CHAPTER 13

Ageing, Dying, and Death in the Twenty-first Century

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Overview

- What are the prevailing social attitudes towards death and dying?
- How are ageing, death, and dying experienced in Western society?
- What is ageism?

This chapter is concerned with the social construction of ageing, death, and dying in contemporary Australia. Experts are involved in institutional policy decisions, some arguing that the aged are a ‘social burden’, placing a strain on health and other resources as they become frail and immobile. While death, statistically, is postponed until old age for non-Indigenous Australians, there is an increased awareness of the risks associated with contemporary living and of ever-emerging new risks, which generate fears of death and suffering, even among the young. Medical life-and-death decisions have become complex as the boundaries between life and death have become blurred. Significantly, these decisions are being made within an environment of economic rationalism, with pressure on medical and health professions to cut health care costs. Medical, legal, and other discourses associated with the process of dying have provided a contemporary language for discussing death, but these discourses do not address ‘ontological insecurity’ (Giddens 1991)—that is, existential concerns that are likely to emerge in the experience of dying.

Key terms

ageism  
class  
collective conscience  
discourse  
etnicity  
economic rationalism  
euthanasia  
gross domestic product (GDP)  
gender  
globalisation  
ideology  
individualism  
medicalisation  
public health  
social construction  
social death  
state
Introduction

Biological life and death are not of themselves the reality that people experience and to which they respond. What is perceived as real and normal about events and processes such as ageing, dying, and death is **socially constructed**, and depends on the historical, social, and cultural contexts in which they occur and are given meaning. At the beginning of the twenty-first century in Australia, for example, the death of a young person is considered tragic because it is 'premature'. Not too far back in history, however, it was normal for the young to die; to reach old age was extraordinary.

Age structures are shifting radically as populations age, and it is predicted that this phenomenon will continue to have profound implications within the areas of health and medicine, as well as in the broader social, political, and economic spheres. These social processes are deeply connected with people’s lives. Anthony Giddens (1991) argues that a characteristic of ‘late modernity’ (present-day society) is the interconnection of individual experiences with **globalisation**. People may have little, if any, personal contact with death, but television brings into their homes graphic and selected images of death and dying from around the globe. At the institutional level, international agencies influence national policies, which affect individuals. Recommendations of the World Health Organization (WHO), for example, become translated into Australian health policies. These policies are reflected in health promotion and education activities, which assist people to maintain their health into old age. These are contemporary resources and strategies, which have become available, and which are replacing traditional relationships (Giddens 1991). In times of personal crisis—for example severe illness or bereavement—modern experts—doctors or counsellors—are more likely to be sought for guidance than is a priest. The terms ‘life span’ and ‘life cycle’ are representative of changes in life as people age. In past eras, the life cycle linked the generations and resonated with the seasonal cycles of nature. The cyclical notion of renewal following death provided death with meaning. No effort was required to believe in life after death, as it appeared to be perfectly natural that this was so. The life span, by contrast, is linear. It has a definite beginning and end. Emphasis is given to what can and ought to be done to improve the quality of the life span, and how it can be extended. Differences, even conflict, between generations are highlighted—for example between the baby boomers and generation X. The baby boomers, stereotypically, are accused of spending their children’s inheritance or conversely of becoming the ‘sandwich’ generation, ‘caught between parents who are living longer and children who won’t leave home’ (Sampson 2000). As Giddens (1991) argues, life in late modernity is profoundly different from life in earlier times. In his analysis the contemporary social world is forever changing, with an array of novel resources, previously unimaginable, becoming available to individuals to create their own

**social construction/constructionism**

Refers to the socially created characteristics of human life based on the idea that people actively construct reality, meaning it is neither ‘natural’ or inevitable. Therefore, notions of normality/abnormality, right/wrong, and health/illness are subjective human creations that should not be taken for granted.

**globalisation**

Political, social, economic, and cultural developments—such as the spread of multinational companies, information technology, and the role of international agencies—that result in people’s lives being increasingly influenced by global, rather than national or local, factors.
euthanasia
Meaning ‘gentle death’, the term is used to describe voluntary death, often medically assisted, as a result of incurable and painful disease.

public health/public health infrastructure
Public policies and infrastructure to prevent the onset and transmission of disease among the population, with a particular focus on sanitation and hygiene such as clean air, water, and food, and immunisation. Public health infrastructure refers specifically to the buildings, installations, and equipment necessary to ensure healthy living conditions for the population.

lifestyle, while traditional linkages, such as close family ties, lose significance. Giddens (1991) acknowledges that disadvantaged groups are marginalised or excluded from the new opportunities. Moreover, death, he argues, has been sequestered from social life. Not only has it physically been removed to the hospital, but questions and anxieties arising from the universality of human finitude have, at least until very recently, been repressed.

The health and medical care that elderly people can expect to receive is the result of institutional planning and strategies. Other social responses to the ageing population come from those experts who contribute to bodies of knowledge that affect experiences of ageing and old age. Expert knowledge informs health and medical practices, and influences or directly advises government policy-makers. In Australia, people continue to die in hospitals, but hospices and palliative care have come to be associated with dying. Euthanasia, although illegal in Australia, is receiving support as an alternative ‘good death’, while also generating controversy. Opinions concerning euthanasia are deeply divided among health and medical professionals. This may affect relationships between professional carers who are sharing the care of patients. The wider social context within which health and medicine are practised—especially economic and political concerns about escalating public health and medical costs—cannot be excluded from consideration. What are the consequences of all these conditions for the ways that ageing, death, and dying are experienced?

Historical overview

The age profile of Australia’s population has been changing due to people living longer and a declining birth rate. Figure 13.1 demonstrates these changes over the period 1901 to 2002, expressed as a percentage of men and women in certain age groups.

