of human life (Tuomainen and Myllykangas 1994:43) and one of the most important values of human beings, which has also been confirmed by numerous experimental studies (Suhonen 1988:37, Hämäläinen et al. 1994:53–54, Pajumaa 1991, Hansson 1994, Verkasalo et al. 1994, Niemelä and Raudik 1995:75). According to Schwartz's theory of universal values, health belongs to the security

dimension of value, the principal content of which is safety, stability and harmony of the society, of relations and of self. It derives from basic individual and group requirements. Security as value type emerges in regions on the boundary between the individual and collective interests. Health as a value is closely connected with the values of hedonism. This value type is derived from organismic needs and the pleasure associated with satisfying them (Schwartz 1992).

Falling ill denotes a threat to one's welfare – economic difficulties, inability to work, decreasing social contacts and the absence of social support, dissatisfaction with coping with life (Ritakallio 1991:48, Valkonen 1992:241, Kontula et al. 1992:7). Illness is the deficit of welfare resources and at least a temporary factor that decreases the quality of life and coping. Deteriorated state of health means insecurity and defencelessness (Suominen 1993:120, Bäckman and Söderqvist 1990:8, Wiman 1990: 93, Lazarus and Folkman 1984:179, Antonovsky 1980:123–128).

Falling ill in general and especially disability have a central role in the process of exclusion. However, not all people whose state of health has deteriorated are excluded. In the complex of falling ill, poverty and exclusion, all three components separately can occur as the causes of the rest or as the results of the influence of the rest (Mannila 1996, 26–27).

2. Concepts of health, state of health, disease and illness

There are various definitions and ways of analysing health. Negatively defined, health means that there is no disease, no experienced illness or associated pain, strain, distress (Aggleton 1990:4,6).

Positive definition of health is problematic. For example, health has been defined as the state of complete physical, mental and social welfare. This definition applies to the level of an organism, an individual and also the society (Suokas 1992:133). The concepts of *health* and *state of health* are often used in the same meaning. However, the contents of these two terms are different, health being an abstract concept and state of health being associated with particular individuals and a moment of time (Manderbacka 1995:11), or state of health being discussed as a concept with its sub-concepts health and illness.

Although not synonyms, the concepts of *disease* and *illness* are not usually distinguished in everyday language. Disease ordinarily has a general cause, typical progression and characteristic features. Illness is an experienced disease, a meaning, an observation or a doubt. Illness is a wider concept than disease and due to experience it is more or less singular (Kokko 1988:12, 1990:60–61, Kleinman 1981:72–73, 77). Illness brings human existence into the concept of disease through meanings, interpretation, support from surroundings, the opportunity of labelling (Kokko 1990, 61, see also Downie and Telfer 1980:15–17, Radley 1994:3). Consequently, in the concept of illness behaviour

and experiences are added to disease. Reactions to disease are personal, social and culturally defined. The disease can be interpreted only in the context of social relations and meanings. In some cultures a disease is understood to be constructed both by the individual and by the family (Kleinman 1981).

Health and falling ill have also been discussed with the help of the concepts of normality and deviation. Illness is considered a deviation as it is seen as an undesirable situation for the sick person, his/her family and the society. Falling ill brings about disturbances in biological and social activity, a risk of economic problems, even death (Cockerham 1982:101–103).

In every society the cause of suffering also belongs to the belief system. The idea about the cause (intrinsic and extrinsic) of a disease is part of the concept of health and disease (Aggleton 1990).

3. The meaning of illness

Human beings have the need to interpret the world they live in. Interpretation of the world leads to an attitude towards the world and other people. The attitude influences our perception, experiences, the assignment of meanings (Kallenberg 1978:13, 16).

The development of a meaning system is connected with learning by others, with different forms of social action and through these with tradition. The maintaining of meaning system is also a social process. (Aaltola 1992, 96.) Cultural studies suggest that even the most individual interpretations about the world are similarly social, cultural constructions (Alasuutari 1994). Different kinds of social rules motivate and define the individual way of giving meanings. They also direct both thinking and acting (Siljander 1991).

For a long time the meanings of illness were discussed proceeding from the naturalistic-causal viewpoint, the effects and influences of falling ill were analysed mainly medically. Starting from the 1980s, health and illness were more and more discussed as a process of mutual communication between an individual, the social environment and the society (Urponen 1989:20, 23, see also Bäckman and Söderqvist 1990:1).

Social, cultural and collective factors as well as the time precipitate into experiences and meanings of falling ill. The attitude of people towards a sick person reveals the norms and laws of accepting the sick person, sympathising with him/her or distinguishing and even punishing the sick person. Social and cultural meanings of falling ill can be serious sources of suffering for the sick person (Honkasalo 1994:10, see also Töttö 1982:119, Cassell 1991:39, Lipowski 1970:38–39).

