

Aging and Morality

Deborah Carr and Elinore Avni

Abstract

The sociological examination of morality has been reinvigorated in recent years, yet surprisingly little sociological attention has focused on the moral questions raised by population aging. Population aging, or the growth in the number of persons aged 65 and older in the United States and worldwide, has intensified scholarly and policy debates that are moral at their core—including questions regarding suffering, care ethics, distributive justice, and self-determination at the end of life. We describe key trends in population aging in the United States and worldwide, and show how these demographic shifts have created ethical challenges for social institutions including families, governments, and health care systems. We then focus on four contemporary challenges in rapidly aging societies, highlighting the moral questions they pose: the long-term care crisis; public income supports for older adults; decisions regarding the provision of ethical and effective medical care; and physician-assisted suicide. We identify the moral frameworks that can be used to

understand these challenges, and highlight the implications of ethical debates for policy and practice. We conclude by underscoring vast and persistent socioeconomic and race disparities in the quality of life and death experienced by older adults, and the moral implications of these disparities.

Keywords

Aging · End of life · Long-term care · Medical aid-in-dying · Social policy

1 Introduction

The sociological examination of morality has been reinvigorated in recent years, addressing questions about the “shoulds” and “should nots” of human activity (Hitlin & Vaisey, 2010). The scope of sociological theory and research that explicitly or implicitly addresses concerns of morality is broad, encompassing questions about crime and punishment, the distribution of public goods, political behavior, the sociocultural and structural forces that shape conceptions of morality, and more. Surprisingly little sociological attention has focused on the moral questions raised by population aging, however. Population aging, or the growth in the number of persons aged 65 and older in the United States and worldwide, has intensified scholarly and policy debates that are moral at their core. Who should provide

D. Carr (✉)

Department of Sociology and Center for Innovation in Social Science, Boston University, Boston, MA, USA
e-mail: carrds@bu.edu

E. Avni

Department of Sociology, Boston University, Boston, MA, USA
e-mail: elinorea@bu.edu

care for the large and growing population of older adults? What role can and should public policies play in upholding a reasonable standard of living for older adults who are no longer working for pay? Who should make decisions regarding costly end-of-life medical care for the rising numbers of older adults who lack decision-making capacities? Under what conditions should dying older adults have the legal right to end their own life through physician-assisted suicide?

In this chapter, we provide an overview of key trends in population aging in the United States and worldwide, and show how these demographic shifts have created new moral and ethical challenges for social institutions including families, governments, and health care systems. We then focus on four contemporary challenges in rapidly aging societies, highlighting the moral questions they pose: the long-term care crisis; public income supports for older adults; decisions regarding the provision of ethical and effective medical care; and physician-assisted suicide. We suggest moral frameworks that can be used to understand these challenges, and highlight the implications of ethical debates for policy and practice.

2 Population Aging and Its Consequences in Contemporary Society

The U.S. population is older than ever before; in 2020, adults aged 65 and older accounted for 17% of the total population. One in five Americans will be aged 65+ by 2030, and one in four will have reached old age by 2060. These trends are not limited to the United States. By 2050, a projected 16% of the global population and 25% of persons in North America and Europe will be over the age of 65. In 2018, for the first time in history, persons aged 65 and older outnumbered children under five years of age globally. The oldest-old population will increase at an especially steep rate. The number of U.S. adults aged 85+ is projected to triple from 6.7 million in 2020 to 20 million by 2060, while the number of centenarians is projected to quadruple from

72,000 to over 300,000 (Mather & Kilduff, 2020). Similar patterns are anticipated on a global scale; the number of persons aged 80+ worldwide is expected to triple, from 143 million in 2019 to 426 million in 2050 (United Nations, 2019).¹

Population aging and extreme longevity have been driven by historical changes in the age at which and causes from which people die. These changes have created unprecedented ethical questions regarding suffering, care ethics, distributive justice, and self-determination at the end of life. Prior to the early twentieth century, most U.S. deaths struck quickly after one became ill, typically from infectious diseases like diphtheria and pneumonia (Omran, 1971). Infant and child mortality rates were high, with 20% of infants dying before the age of 5 years in the early 1900s (Preston & Haines, 1985). Technological and medical advances throughout the twentieth century led to major improvements in infant and child survival, such that people started to survive until midlife and old age in vastly larger numbers (Olshansky & Ault, 1986). Infectious diseases diminished as a share of all deaths, and were replaced by chronic illnesses that struck at older ages. Chronic diseases like cancer and heart disease typically have a long duration between illness diagnosis and death. These epidemiologic changes transformed death from an unexpected and swift event that could occur at any age, to an expected and protracted process in later life.