Life expectancy in Australia for both men and women has been rising in recent years, the magnitude of which can be gauged by the proportional increase in the elderly population aged 85 years and over of 165 per cent between the twenty-year period 1983 to 2003 (ABS 2004a). As the so-called baby boomers (those born between 1946 and 1965—a period of high birth rate) reach the age of 65 and over, the ageing of Australia will further increase. Although most countries in the world are experiencing a trend towards ageing, there continues to be huge discrepancies both between and within countries. In poor countries life expectancy can be as low as 37 years, with large numbers of children not reaching their fifth birthday (World Bank 2004). In contrast to the general ageing of the Australian population, only 2.8 per cent of Australia’s Indigenous population were aged 65 years and over in 2001 (ABS 2004; see chapter 6).

Throughout Western history, until relatively recently, it was uncommon for people to live into old age. Little could be done to control epidemics, diseases, infections, and childbirth
complications. Historian Philippe Aries (1981) suggests that, because of this, death remained 'tame' throughout most of the long history of Western civilisation; it had to be accepted as fate. Fate offered the solace of a better existence in the next world for those who righteously accepted life in this world as a 'vale of tears'. Slowly people became aware that life conditions were not completely out of their control and that action could be taken to improve some situations. The Enlightenment—an eighteenth-century intellectual movement—marked the beginning of a growing optimism that there were secular answers to life's problems. Causes, and therefore prevention and cures, of illness and disease could be discovered. Medical interventions such as vaccinations and antibiotics have generally been credited with the decline in mortality that has occurred in Western societies. Against this, it has been argued that public health measures, introduced earlier through quarantine and sanitary reform, were the reason for decline in disease. No doubt both public health measures and medical treatments have contributed to people living longer. Better standards of living—including working conditions, accommodation, availability and affordability of nutritious food, and education—have also made a significant difference.

The medical profession came to occupy a position of dominance in the health area, symbolised and institutionalised by the establishment of the prestigious modern hospital. Fighting to save lives became a central task of hospitals, which also became the sites at which deaths occurred when the battles were lost. Dying and death were thus removed from the homes and
neighbourhoods where they had always resided, thereby becoming separated from everyday life. The idea that death can be avoided or postponed indefinitely is fostered as people live increasingly longer lives, and younger deaths are seen as premature and abnormal. Optimism is invoked by claims that quality of life can be enhanced or maintained by healthy living. A steady stream of media reports inform people of the promising results of new curative or preventive research findings. Medical technology has become very sophisticated and expensive. People can be kept alive through surgical procedures such as heart bypasses, organ transplantsations, as well as continually updated pharmaceutical drugs and technological therapies. The mapping of the human genome has produced radical promises for the elimination of hereditary diseases (see chapter 12).

Somewhat paradoxically in the light of these actual and potential achievements aimed at conquering death, together with the institutional sequestering of death, dying and death are returning to everyday life. The limitations of medical technology’s endeavour to eliminate diseases are apparent in the chronic, sometimes debilitating, ailments associated with ageing. Also, technology blurs the distinction between life and death: is chemotherapy, for instance, prolonging life or prolonging the dying process? With increasing awareness of risk, and of ever-emerging new risks, life seems dramatically less secure. Death may be lurking in unprotected sex, contaminated food, the very air we breathe.

The social construction of old age

There are considerable differences in social and cultural responses to old age and hence in meanings and experiences associated with old age, some of which are discussed in this chapter. Subjectively, people have very different views of when old age begins. To children, thirty years of age can seem old but in today’s society, where everyone is encouraged to lead a healthy, active lifestyle, many aged people may not feel old. A particular construction of old age that has disappeared is the virtue of ‘growing old gracefully’, in contrast with what was derided as ‘mutton dressed up as lamb’. In today’s consumerist society ageless faces and ‘taut and terrific’ bodies are displayed in the media as the norm to be desired and achieved. Anti-ageing theorists, such as Deepak Chopra, argue that while chronological age (age from birth) cannot be altered, biological age (functioning of body) and subjective, psychological age (how young a person feels) can be changed. Older people can be ‘rejuvenated’ by means of, for example, meditation, injections, cosmetics, exercise, vitamins, nutrition, ‘detoxing’, fasting, and surgery. Nature no longer determines ageing processes involved in diminishing sexual prowess of men who can now become sexually youthful with a chemically induced erection.

When do people become old?

For much of the twentieth century, the legal age for male retirement from the workforce was 65 years, and this age became the hallmark of a socially defined ‘old age’ in countries such as Australia. From the latter part of the twentieth century there have been dramatic changes that
have confused meanings of old age. Since the latter part of the twentieth century there have been dramatic changes that have made ‘old age’ an ambiguous term. The social definition of ‘old age’ is no longer strictly determined by the age of retirement. The statutory age for men to receive an age pension was traditionally 65 years and for women 60 years, though since 2004 women’s retirement age has been changed to match that for men. These classifications are in contradiction with the marked shift that has been occurring in the requirements of the labour market. The workplace has changed dramatically from the time when men were the breadwinners and women the homemakers. Women have entered the workforce, capitalism has globalised, casual work has increased at the expense of full-time work, and workers face constant job-insecurity. Many workers are retiring early and in most cases this is not simply a matter of choice. Workers, now referred to as resources—human resources—become redundant as their skills become outdated or as companies ‘downsize’, or shift their production or services ‘off shore’. While the current federal government wants to encourage older workers to remain economically independent by continuing in the workforce, it is not clear how this is to be achieved. Without the government resorting to coercive mechanisms it would seem that only those older people whose skills are perceived to be valuable to an employer and who consider their remuneration worthwhile are likely to freely make this choice.

Retirement incomes in transition: changing experiences of old age

Following Federation in Australia a national provision for a flat-rate age pension was introduced, and the age pension has remained the retirement income of most Australians, although this is now changing. Historically, many developed countries, especially in Europe, have had a compulsory earnings-related retirement pension system, or a system combining universal and earnings-related pensions. The universal age pension in Australia, which traditionally most Australian retirees have relied on as their sole income, has been low by comparison. Nevertheless, throughout the industrial era Australians accepted their modest, non-contributory age pension as their right, an acknowledgement as citizens who had contributed to their country through years of hard work and paid taxes. The view was that the *state’s* wealth and prosperity was due to the communal contribution of citizens, without regard to particular levels of individual contribution, so that all citizens were entitled to support when no longer able to provide for themselves (Macintyre 1999).