Diagnoses also carry individual and cultural meanings (Töttö 1982:119, Toombs 1992). An illness is interpreted through the diagnosis. In a society the reactions to a disease depend on many sociocultural factors, for example on the

economic system, on the variations in the populations (size and structure) or on the changes in the religious and ethical values (Cockerham 1982:123–124; Järvikoski and Härkäpää 1995:55–56).

Mary Rawlinson (1982:74–75) discusses the meanings of illness from four points of view: 1) continuation of familiar everyday life, 2) predictability of the whole life, 3) self-concept and body image, 4) social network.

People experience falling ill primarily through effects on everyday life and not as a process of disease. In experiences stress is laid on the functionality of health and its close connection with everyday life (Toombs, 1992:19–20, Lahelma 1992:193). One of the criteria of determining the damaging effect of an illness is the continuation of one's habitual life or a change of life (Rawlinson 1982:74–75, Oras 1987:70). There are also other criteria to determine the seriousness of illness, such as pain, physical restrictions, external symptoms, prognosis, danger of death.

The emergence of difficulties in fulfilling one's aims and in social participation is one of the viewpoints on forming individual meanings of falling ill (Doyal and Gough 1991:50–51, 54, see also Lahelma 1991a:147, Laitinen 1974:3).

Illness damages a person's unity with and connection to the surrounding world. Illness is an irregularity in the relations of the body and the world, in "existing in the world". Existential loneliness is an inseparable part of a serious illness (Toombs 1992:96). Ontological crisis is related to the illness – relations to oneself and to world are analysed. The problems of falling ill and suffering are connected with the question of existence and the meaning of life (Kallenberg 1987:122, Honkasalo et al. 1994:3).

From the viewpoint of the concepts of freedom and autonomy, falling ill is always in connection with a certain restriction of freedom. At least elderly people consider health a freedom from sufferings and restrictions caused by illness. Freedom can also be freedom from the help and servicing offered by others (Åstedt-Kurki 1992:52, 1989:61).

Lipowski (1970:98–100) has given the following general meanings of illness: 1) challenge, 2) enemy, 3) punishment, 4) weakness, 5) relief (from obligations), 6) strategy, e.g. to obtain attention and support, 7) irreparable loss or damage or 8) value, when we consider sufferings as factors contributing to individual development or, for example, creativity.

Herzlich (1973:105-125) discusses the meanings of illness in three main groups: 1) destructive illness – due to illness one often has to give up several roles, illness may cause economic difficulties, exclusion; 2) illness as a liberator – freedom from everyday life, social obligations, a chance to have a rest and to contemplate; and 3) illness as an occupation – an active fight against the illness.

Experience of illness is the complex of cultural, individual and interpersonal meanings (Turner 1990:34). Social and cultural meanings of illness can be the main source of individual sufferings (Honkasalo 1994).

4. Illness as insecurity

One of the main motives of human activities is the attempt to obtain security – that means protecting oneself against the dangers, aspiring to gain freedom from fears and threats (Hellsten 1992:133, see also Riihinen 1996:18). Staying alive and avoiding unnecessary sufferings is connected with physiological needs, health and social needs of people (Allardt 1987:21, 213–214). At the same time life as such is always accompanied by a certain feeling of insecurity, since life is never entirely ruled by and under control of people (see e.g. Kidel 1988:7).

An individual's experiences of insecurity can be treated as touching on all human existence. In that case the concepts of meaninglessness and aimlessness join closely in the conception of insecurity. On the worst occasion incompetence in solving the problems of meaninglessness and insecurity may lead to withdrawal, illness, deviations, even suicide (Riihinen 1979:825–826), on which occasion insecurity has expanded to the whole existence.

Many researchers define security as the continuance of things considered good and important (for example, life and health) (Kaufmann 1970:24–27, Riihinen 1979:820–823, Gould 1979:328, Niemelä 1994:9). Experience of insecurity acts as a resource of pressure to obtain satisfactory coping with life. Insecurity and coping as concepts stand in very close connection. On the best occasion, the experience of insecurity forces an individual to develop means of decreasing insecurity (Niemelä 1991:13, Suhonen and Suhonen 1973). Coping can be defined as "all cognitive and motor activities which a sick person employs to preserve his bodily and psychic integrity to recover reversibly impaired function and compensate to the limit for any irreversible impairment" (Lipowski 1970:91). Deficient coping may increase the experiencing of insecurity feelings.

On the other hand, coping can be looked at as an experience of the presence of opportunities of using different resources (Antonovsky 1991:40). For example, a sick person can experience close people, God and the doctors as promising resources.