Three-quarters of U.S. deaths today strike adults aged 65 and older, with two-thirds of these deaths attributed to chronic illnesses. Heart disease, cancer, stroke, liver disease, and dementia consistently rank among the leading causes of death among older adults, with COVID-19 breaking into the top three in 2020 (Woolf et al., 2020).

¹ The impact of COVID-19 on future population aging trends is unclear. Although older adults accounted for roughly 80% of the more than one million COVID-19 deaths in the United States as of October 2022, reducing the size of the aged 65+ population, concomitant declines in birth rates reduced the share of infants in the overall population. Projections regarding population growth via net migration are uncertain, typically among working-age and young people, yet these trends also would bear on the total share of the population ages 65+ (CBO, 2022).

The former five conditions are chronic or long-term illnesses, so the period between disease onset and death may last for weeks, months, or even years, raising difficult questions about the competing values of sustaining life versus curtailing human suffering. The end-of-life period typically is marked by spells of pain, breathing difficulties, emotional distress, fear of being a burden, diminishing cognitive capacities, and a high need for personal care (Warraich, 2017). Persons with long-term chronic illness also face complex decisions regarding the medical treatments that they wish to receive or reject. These decisions can be fraught when the dying patient engages family members or caregivers in the process, especially when they disagree about an appropriate course of treatment (Carr & Luth, 2019).

End-of-life medical care is costly, with a large share of these expenditures borne by publicly funded programs like Medicare and Medicaid in the United States, raising ethical debates regarding the allocation of public funds (French et al., 2021; Livne, 2019). An extreme consequence of protracted disease and suffering is that some dying patients may take steps to end their life, with the assistance of a physician. As such, legislators, voters, and care providers are embroiled in intense debates regarding the morality of physician-assisted suicide or “medical aid in dying” (Emanuel & Emanuel, 1998).

Population aging does not refer solely to absolute numbers of older adults, but also their relative share of the total population. Policy makers may rely on an indicator called the old-age dependency ratio, which is the number of persons aged 65+ relative to the working-age population aged 15–64. These ratios provide an indirect (albeit imperfect) indicator of the potential support available for older adults. Among the most pressing policy challenges for the twenty-first century is ensuring adequate financial support for older adults’ publicly funded pensions and health care (i.e., Social Security and Medicare in the United States), and addressing the dire shortage of both family and paid caregivers. Older adults with significant physical and cognitive limitations that undermine their daily functioning

are dependent on unpaid family or paid professional caregivers. Solutions are predicated, in part, on the availability of working-age persons, whether as direct caregivers or as taxpayers contributing to the public safety net (Osterman, 2017). In 2020, the old-age dependency ratio reached an all-time high of 25.6 in the United States and a remarkable 48 in Japan in 2020, suggesting a considerable burden for care and financial support (Carr, 2023). Imbalanced old-age dependency ratios raise important questions regarding distributive justice and the ethics of care for the rapidly aging population.

3 Contemporary Moral Debates in Aging Societies

We summarize four societal challenges that emerge from population aging, describe the sources of and potential solutions to these challenges, and show how each such challenge is moral at its core. We also highlight moral frameworks that can be used to help understand competing views of each such challenge.

3.1 The Long-Term Care Crisis

The United States has an insufficient number of working-age adults to provide informal care to their aging kin, and the shortage of family caregivers is projected to escalate in the coming decades. AARP projects that the ratio of potential family caregivers to care recipients in the United States will plummet from 7 to 1 today, to just 3 to 1 by 2030. An estimated one in four members of the large Baby Boom cohort born between 1946 and 1964 is projected to become an “elder orphan” or “solo ager” without a spouse, child, or other family member to be their primary caregiver in old age (Carney et al., 2016). Although some older adults have the means to pay a home health aide or visiting nurse, this option may be out of reach for those with limited financial resources, especially given Medicare’s limited coverage of home-based services (Carr, 2019).