In many countries across the globe, including Australia, a current concern associated with increasing ageing populations is the ‘looming’ prospect of fiscal strain on governments, particularly in financing pensions and health care. This is occurring at a time when *individualism* and *economic rationalism* have become dominant ideologies.

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**state**
A term used to describe a collection of institutions, including the parliament (government and Opposition political parties), the public-sector bureaucracy, the military, the police.

**individualism/individualisation**
A belief or process supporting the primacy of individual choice, freedom, and self-responsibility.

**economic rationalism/economic liberalism**
Terms used to describe a political philosophy based on small-government and market-oriented policies, such as deregulation, privatisation, reduced government spending, and lower taxation.
Individuals are expected to be personally responsible for their own retirement income (Macintyre 1999). The young cannot delay contemplating their old age, and are targeted by financial institutions with the message that they must plan ahead and start saving for their retirement if they wish to maintain a comfortable lifestyle. With the Australian non-contributory age pension no longer perceived as an entitlement on the merit of past contributions, but operating on a ‘pay-as-you-go’ principle, age pensioners are identified as being dependent on the taxation contributions of current workers. Caught in the transitional period of a transforming ideology, ageing baby boomers heading towards retirement, who had reasonably expected to receive an age pension, are being labelled as selfish and irresponsible for not having financed their own retirement.

In an effort to limit the age pension to a ‘safety net’ for those most in need, the Australian government introduced a compulsory Superannuation Guarantee scheme in 1992, requiring employers whose employees earn $450 a month or more to make superannuation contributions on behalf of their employees to private superannuation funds. The level of superannuation under this scheme commenced at 3 per cent of an employee’s income and has gradually increased to 9 per cent. With the exception of employees in the public sector, personal contributions to superannuation are generally voluntary. Not surprisingly, low income earners have been less likely to make personal contributions (yet those on the highest incomes are also less likely to contribute to superannuation, presumably making more lucrative investments) (ABS 2004). To encourage lower income earners to make personal contributions to superannuation, the Australian government has introduced Super Co-contribution. Currently, those earning between $28,000 and $58,000 are entitled to a co-contribution from the government, with the maximum assistance of $1500 per annum given to those on the lower threshold, who themselves contribute this amount (Australian Taxation Office 2004).

In contrast to what occurred during much of the twentieth century, it seems likely that experiences of old age in the twenty-first century will be individualised, as the greater the disposable incomes that individuals have, the more chance they have of investing their money, or paying higher levels of superannuation, in order to maximise their retirement income. Greater disparity between retirement incomes is likely between those with the resources to plan ahead and save for their retirement and others unable to do so. Low paid workers and those with limited participation in the workforce—for example many women and workers in industries where there is a practice of employing labour on a casual basis—will remain dependent on the age pension.

Ageism

Ageism, according to Hepworth (1995, p. 177), is ‘prejudice against older people collectively stereotyped as a section of the population disqualified by reason of their chronological age from making a full contribution to society’. A popular belief is that the elderly are not
valued in our technological society because the knowledge they have acquired over their life-
time is irrelevant, whereas the aged were respected in bygone days for their wisdom. Historical
studies indicate, however, that attitudes towards the elderly have fluctuated over time and
between cultures (Bytheway 1995). The significant question is how ageism is constructed in
today’s society. The workplace has become ageist. Many workers in their forties and fifties,
especially males, are considered too old for retraining after being made redundant.

Stereotypical views of old age also contribute to ageism. Old age is associated with mem-
ory loss, incontinence, lack of cleanliness, making mistakes, slowness, becoming argumentative
or withdrawn, or acting childishly. Old age is considered something to be feared, as it is
increasingly associated with becoming demented. This embedded view is in sharp contrast with
the contemporary value placed on youth, health, and fitness. There is little wonder that for
many, old age has become something to postpone as long as possible. Moreover, aged people
may themselves internalise ageist views, their feelings of self-worth diminished by their loss of
youth, fitness, and choice.

The current terminology of ‘agelessness’ may be perceived as introducing a positive attitude
to old age, but this is questionable. Molly Andrews (1999, p. 301) cautions that it is a seduc-
tive term, allowing us to believe ‘we can transcend age’. Such an anti-ageing stance denies the
importance of individuals’ biographies in terms of the role played by unique life experiences in
the ‘ageing’ process. Agelessness is compatible with secular society, by evoking images of an
earthly life where ageing can be avoided. At the most, agelessness can only offer a temporal
transcendence, in contrast with traditional religious hope for immortal life beyond the poor
health and death that naturally accompany old age.

The mass media, in their variety of forms—television, films, magazines, billboards, and
the Internet, particularly through advertising—provide stereotypical images of age. Elderly
people may be presented as incompetent. Consider, for example, Eldie’s mother in Absolutely
Fabulous. Retirement finance or housing are often accompanied by images of a smiling and contented older couple. As the so-called baby boomers reach ‘old age’ they will become increasingly targeted by corporations and it will be interesting to see what
marketing images will be used. Old age is attributed to a diverse group of people whose ages range from 50 to over 80, depending on how old age is defined. Stereotypical images oversimplify, being unable to cap-
ture the diverse situations of older people, or the effects that their dif-
ferent gender and cultural backgrounds, or their class positions, have
on their lives.