The present research concentrates on negative meanings of illness in a person's life. Negative meanings of illness endanger security, freedom and independence. Falling ill may also include some positive meanings (rest, withdrawal from everyday routine, possibility of being under attention and nursing, time to think and evaluate things and perceive oneself in a new way) (Kidel 1988:5, Kitto 1988:111–113, Åstedt-Kurki 1992:80).

5. The study of the meaning of illness within the framework of insecurity research project

The present analysis is based on the results of the research project "Insecurity, its causes and coping methods" between the universities of Tartu and Kuopio. The

general aim of the research was to find out to what extent and in what ways does insecurity reveal itself in Finland and in Estonia, by comparing the two countries. One of the parts of the project was to describe the contents of insecurity and fears in illness. Insecurity as well as coping with it can be described as phenomena of several levels, but on studying insecurity due to illness we are dealing with micro-level, the initial point of which is an individual with his dimensions (health also belongs here).

In the mentioned research project security/insecurity are discussed proceeding from two main scientific paradigms. The first – empirical-positivistic, causal approach – consists in explaining security proceeding from an external situation. The second approach, which can be called phenomenological, consists in mapping the internal meaning of insecurity in the subjective world of experiences of an individual (Niemelä et. al.: 1991).

The preliminary study carried out in Finland revealed the following as dimensions of insecurity: illnesses, problems of human relations, working sphere, society, world politics, environment and values.

In order to ascertain the ways and extent of insecurity, as well as the reasons of insecurity in the case of all dimensions of insecurity, the following questions were asked: "Which of the following... (e.g. things connected with illness, accidents and falling ill) ... cause insecurity, fear in you?", "Have you experienced the following things?" The possible generators of insecurity connected with falling ill were: (1) becoming physically disabled, (2) danger of death, (3) losing working capacity, (4) need for institutional care, (5) losing the ability of coping alone, (6) difficulties in getting help or care when needed, (7) pain and suffering, (8) trouble to the family or other close persons, (9) becoming dependent on others, (10) being neglected/forgotten, (11) weakening/loss of memory, (12) weakening ability of mental coping. The respondents were asked to mark the circumstances which caused insecurity for them in connection with falling ill. In addition to that it was asked how the respondents evaluated their state of health and how much they experienced insecurity due to their state of health.

The basis of the research is the standpoint according to which the fears and insecurity aroused by falling ill express primarily those individual meanings that the respondents attach to illness and health. This supposition is based on previously obtained results which indicate that people who feel more insecure in connection with falling ill do not consider their actual state of health worse than those respondents who feel less insecure (Kotakari and Raudik 1995). Although hereafter we can see that, for example, young people have better state of health and they also experience less insecurity due to their state of health or that the state of health of the Estonians is worse (than that of the Finnish) and on an average the Estonians experience more fear in connection with that, the mutual causal connection between these two factors, however, has not been statistically confirmed. Obviously the connection functions through age and also through the social, cultural etc. peculiarities of the concrete country.

Data about the Estonians was received on questioning 944 respondents aged 13–85. The sample was formed on the ground of the data of the census of 1989 by quota sampling and covered the whole territory of Estonia. The amount of respondents from each county is in accordance with the percentage of inhabitants of that county of the whole population of Estonia. The division of the sample by age and gender is also proportional to the actual demographic characteristics of the county. Data collection was started in the middle of 1993 and completed at the end of 1994.

In Finland the sample was formed on the principle of equality of age groups, i.e. from each examined age group (13–17; 18–24; 25–34; 35–44; 45–54; 55–64; 65–74; over 75) there was an equal number of respondents in order to compare the age groups. In the analysis of general data weighting of age groups was used according to the data of the census of 1990. Data was collected from 4 counties located at different regions of Finland and from Helsinki. There were 5,864 Finnish respondents and the questioning was carried out in the years 1992–1994.

6. Age as a determiner of the meaning of illness

On the basis of similarities/differences in the meanings of illness and also proceeding from the social position, we divided the respondents into three major groups in order to find out the peculiarities of age in the meanings of illness: 13–24 (the young people, studying), 25–54 (the working age people) and 55–85 (the representatives of pre-retirement and retirement age).

The meanings of illness do not differ by age groups to such extent that one age group fears only some things in connection with falling ill and another age group fears other things. For example, people of all ages fear becoming disabled, causing difficulties to close people and dependence more than weakening of memory or becoming neglected. On explaining age tendencies, we shall use a comparison – what value does a factor acquire for a concrete age group. With the aim of making everything clearer, we shall describe the results also graphically (figures 1–16).