Paid caregivers also are in short supply, a crisis that was exacerbated by COVID-19. The pandemic left many care workers exhausted, demoralized, and anxious to find other jobs. In 2020, about 4.6 million Americans were employed as direct care workers, including home health aides, nursing assistants, and personal care workers both in private homes and at long-term care facilities. According to the Bureau of Labor Statistics (2022), home health aides and personal care workers top the list of occupations expected to grow over the next decade, with more than one million new job openings projected by 2029. Yet this statistic is a dramatic underestimate as it counts only those caregivers hired by companies; if the estimate also includes caregivers hired directly by families and patients, more than seven million workers are needed by 2026 (Paraprofessional Healthcare Institute, 2021). Despite this desperate need for care workers in the United States, the pay is dismal—just \$27,000 per year or about \$13.50 per hour. Immigrant, Black, and Latinx women make up the majority of care workers, and about 15% live in poverty (Osterman, 2017). Given widespread racism, sexism, and xenophobia, these workers have little bargaining power to better their working conditions (Banerjee et al., 2021). Immigrant women providing paid care in the United States often leave behind family members in their home country, in need of care themselves (Kittay, 2009; Örténblad, 2020).

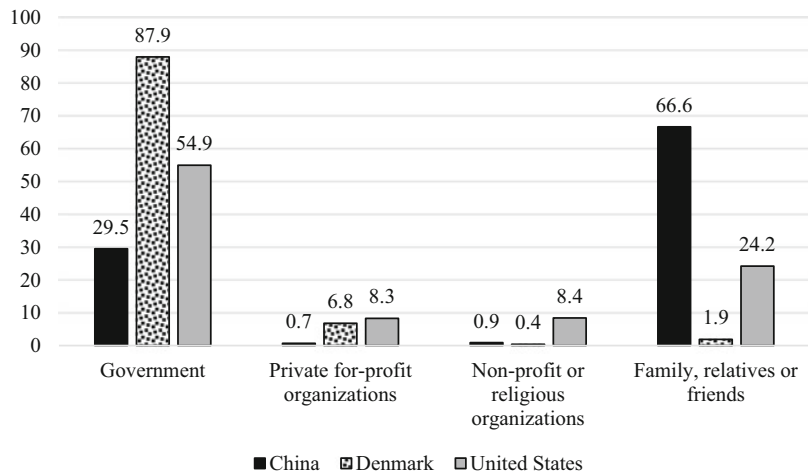
The long-term care crisis raises important questions about who bears responsibility for older adults' care. The direct provision of and financial support for older adults' long-term care varies throughout the world, with most analyses contrasting welfare state regimes, such as those reliant on private markets versus regulated institutions. In the United States, long-term care is partly funded by public dollars, with the largest share (62%) covered by Medicaid, the federal and state health program for low-income individuals. Older adults with limited income and those who have "spent down" their savings are typically eligible for Medicaid. Elder care also is financed privately, with about 25% of costs covered through out-of-pocket payments by older adults

and their families, some of whom have purchased pricy long-term care insurance. In stark contrast, the costs of long-term care in Denmark are almost wholly paid for by the government. Denmark is classified as a Social Democratic regime, with a high degree of decommodification and defamilization, meaning that public programs emphasize reliance on the government and public supports rather than on family and private supports (Esping-Andersen, 1990).

However, a nation's history as part of a "cultural zone" also may influence care systems, independent of economic or political factors (Inglehart & Baker, 2000). Sociologists of morality could identify the cultural and ethical contexts that shape elder care provision, especially in rapidly aging societies. For example, cross-cultural examinations of public attitudes regarding "who should provide care to older adults" can shed light on the particular care ethic to which a society abides and can provide a roadmap for gauging the political and popular feasibility of social policy alternatives. Such inquiries could also shed light on cross-national differences in the concept of "moral background," in which decisions are based on a weighing of economic costs versus ethical concerns (Abend, 2014).

Fig. 1 shows the proportion of adults in China, Denmark, and the United States who believe that older adults' care should be supported primarily by the government, private for-profit organizations, non-profit/religious organizations, or family/friends (Avni, 2023). These three nations differ markedly in their views, with each prioritizing a different source of care. The overwhelming majority in Denmark (88%) believe the government should support older adults' care, whereas most Chinese adults (67%) believe this responsibility should be met by families. Just 2% of Danes believe it is the family's responsibility to provide elder care, whereas less than one-third of Chinese adults say the government should support such care. U.S. adults show less agreement, with just over half endorsing the government, a quarter believing that families should bear primary responsibility and equal minorities (8% each), assigning responsibility to private corporations and non-profit/religious

Fig. 1 Frequency Distribution of Responses to Question “Who Should Provide Care for Older People?” by Nation (The International Social Survey Programme, 2012). Source: Avni (2023)



organizations. These patterns reflect the political economies of each nation, and they also reveal prevailing ethos guiding care.