Ageism can result in the progressive exclusion of elderly people from the social world, a situation for which Mulray (1993) has coined the term ‘social death’, and which can occur well before biological death. Many people’s lives become more restricted as they retire and have less income. Over a period of time they become frail, are marginalised by family members, are visited less frequently, and become socially isolated. Finally they cease ‘to exist as an active agent in the ongoing social world of some other party’ and become a ‘non-person’ (Mulray 1993, pp. 33–6).

class (or social class)
A position in a system of structured inequality based on the unequal distribution of
power, wealth, income, and status. People who share a class position typically share similar life chances.

social death
The marginalisation and exclusion of elderly people from everyday life, resulting
in social isolation.
Ironically, stereotypical and ambivalent images of ageing and old age are also constructed by experts, through bodies of knowledge that are generated in order to provide ways of understanding ageing and old age. Specialised forms of knowledge inform the practices of medical and health professions, as well as the practices of bureaucrats and others involved with making policies that affect the aged or aged care. Experts define the problems and solutions connected with old age, and policies are developed from the ways that experts define old age. The construction of age by experts establishes images of what is ‘normal’ for particular age groups. The result is contradictory. On the one hand, old age is presented as a burgeoning social problem, as the numbers of people living longer increase and become an economic and social burden. On the other hand, the aged are perceived as being responsible for their own quality of life, and having the potential to remain healthy and active participants in society. Both approaches are ageist constructions, contributing to stereotypical views.

**Old age as a ‘social burden’**

Nationally and internationally, rather than the longevity of populations being appreciated as an achievement to be applauded, this trend is being viewed increasingly with dismay. Indeed, current concern about the perceived burden of the aged is said to be reaching the level of hysteria, with a ‘sense of impending crisis’ pervading several international reports (Walker 1990, p. 378). It has become commonplace for newspaper reports to blame the present and future aged for a predicted looming economic crisis under alarming headlines. On 25 November 2004, for example, visitors to the web page of the *Sydney Morning Herald* were greeted with, ‘Health costs to double in 40 years’ because in 40 years’ time people over 65 will constitute over a quarter of the Australian population (Metherell 2004). Another headline extolled, ‘Growing fears over booming aged numbers’ with the Productivity Commission predicting that ageing ‘will open a “fiscal gap” of 7 per cent of gross domestic product for federal and State governments by 2045’ (Wade 2004).

Key economic advisers to the Australian federal government present the aged as an expanding group of unproductive people who, as they age further, will require increasingly high levels of health care and other resources (National Commission of Audit 1996, pp. 124–33). While it is hardly surprising that older Australians have more health problems than younger Australians and that this is reflected in higher health care expenditure, costs should be interpreted carefully. Data from the Australian Institute of Health and Welfare (1999b) show, for example, that 35 per cent of the total health services expenditure in 1993–94 was used by Australians aged 65 years and over, although they comprise only 12 per cent of the total Australian population. The authors explain that over the period they were studying, 1982–83 to 1994–95, costs associated with an ageing population contributed to only 0.6 per cent of the growth in health expenditure. New technologies and increasing pharmaceuticals costs were major contributing factors. Apart from that, total health services expenditure does not refer simply to government spending but includes non-government spending, more than half of which is individuals’ own spending on their health services. Total health service expenditure also includes health insurance, which is comprised of

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gross domestic product (GDP)
The market value of all goods and services that have been sold during a year.
individuals’ contributions. Added to this, the source of Medicare funding is individual contributions through taxation. Much of the health care costs attributed to older Australians actually refers to accommodation expenses in nursing homes for the very old. It needs to be borne in mind, too, that older Australians paid taxes over the years of their employment and that many contributed to health insurance schemes during the years when they were younger and healthy, but in their old age, when they are likely to be in most need of health services, many can no longer afford to pay the high premiums required of them. It may well be asked whether health insurance companies are taking advantage of many older Australians by taking their money through their young and healthy years, but providing services only to the aged who can continue to pay high premiums. Leading up to the 2004 federal election, while the Labor Party promised free hospitalisation to all people aged 75 years and older through MedicareGold, the Coalition offered assistance (a rebate) only to aged people with private health insurance.

Ross Gittins, economics editor for the Sydney Morning Herald, is one economist who believes that the elderly are being unfairly blamed for predicted federal budget deficits, stating, ‘Ageing isn’t the villain …’. His interpretation of the Intergenerational Report suggests that ‘less than a third of the projected increase in health care spending is related to the ageing of the population’ (Gittens 2004). He also argues that it should not be seen to be a bad idea to introduce higher taxation in order to meet future government spending.

Another argument for the aged being a social burden is that they constitute the major unemployed, and therefore economically-dependent, group. As a result of an expected huge increase in the numbers of people 65 years and over, it is projected that economic dependence in Australia will increase dramatically during the twenty-first century. These projections are questionable. Projections 40 to 60 years into the future can be based only on present trends and on present interpretations of prevailing and perceived future conditions, yet usually there is little, if any, admission of uncertainty.

These estimates do not take account of the fact that a portion of retired people over the age of 65 years are wealthy and independent. Nearly 28 per cent of Australia’s invested wealth is owned by males 65 years and over and females 60 years and over (National Commission of Audit 1996, p. 139). This reflects, at least in part, the historically high rate of home ownership in Australia, although the bulk of the wealth is likely to be confined to a small number of very wealthy older Australians. It can also be argued that the definition of economic dependency is too narrow for other reasons. Older people’s past contributions to the economy during their working lives, taxes paid during that time, unofficial caring and financial assistance provided to adult children and grandchildren, and other voluntary work are all discounted. The benefit of these services to the nation is ignored. Further, stereotyping the aged as a collective social burden has sexist implications, as well as being ageist, because the majority of older people are women. Finally, anxiety about the baby boomers becoming a burgeoning social burden neglects the growing influence of aged people with disposable income as a market sector for a range of services (ABS 1999c). Employment will be generated in the tourist industry, for example, to cater for the growing numbers of retired travellers.

With the increase in casual and part-time work at the expense of full-time employment, it will be difficult for many younger people to buy their own home and save for their future retirement.
The causes and solutions do not lie with these victims of global capitalism and economic rationalism, but with government policies.

The situation is complex, as power, wealth, and health are unequally distributed among the aged and those who will age in the future. Social class, status, gender, and ethnicity may be contributing factors in determining whether people retire with chronic health problems, resulting from long years of repetitive or heavy manual work, or whether they retain positions of power for many more years as members of boards of directors or as consultants. The recent policies and strategies that have been set in place for differential retirement incomes will exacerbate these inequalities. It is well to remember that terms are never neutral. While experts warn that the ageing masses are likely to be a ‘social burden’, this term is not directed at, say, ex-politicians, most of whom retain substantial benefits at public expense throughout their retirement.