Age group 13–24: falling ill as the opposite of existence. Although people aged 13–24 consider their actual state of health significantly better than the respondents belonging to the older age groups (Figure 17) and they experience fear and insecurity due to their actual state of health less than the older age groups (Figure 18), young people, however, have fairly more fears connected with falling ill.

In Figures 1–16 the category axis indicates age groups, the scale axis indicates the mean (scale 0–1).

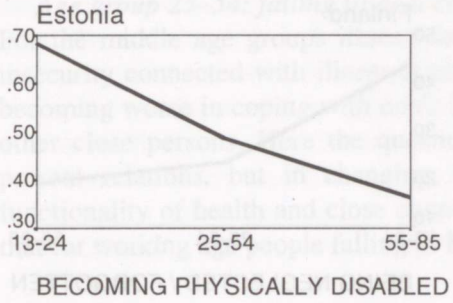
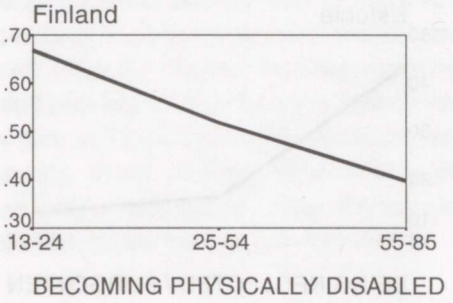


Figure 1.



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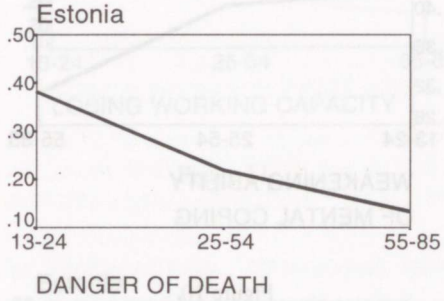

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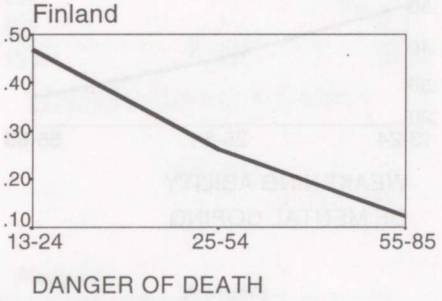

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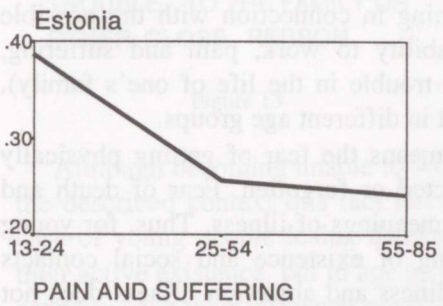

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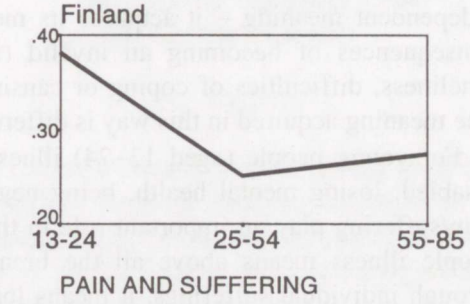

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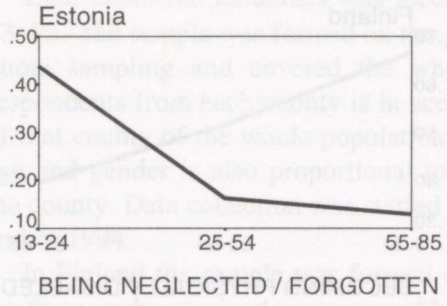

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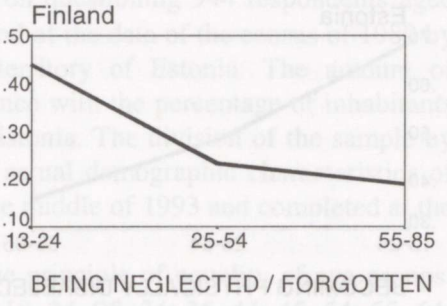

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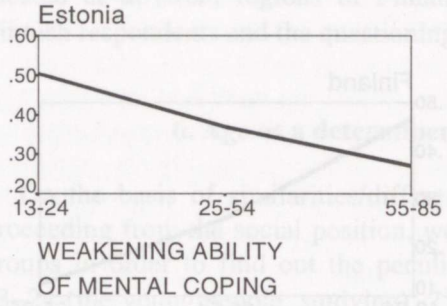