‘Successful ageing’

Recognition of the discriminatory effects of ageism, especially in a world that is rapidly ageing, has prompted resistance to the notion of the aged as a ‘social burden’. Theoretically this cause has been assisted through Laslett’s identification of a stage in life that has become known as the ‘third age’. Laslett states that nearly all elderly are, or have the potential to be, healthy and active, and many are highly productive. Conceivably the length of this period could be extensive, as the biological limits of the human life span are uncertain, with predictions ranging as high as 120 years, or even well beyond (Laslett 1989, p. 13). Health promotion focuses on the healthy elderly, who age ‘successfully’, and offers advice to encourage individual responsibility for maintaining healthy lifestyles into old age. Age is no longer perceived as a barrier to health promotion activities. It is possible for older people to achieve measurable health improvements and fitness levels. To be healthy has become a moral imperative; to age ‘successfully’ is a moral duty.

Within this positive view of ageing, the continuing rise in life expectancy poses the possibility of life continuing indefinitely. Illness, deterioration, and death do not fit into the construction of ‘positive health’. Death cannot, in the end, be denied, but with medical cures and disease prevention, death may be postponed, avoided, or resisted. Individuals are encouraged to concentrate on daily healthy living (choosing and eating healthy foods, making time for daily exercise, coping with stressful situations as they arise). They are reassured by the continuing advancement of medical techniques to combat disease (for example bypass surgery, transplantations, chemotherapy, and so on) and, more recently, by the potential of genetic intervention. The result of the construction of ‘positive’ or ‘successful ageing is the idea of an indefinitely extended and healthy middle age, with death coming quickly at the end of a satisfactory life. Aged people are likely to be more realistic, however, having experienced, and continuing to experience losses through their own illnesses or disabilities and the death of those close to them.
In *Australia’s Health 2004*, the diversity in health of those aged 65 and older is recognised by categorising older Australians into three groups in assessing their health: those 65 to 74 years, 75 to 84, and 85 and over. The studies on which this report is based, indicated that despite the fact that over 50 per cent of people over 65 had a long-term disability that restricted everyday activity and most did no exercise, or had low levels of physical activity, the great majority in all of the above age groups considered themselves to have good to excellent health (AIHW 2004, p. 384). Most older people in these studies thus appear to appraise their own well-being from the vantage point of their age in common with others, and what realistically can be expected, rather than aspiring to ‘successful’ ageing and the expectation that they remain healthy and fit for as long as possible.

It is the final stage of life that is one of ‘decrepitude and dependency’ according to Laslett (1989). He suggests that the repercussions are profound: for personal relations (in terms of time and effort), especially for families, and for national budgets (in terms of supplying hospital and medical care) (Laslett 1989, p. 13). It is during this final stage, then, that old age is perceived as a social burden. That the last years of a person’s life are represented by the term ‘social burden’ says much about the way old age is constructed by experts in today’s society. Measuring and discussing chronic illness and dependence on the services of others in terms of cost ignores personal suffering, as well as the right of everyone, regardless of age, to be treated with dignity.

### Services for the aged

Most aged, even frail aged, manage to remain at home rather than go into institutional care. Institutional care is expensive and takes people, in their declining years, away from all that is familiar to them. A number of community care programs are available to assist the elderly to stay at home. In Australia and other Western countries, residential care is restricted to those who are assessed—in Australia, by Aged Care Assessment Teams—as being unable to be appropriately supported at home. Two levels of residential care are available: high level (nursing homes) and low level (hostels).

Fees for these aged residential care services are income-tested, with quarterly reviews. From 1 July 2004 the maximum basic daily care fee that can be charged is $27.15, but for permanent non-pensioners, or those needing more than basic daily care, an additional accommodation fee of up to $16.25 per day is payable. In addition, an accommodation bond of up to $116,500 is payable for those calculated as having sufficient assets. The service provider is allowed to retain interest rates derived from the bond, keep a retention amount (for building maintenance, upgrades and so on), and refund the residue of the bond (if any) when the resident leaves, or more likely dies (DOHA 2004a).

Aged people who are dependent and frail, especially if they are poor and unable to contribute to their care, have, in a very real sense, become captives in institutions—nursing homes and hostels. Many of these institutions, in numerous ways, resemble workplaces rather than homes. The quality of services—including availability of privacy, leisure activities, timing of meals, and so on—is determined by staffing needs and salary awards (Fine 1988, p. 71). All
residential aged care services receiving Commonwealth subsidies have been accredited as meeting the standards that are expected of them (Aged Care Standards and Accreditation Agency 2004), yet it is reported that the Aged Rights Advocacy Service (ARAS) received over one thousand complaints on residential care issues during the period 2003 to 2004. These are likely to be the ‘tip of the iceberg’, owing to fear of retribution. Some incidents reported to ARAS involved having urine tipped over clothes, rough handling, and verbal abuse (Pippos 2004). This appears to be a growing social problem that requires investigation, not merely at the incident level, but in relation to the appropriateness and adequacy of the training of professional carers, their working conditions, and resident management, as well as government policy and funding (DOHA 2004b, c).

The provision of care to assist aged people to remain at home is the preferred option for the frail aged and a number of Community Aged Care Packages (CACPs) offer appropriate help to those assessed as eligible by an Aged Care Assessment Team, for instance, with personal hygiene, social support, transport, laundry, meal preparation, and gardening. Clients are charged according to their income and the level of services they require. The maximum care recipient contribution per day is $5.67, based on 17.5 per cent of the maximum basic rate of the pension at $453.60 per fortnight.

An ideology of ‘community’ has accompanied governmental decisions to rely more on non-institutional, rather than institutional, care. Notions of ‘community’ carry connotations of neighbourhoods in which people have the time and motivation to help one another, and especially to be willing to care for the sick and needy in their midst. Instead, modern suburbia can be isolating, with people being divided by traffic, urban developments, and poor public transport. Acutely ill people remain in hospital for only a short time as a result of prevailing budgetary constraints; they are discharged before being able to resume their own care and consequently may require intensive home support services. This may mean that services for the

| Table 13.1 | Informal and formal assistance for persons 65 years and over, 1998 |
|-------------|-----------------|-----------------|-----------------|
| Source of assistance | 65–79 years (%) | 80 years and over (%) | 65 years and over (%) |
| Informal | 82.9 | 84.2 | 83.3 |
| Family* | 76.1 | 76.6 | 76.3 |
| Partner | 42.9 | 16.7 | 34.5 |
| Adult child | 26.7 | 33.8 | 28.9 |
| Friends | 13.8 | 15.7 | 14.4 |
| Formal | 55.9 | 66.9 | 59.4 |
| Private for-profit | 39.7 | 43.8 | 41.0 |
| Private not-for-profit | 6.5 | 13.5 | 8.7 |
| Government | 24.1 | 35.8 | 27.8 |

* People may receive assistance from more than one source and therefore components do not add to totals.

Source: Adapted from ABS 1999b
frail aged with chronic problems may not be a priority and that they must fend for themselves, pay for services if they can afford it, or rely on voluntary assistance or family support. The burden of home or ‘community’ care, to a very large extent, falls back on the family, and in particular on those in the family who are willing to take up and maintain the responsibility of caring for their elderly relatives. Table 13.1 shows that the largest source of ‘community’ assistance is informal, being provided by family and/or friends, and that to a large extent individuals pay for the formal services they receive.

In many cases family members, most often the female members, have multiple caring responsibilities, such as looking after dependent children, as well as aged parents, or providing assistance to their adult children and grandchildren, as well as an aged spouse or parent. It appears that abuse of the elderly is carried out mainly by their own children, and that the common harm is financial exploitation (Propos & Clarke 2003). The term ‘abuse of the elderly’ is emotion-laden and requires clarifying in terms of what constitutes professional abuse (discussed previously) and family abuse. Further research is required to gain a more comprehensive understanding of the social conditions in which abuse arises.

Dying and death

Most people in Australia die after the age of 65. In 1998, for example, 78 per cent of all deaths were of Australians aged 65 years and over—an increase from 63 per cent in 1968 and 72 per cent in 1988—while a quarter of all registered deaths in 1998 were of persons aged 85 years and over, which is double the proportion of such deaths in 1968 (ABS 1999a). The health and social problems of Aboriginal people and Torres Strait Islanders are reflected in the fact that they die twenty years earlier than the rest of the population. While the death of old people is accepted—they are said to have had their ‘good innings’—young deaths are perceived as premature, and therefore problematic. Some deaths are not caused by disease—for example accidents, motor vehicle traffic accidents, suicide, and homicide—but cancer and ischaemic heart disease are the main causes of death in Australia.

Death has become an ambivalent process, rather than an event. Brain death has become the accepted criterion for death so that an apparently live patient whose heart is still beating but whose brain no longer functions is declared dead, thus becoming a source of fresh body parts for patients who would otherwise die. Medical intervention can retard the advancement of many diseases, which once would have killed more quickly, so that it is possible for individuals to continue their normal social activities for months, or even years, after having been diagnosed with a terminal illness, albeit often in a state of uncertainty about how much future they have. Patients are now likely to be informed of their dying status, and urged to make preparations for the time when they may no longer be competent to make decisions. They can discuss their preferences for their final stages of life and for their death—for example their medical treatment and funeral. Living wills or advance directives can be drawn up and/or an enduring power of attorney given to a trusted person to ensure, as much as possible, that the dying maintain control over their lives. The underlying assumption is that all people want to be informed
that they are dying, that they all have the knowledge, and the will, to plan ahead—to consider their potential future circumstances, and choose possible alternative ways of dying—and that their wishes will be adhered to.

New ethical issues have arisen in relation to death and dying for which there is often no easy solution. People are encouraged to donate organs in order to save lives, but executed prisoners in China have their organs taken. In some countries there is a black market in organs. In Australia, the kidney supplied to Kerry Packer by his employee raises the question about the meaning of ‘donation’. There is also the question as to how patients are selected as organ recipients. How many Aboriginal people, for example, have received organ transplantations? Challenging ethical questions arise in relation to dying, such as, in relation to the withdrawal of treatment, at what stage should patients be taken off ventilators? Who decides, and when, whether the lives of patients who have suffered severe brain trauma will continue to be worthwhile? Is it ever ethical to withdraw nutrition and fluid from a patient? Should euthanasia be legalised in Australia, and if so, what should be the conditions of its legalisation? Should priority be given, in terms of health care costs, research, and expertise, to more sophisticated technology and treatment, or to palliative treatment for the chronically ill and dying?

A good death

The ideal ‘good death’, prior to its medicalisation, and prior to the secularisation of society, was to die at home, surrounded by friends and neighbours, accepting this last earthly suffering as a preparation for eternal life after death. Death often came early and relatively quickly, as there was little that medical therapies or the medical profession could do. In the face of the inevitable, the doctor retreated, leaving the priest to perform the last rites. When the hospital became the place where people were sent to be cured, or to die, no longer was the dying person, or the person’s family, in charge of the dying process. The patient became the property of the hospital, with visiting hours restricted and subject to hospital rules for the convenience of hospital organisation and staff. The image of dying in hospital became that of patients attached to an arsenal of equipment in a futile attempt to defeat death, and resulting only in the unnecessary prolongation of their suffering. This is likely to have contributed to prevalent fears of experiencing suffering, degradation, and loss of control during a drawn-out dying period. People are made more fearful by descriptive media accounts of dying with cancer, HIV/AIDS, and dementia.