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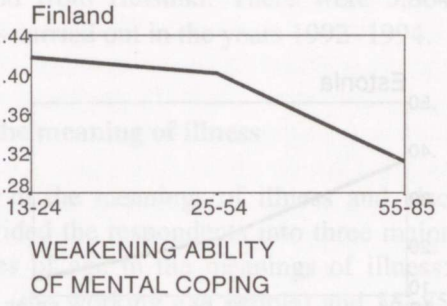
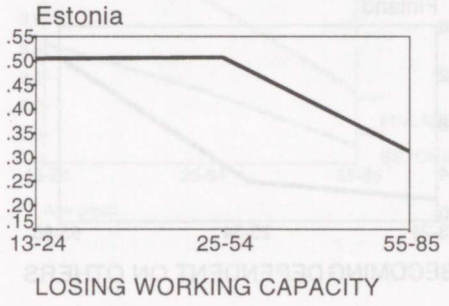


Figure 10.

To the respondents of all ages, becoming physically disabled is the biggest factor of insecurity in connection with falling ill. At the same time becoming physically disabled cannot be treated as a source of insecurity with an independent meaning – it acquires its meaning in connection with the possible consequences of becoming an invalid (inability to work, pain and suffering, loneliness, difficulties of coping or causing trouble in the life of one's family). The meaning acquired in this way is different in different age groups.

For young people (aged 13–24) illness means the fear of getting physically disabled, losing mental health, being neglected or forgotten. Fear of death and pain/suffering play an important role in the meanings of illness. Thus, for young people illness means above all the breaking of existence and social contacts through individual sufferings, it means loneliness and abjection. Illness does not belong to the reality and everyday life of young people compared to the older population. For them illness is the opposite of an active physical and social existence. So, for young people aged 13–24, illness has an existential rather than a functional content.

Age group 25–54: falling ill as a change of relations and the way of existence. For the middle age groups illness does not bear a deep existential content but insecurity connected with illness is above all related to losing working capacity, becoming worse in coping with one's life and causing trouble to one's family and other close persons. Here the question is not in breaking one's existence and present relations, but in changing, reforming them. Falling ill contains the functionality of health and close connection with everyday life. Thus we can say that for working age people falling ill has the functional meaning above all.



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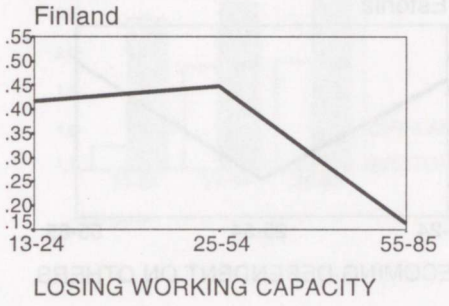

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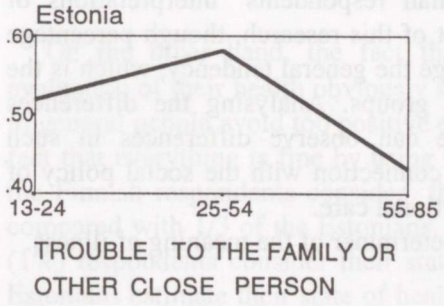

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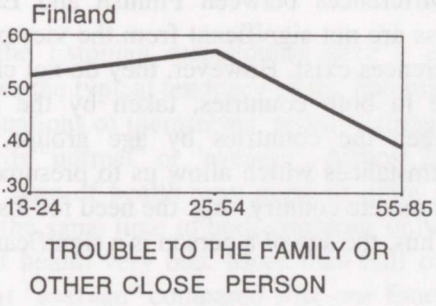
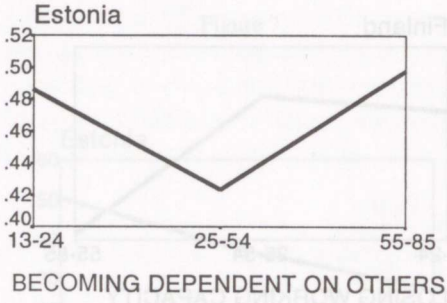


Figure 14.

Although becoming unable to work causes insecurity also for young people, in the described context this fact has a slightly different meaning for them. In the case of young people losing their working capacity can be interpreted as losing their active existence, but in age group 25–54 the consequences of losing working capacity have their influence mostly on the level of everyday life.

Age group 55–85: falling ill as a loss of autonomy. For older people the meanings of illness are more clear-cut than for young and middle-age generations. For older people insecurity connected with falling ill means first of all becoming

dependent on others, the need for institutional care and a threat of weakening/loss of memory. The meaning of fear of death has a fall in comparison with the younger age groups, as well as the fear of becoming physically handicapped, becoming neglected or forgotten, pain and sufferings, weakening ability of mental coping, trouble to the family/other close person and the fear of losing working capacity. Here we deal with an opposite meaning of illness compared with age group 13–24 – illness is not a fear of loneliness, but insecurity due to losing the possibility of being alone, due to total dependency, thus – the loss of autonomy.



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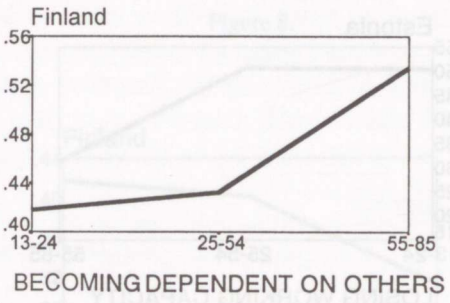

Figure 16.

Differences between Finnish and Estonian respondents' interpretations of illness are not significant from the viewpoint of this research, though percentage differences exist. However, they do not change the general tendency, which is the same in both countries, taken by the age groups. Analysing the differences between the countries by age groups, we can observe differences in such circumstances which allow us to presume a connection with the social policy of the concrete country - e.g. the need for institutional care.

Thus, the age of a person is a significant determiner of the meaning of illness.

7. The meaning of illness in Estonia and in Finland

The Estonian respondents' evaluation of their state of health is lower than that of the Finnish (Figure 17). On the one hand, the basis of this fact is the objectively (shown by statistics) worse state of health of the Estonians during the completion of this research. The evidence of this fact is the shorter and still shortening average lifespan – in Finland 79 years in case of women and 72 years in case of men, in Estonia 75 years in case of women and 64 years in case of men (Kela 1993:11, Tilastokeskus 1995:19, Eesti Sotsiaalstatistikat 1994:9, Laidmäe 1994:17). Major social changes and social insecurity inevitably found their

expression also on the level of an individual. This period in Estonia is characterised by the increase in occurrence of many diseases (infectious, cardiovascular, venereal diseases, tuberculosis, malignant tumours), the number of suicides also increased (Leps 1993). The health system of Soviet times which laid the main responsibility for people's health on doctors, not on the people, gradually fell to pieces.

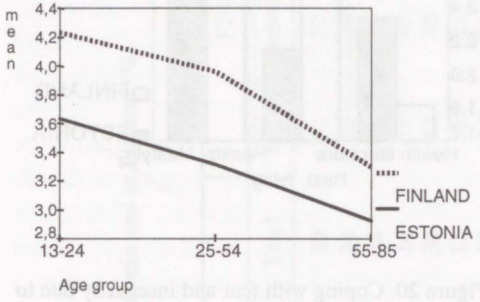

Figure 17. Evaluation of the state of health by age groups in Finland and in Estonia (5-very good; 4 – good; 3 – average; 2 – bad; 1 – very bad)

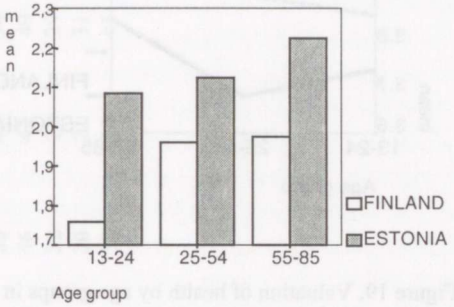

Figure 18. Experience of fear and insecurity due to the actual state of health by age groups in Finland and in Estonia (1 – not at all; 2 – to some extent; 3 – comparatively much; 4 – very much)

On the other hand, the fact that the Estonian respondents have a lower evaluation of their health obviously shows the typical tendency of the Estonians – in general people avoid too positive evaluations of themselves; people express the fact that everything is fine by using words "normal" or "average". Almost 2/3 of the Finnish respondents consider their state of health very good or quite good compared with 1/3 of the Estonians. At the same time in both countries only few (1%) respondents consider their state of health very bad. More than half of the Estonians estimate their state of health as "average" compared with one fourth of the Finnish. Also the comparative study of Estonian and Finnish young families shows the same tendency – significantly more Finnish respondents consider their child's and family members' state of health "very good" compared with the Estonians (Hämäläinen et al. 1994).

Such hidden, not worded and even unconscious understanding of the Estonians that everything that deviates from norm is bad, fearsome or ill-omened, that "well" equals to "normal" or even to "moderately bad" (e.g. it is even good to have an influenza when the epidemic of influenza is raging – escaping the illness then means something worse in the future), originates from folk belief and its roots extend to pre-Christian time. Also the conviction that on praising something you will "doom it to failure" is characteristic of the culture of the Estonians; even

today people are subconsciously guided by that conviction, especially in Southern Estonia which is less accessible to external influences (Kõivupuu 1993, Kõiva 1995, conversation with folklorist M. Kõivupuu).