Palliative care and, more recently, euthanasia may be thought of as providing contemporary ideals of a ‘good death’. A good death may be envisaged as having a period of time during which the dying individual and relatives prepare for their forthcoming separation, for affairs to be put in order, and for the spiritual side of death to be approached. The aim of palliative care is to alleviate suffering in order to allow for these opportunities. Others may wish to die suddenly and painlessly after living a healthy, active life in old age, and when nature does not oblige, euthanasia or physician-assisted suicide may appear to offer a good death.
Palliative care

Palliative care is usually associated with care offered to the dying within a hospice. Hospices are not available to all the dying in Australia—for example to those living in rural areas or the elderly in nursing homes. While local medical and health workers are able to provide palliative care, doctors and nurses in hospices specialise in palliative care. The word ‘hospice’ derives from the hospice of medieval Europe, which offered refuge to pilgrims as well as to the sick and destitute. Cicely Saunders is regarded as the founder of the modern hospice movement at St Christopher’s Hospice, London, in 1967. Hospices can provide both in-patient care and care to patients in their own homes. The aim is to offer comprehensive support by controlling pain and other symptoms, as well as addressing the psychological, social, and spiritual needs of the dying person.

In recent years, the limitations of palliative care have been pointed out. Individuals have their own particular needs and it is argued that, especially as hospices have become more medicalised and institutionalised, tension has developed between the maintenance of the ideal of a good death and the maintenance of the hospice organisation (McNamara et al. 1994). Hospices have tended to focus on patients with cancer and, more recently, HIV/AIDS, while excluding other types of illness. Palliative care may be restricted to achieving pain relief, which may necessitate rendering patients unconscious. While palliative care has become the professional domain of nursing and medicine, the professor of palliative care at La Trobe University is sociologist, Professor Allan Kellehear. Kellehear (1999) argues that palliative care is underdeveloped and should be available to those with life-threatening illness, rather than only to those in the later stages of terminal illness. It should be concerned with promoting the health of the ill as well as wider social aspects of illness. Palliative carers have traditionally been opposed to views supportive of euthanasia, aiming neither to hasten death nor to prolong dying. Yet, while such views continue, they are becoming less than universal. The Australian government is opposed to euthanasia and has published its first Guidelines to a Palliative Approach in Residential Aged Care (DOHA 2004b).

Euthanasia

Euthanasia and physician-assisted suicide provide the medical means of ending life that is perceived as being unbearable, usually, although not necessarily, in relation to terminal illness. These actions are illegal in most countries. The Netherlands is a well-known exception, and physician-assisted suicide has been allowed in the US State of Oregon since 1997. For a short time in Australia, euthanasia and physician-assisted suicide for the terminally ill were permitted in the Northern Territory. This was during the period from July 1996 until March 1997 when the Commonwealth Government overturned the Northern Territory’s legislation.

The ‘requested death’ movement, which, through groups such as the Voluntary Euthanasia Society and the Hemlock Society, advocate the legalisation of euthanasia and physician-assisted suicide, appears to be strongly supported by the public, according to public opinion surveys.

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McInerney (2000), however, discusses the uncertainty of meaning that can be attached to such surveys as survey results may be contradicted by voting results.

The word ‘euthanasia’ literally means a ‘good death’, or ‘dying well’, but within the complex debate that has emerged there are conflicting opinions about what constitutes the practice of euthanasia. The very definition of the term, therefore, is in dispute, and this can cause much confusion when posing the question ‘What is euthanasia?’ The injection of a lethal drug dose by a doctor, with the explicit intention of terminating life at the request of a patient who is competent to make decisions, is voluntary euthanasia, sometimes referred to as ‘active’ euthanasia. When a doctor does not directly cause death, but prescribes or provides the substance that causes death, it is regarded as physician-assisted suicide. This is closely aligned with voluntary ‘active’ euthanasia in that the intention of the doctor and patient is to actively cause the patient’s death, but in physician-assisted suicide, the patient self-administers the fatal dose.

The withdrawal of medical treatment from the terminally ill when it is considered to be useless, and the provision of drugs to the terminally ill to relieve pain knowing that this may result in death, have traditionally been accepted as good medical practices. These measures are sometimes referred to as ‘passive’ euthanasia. It has generally been accepted by the medical profession that while death may be the side effect of pain relief, the intention is to relieve pain, not end life, and also, that if individuals die after the withdrawal of useless treatment, they are merely being allowed to die naturally from their disease, without having their lives artificially prolonged. Within the current euthanasia debate, however, euthanasia supporters may argue that such practices cannot be divorced from ‘active’ euthanasia, because the end result is the same—death.

Euthanasia can also be non-voluntary, as was the case in Nazi Germany where killings, sanctioned by the state under Nazi rule, were carried out by doctors (Morgan 1996, pp. 12–14). This is, of course, murder. Euthanasia intentionally administered to patients who are incapable of making decisions (such as the severely demented), or those unable to make their wishes known (for example the unconscious), is referred to as involuntary euthanasia. Supporters of voluntary euthanasia (for example Baume 1995, p. 14) suggest that the problem of involuntary euthanasia can be overcome by competent people leaving clear instructions of their wishes in a living will or advance directive, as well as appointing an enduring power of attorney to act on their behalf in the case of their becoming incompetent. Against this is the argument that even if these measures become widespread, people may change their mind over time. As well, from a legal perspective, written instructions must be extremely precise and do not guarantee medical compliance (Hoffenburg 1996, pp. 94–5).

Supporters of euthanasia usually focus on arguments for voluntary euthanasia by appealing to the right of individuals to control their own death. The reasoning is that legislation upholding this right will have no impact on others, who can simply refrain from exercising this prerogative. According to this view, legalised voluntary euthanasia provides justice for all. A law that denies choice is unjust and oppressive to those who decide that life has become unbearable for them, or that it has lost any qualities that would make it worthwhile. Opponents of legalised voluntary euthanasia often evoke what is called the ‘slippery slope’ (or ‘thin edge of the wedge’) argument to support their case. They assert that it is not simply a matter of individual rights, but that changing attitudes resulting from the legislation will eventually lead to
the acceptance of some forms of non-voluntary euthanasia whereby the quality of life of those considered too socially burdensome may be perceived as being not worthwhile. While the debate continues, ethical decisions about whether to continue treatment are being taken daily in hospitals. A recent event demonstrates the opposing views that families and the medical profession may take. The family of an elderly man, in a deep coma for several weeks, lost a court battle to keep him on life support at St George Hospital, Sydney. Doctors had intended to place him under palliative care, but he died 15 minutes after life support was removed (Sydney Morning Herald, 12 November 2004).