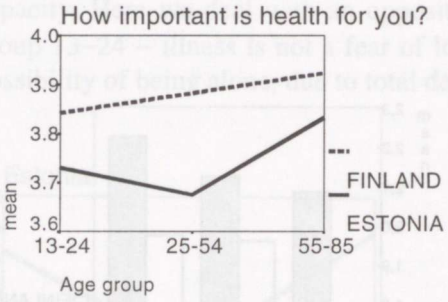

Figure 19. Valuation of health by age groups in Finland and in Estonia

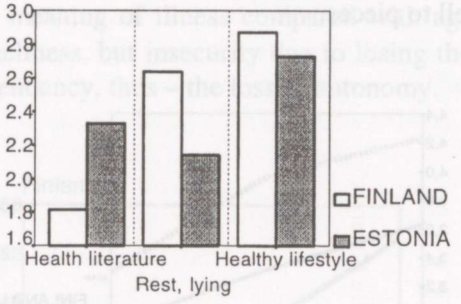

Figure 20. Coping with fear and insecurity due to illness in Finland and in Estonia

Finnish respondents feel insecure about many more circumstances connected with falling ill than the Estonians (Table 1). On the one hand, this indicates that the Finnish attribute more meanings to health than the Estonians. Another possible explanation to this is connected with the lower valuation of health by the Estonians, compared with the Finnish. Taking care of one's health is not placed in the foreground compared with working.

The data of the present as well as some earlier comparative researches indicate that the Estonians evaluate their health less than the Finnish (Hämäläinen et al. 1994:54–55, Laidmäe 1994:20–22, Niemelä and Raudik 1995:74–77). However, the comparative study of values by Verkasalo, Daun and Niit (1994:101–107) has revealed contradictory results, but the sample of the mentioned study was significantly smaller in the case of both countries and it represented only young, studying people. (On the basis of the present study the most notable difference occurred between the Estonians and the Finnish of working age. See Figure 19).

To a certain extent the valuation of health determines the content of insecurity due to illness and thus also the meanings attributed to health. Whereas this connection is not identical in the case of Estonian and Finnish respondents, we can state that the character of the mentioned connection is primarily culturally determined.

Table 1.

Factors causing insecurity connected with falling ill in Estonia and in Finland (%)

	ESTONIA				FINLAND				
	Male	Female	p<	**Total**	Male	Female	p<	**Total**	p<
Becoming physically disabled	52	48	–	**50**	51	52	–	**52**	.001
Danger of death	23	24	–	**24**	23	29	.001	**26**	–
Losing working capacity	53	40	.001	**46**	37	33	.001	**35**	.001
Need for institutional care	16	16	–	**16**	35	40	.001	**38**	.001
Losing the ability of coping alone	26	34	.01	**30**	42	40	–	**41**	.001
Difficulties in getting help or care when needed	9	12	–	**11**	15	21	.001	**18**	.001
Pain and suffering	24	32	.01	**28**	24	31	.001	**28**	–
Trouble to the family or otherclose person	51	55	–	**53**	47	54	.001	**51**	–
Becoming dependent on others	43	48	–	**46**	42	49	.001	**46**	–
Being neglected / forgotten	22	22	–	**22**	23	29	.001	**27**	.001
Weakening / loss of memory	17	22	–	**20**	21	31	.001	**26**	.001
Weakening ability of mental coping	32	43	.01	**38**	33	41	.001	**38**	.001

The valuation of health is connected with how people cope with problems, fears and insecurity because of falling ill. Here as well exist significant differences between the Estonians and the Finnish. The Estonians, compared with the Finnish, much more prefer studying literature about health – physically, this is a passive activity. Actions aimed actively at one's body (for example an effort to lead a healthy life, also rest and lying) occur more in the case of the Finnish (Figure 20).

Those Finnish respondents who value their health, experience notably more insecurity connected with falling ill in *all* aspects (becoming dependent on others, complications of coping with one's life, pain and suffering, becoming unable to work, difficulties in getting help or care when needed, becoming neglected or forgotten) compared with those who do not valuate their health. In the case of the Estonians the picture is different. Those who valuate their health experience insecurity and fear connected with illness much more due to the danger of death. At the same time they feel less frightened by the possibility of losing their working capacity and making their family members' life more difficult, compared with those who consider health less important. On comparing those Estonian and Finnish respondents who consider health less valuable, we can mark another difference – the Estonians, much more than the Finnish, are afraid of losing their working capacity, causing difficulties in the lives of close people and becoming dependent on others, but they feel the fear of death much less than the Finnish. Thus, in the case of the Finnish the increase in health valuation is accompanied by the increase in fears and insecurity in almost all aspects connected with falling ill (except the fear of death and becoming disabled) – consequently, in the case of the Finnish the higher valuation of health means that more meanings are attributed to health, primarily functional in their content. In the case of Estonian respondents, together with the increase in health valuation the meaning of death comes to mind. This seems to indicate that the basic content of health is the absence of the danger of death, the opposite to non-existence.