**Future directions: death and dying**

The euthanasia debate has highlighted, and probably provoked, attitudinal divisions among medical and health professionals, but what they have in common is a paramount aim to relieve the suffering of dying patients. While pain relief is only one factor driving the euthanasia debate, it is a serious factor for those dying patients who suffer uncontrolled pain, and for others who fear that this will be their fate. The interest of researchers and funding bodies, as well as of appropriately trained medical and health practitioners, is required to bring adequate and sustained pain relief to the dying, which at the same time allows them to retain some control over their lives.

Euthanasia and physician-assisted suicide are morally wrong, according to the main religions in Australia, most notably the Catholic and Anglican religions. Religion, according to Émile Durkheim, provides a *collective conscience*—that is, a moral framework that transcends any individual conscience or morality (Durkheim 1893/1984). Many people, however, no longer accept moral answers based on traditional authority. Giddens (1991) suggests that, although traditional authority, including religion, continues to exist, there are many other competing authorities in the modern world of expertise (Giddens 1991, p. 195). The modern world is characterised by expert systems in all areas of life. Individuals are presented with choices from a wide range of contested and changing bodies of expert knowledge and techniques (Giddens 1991, pp. 18, 121). When making life-and-death decisions during times of illness, medicine, rather than religion, is likely to be regarded as more significant because of the high value that is placed on medical knowledge and technology that can save or maintain life. Alternative healing methods have become popular for some, either to complement medical treatment or to replace it when treatment is not achieving a cure or reprieve (see chapter 17). Medicine, however, remains the area of expertise that controls the knowledge, drugs, and technology associated with health and illness, and the dying process.

Medical and health professionals are under increasing pressure to consider the economic outcome of their practices, as the Australian government, following world trends, is seeking methods to achieve cost-efficiencies in distributing funds and setting priorities for the allocation of health services. Medical life-and-death decisions are being made within this environment, and are no doubt influenced by it. Perceived quality of life is an important factor in making such decisions, but ‘quality of life’ is not a neutral term.
Historically religion has provided a language for speaking about death to the dying, but from the time death was ‘transferred’ from home to hospital, and for the first half of the twentieth century, death became something of an embarrassment. It was felt that dying persons should remain unaware of their fate, and instead be kept in a state of hopefulness of a medical cure. Now there are new ways of speaking about death, derived especially from medical and legal discourses. Individuals can decide whether they wish to become an organ donor, to appoint an enduring power of attorney, discuss medical treatment such as chemotherapy, and so on. Such language encourages discussion of end-of-life decisions, but does not encourage discussion of existential questions and anxieties that may emerge when individuals are facing their mortality. For the dying, the reality and taken-for-grantedness of everyday life may be called into question, and they may face questions about the meaning of their existence, experiencing what Giddens (1991) calls ‘ontological insecurity’. Sociologists tend not to speak intimately about death, but Kellehear (1999) recognises the importance of understanding the significance of death's meaning for the dying. He states that although many people, especially the well-educated from professional classes—the experts—believe life begins and ends with material embodiment, most people believe in personal survival after biological death. Perhaps all individuals are seekers of immortality in some way. The better educated and the wealthy may simply pin their hopes on achieving secular rather than, or even as well as, spiritual, immortality, as they have more chance of leaving something of lasting material value after their death.

Summary of main points

- It is often taken for granted that death and dying are associated with old age. For most of human history, however, it has been uncommon for people to reach old age. This continues to be the case in many Third World countries, although this is changing.
- In all countries of the world, people are living longer, although there are differences both between and within countries. Aboriginal Australians and Torres Strait Islanders, for example, have a lower life expectancy than the rest of the Australian population.
- Health, fitness, and youth are dominant values in modern society, and this contributes to ageist attitudes towards those who display characteristics associated with old age.
- Expert bodies of knowledge have constructed conflicting stereotypical views of old age. Within these constructions, the aged are either a ‘social burden’ draining scarce resources, or proof that the ills associated with old age can be avoided.
Within the bioethical construction of euthanasia, the proponents of legalised voluntary euthanasia argue that it will enable individual autonomy in life-and-death decision-making. Those opposing legalisation argue that it will lead inevitably to some form of non-voluntary euthanasia and to disregard for human life.

Medical experts control the knowledge, drugs, and technology associated with health and illness, but life-and-death decisions are being made by medical and health practitioners at a time when they are under pressure to cut costs.

The dying may experience ‘ontological insecurity’, raising questions about the meaning of life and death.

Sociological reflection: Living in an ageless world

Imagine a time when medical science has discovered a ‘cure’ for ageing. A one-shot vaccine has been discovered that makes people virtually immortal. Would you take the vaccine? What would be the ramifications of a world in which no one ever grows old, and ageing, dying, and death were things of the past?

Discussion questions

1. What examples of ageism can you think of?
2. How do you distinguish between people who are old and people who are not old?
3. Why are health, fitness, and youthfulness so highly valued?
4. What does death mean in today’s society?
5. Which groups of people do you think are more likely to agree with legalised voluntary euthanasia? Which groups are more likely to disagree? Why?
6. Why is it important to understand the economic and political factors that affect health and medical care?

Further investigation

1. Extending on the information in this chapter, critically analyse policies that affect the aged in Australia.
2. Are the ethical dilemmas that have emerged in relation to dying and death, new dilemmas? Critically discuss this question.
3. Critically discuss whether a ‘good death’ is possible. What is the meaning of death in the sense of a ‘good death’?
Further reading and web resources


**Web sites**

Sociology of Death and Dying: <http://www.trinity.edu/~mkearl/death.html>
SocioSite—Death and Dying: <http://www2.fmg.uva.nl/sociosite/topics/health.html#DEATH>