Attributing more importance to death in Estonia and the fact that the Estonians associate health/illness with the question of existence significantly more than the Finnish, becomes evident also in the fear of the possible death of a close person. Although on the one hand, death or serious illness of a close person may be connected with certain changes in one's life (various rearrangements, economic problems, emotional stress), facing death inevitably leads to interpreting life and death. We can assume that when death is given great importance (in the present case the more it is fared), then the possible serious illness or death of a close person causes more fear.

The possibility of the death of a close person causes more fear and insecurity among the Estonians than the Finnish. This fear is the strongest among young people and it decreases proportionally with the advancing age. Here once again the role of the existential content in interpreting the meaning of health/illness in the case of young people becomes evident.

Thus, in the dimensions of insecurity due to illness there is a difference in the meaning of death in the case of the Estonians and the Finnish. The end of existence (danger of death) and suffering acquire an enormous role in the factor containing the Estonians' individual meanings of illness. Death does not form a whole (a separate factor) in the meanings of illness of the Finnish, but it spreads between other factors, joining with fears connected with individual sufferings and change in social activities. This result was achieved using the method of factor graphs (Saarniit 1995:169–179).

At the same time the Estonians' interpretation of health through death does not mean that the Finnish respondents experience fear of a possible danger of death less than the Estonian respondents. About a quarter of Estonian and Finnish respondents are afraid of the danger of death. Previously we showed that the Finnish tend to give extreme evaluations more easily than the Estonians and that they also attribute more meanings to illness. Thus, the different treatment of death in the two countries emerges not through the comparison of means, but primarily with the help of factor analysis.

The relation to the death is culture-specific. These questions would require thorough discussion and the topic would cross the boundaries of the present article. At any rate, the dichotomy of life and death of the Estonians seems to be more distinct than that of the Finnish.

Another significant difference between Estonian and Finnish respondents is the importance of the possibility of losing working capacity as a result of falling ill. Although it previously became apparent that the more health is valued, the more the Estonians see it as the opposite to suffering and death, but the Finnish respondents consider health as containing functional meanings; the danger of losing working capacity, however, plays an important role in the meanings of illness of Estonian respondents. In the case of Finnish respondents, the loss of working capacity is connected with difficulties in coping and the danger of changes in social roles (i.e. relations with other people and also the suffering due to disturbances in those relations). In the case of Estonian respondents, the danger of losing working capacity remains separate as a meaning of illness, being closely connected only with the danger of becoming physically disabled and becoming dependent. For the Finnish becoming physically disabled is mainly connected with individual suffering, and then with acting and working capacity.

In Estonia, in the culture of all ages, work has been particularly emphasised. Also in Soviet times the results of one's work played an important role in assessing people. We can assume that the working capacity plays an important role also in the welfare interpretation of the Estonians today. In the Estonian society, only having a job and deriving income from it enable coping with one's life. In Finland, however, one can receive also social subsidy during illness (Kotakari and Raudik 1995:191). In both countries efficient economic coping means also the possibility of getting better medical care.

One more notable difference between Estonian and Finnish respondents and health interpretations of both countries is the meaning of losing one's autonomy and the need for institutional care. Approximately 10% of Estonian respondents and slightly over 40% of Finnish respondents are afraid of going into a care institution. The broad network of care institutions in Finland is the indicator of a developed social security system of a welfare state that in certain respects can become an opposite to itself.

Comparing the differences between men and women, thus i.e. to what extent a factor connected with falling ill causes insecurity for men and women; thus what meanings are given to falling ill by men and by women – the general natural tendency shows that women experience fear due to almost all factors connected with falling ill more than men (see Table 1). Only losing working capacity causes significantly more fear for men than for women, both in Estonia and in Finland. However, there is a noteworthy difference between the two countries – in Finland the generic differences are much bigger than in Estonia.

Illness comprises social as well as individual meanings. To summarise we can say that in the case of Estonian respondents the social meanings of illness form two different complexes – in one of them work is emphasised, in the other social roles and in connection with them the weakening ability of mental coping are stressed. In the answers of Finnish respondents the social meanings of illness join into one factor. In the individual meanings of illness, the danger of the end of existence, suffering and loneliness play a significant role for Estonian respondents, the loss of autonomy and becoming dependent is of importance in the case of Finnish respondents.

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