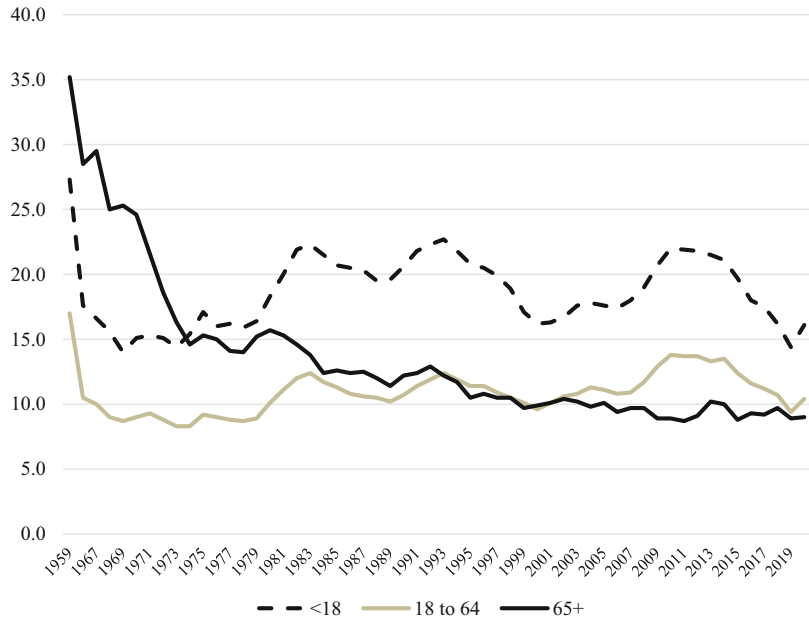
In China, where Confucianist beliefs prevail, the ethical principle of filial piety “commands lifelong parental reverence.” The cultural dictate to “honor one’s parents” underlies a range of behaviors including the provision of their care (Selig et al., 1991). By contrast, the bifurcated preferences revealed in the United States—favoring both the government and families as the primary supports for older adults—may reflect the ethic of reciprocity, such that adult children should provide for the aged parents who cared for them when they were young (Brodie et al., 2015). The ethic of reciprocity also applies to the government; U.S. adults strongly endorse attitudinal statements like “Social Security and Medicare are an earned right,” recognizing that most tax-paying older adults have contributed to the public safety net throughout their working lives and thus are entitled to publicly supported care (Silverstein & Parrott, 1997). In Denmark, the Nordic model emphasizes that the public sector should provide its citizens with welfare services and a social safety net. This model has been linked to cultural support for a Christian-humanist moral repertoire, which emphasizes altruism (i.e., being “a good Samaritan”) and a social responsibility repertoire, which elevates the values of equality, solidarity, and responsibility for one’s fellow citizens (Skarpenes, 2021).

Explorations of the complex interplay between moral values and social policies regarding elder care will become increasingly important in the coming decades, as the financial demands posed by large aging populations increase, potentially threatening family members’ and citizens’ capacity to uphold idealized values like filial piety and altruism.

3.2 Public Income Supports for Older Adults

Population aging means that rising numbers of older adults, most of whom are retired and not working for pay, will rely partly or wholly on public pension programs like Social Security for their economic security (Carr, 2019). Social Security is a social insurance program established in 1935 that provides monthly payments for nearly all U.S. older adults. Women, ethnic and racial minorities, and lower-income persons rely almost exclusively on Social Security for their income, whereas more economically advantaged populations supplement their monthly Social Security payments with private pensions, interest income, and other sources. Thanks to the expansion of the Social Security program in the 1970s, old-age poverty rates have dropped dramatically in the United States. While one in three older adults lived beneath the federal poverty line in the mid-twentieth century, this rate plummeted

Fig. 2 Poverty Rates in the United States by Age, 1959–2020.
Source: Creamer et al., (2022) and U.S. Census Bureau (2019)



and has wavered around 10% since 1990, as shown in Fig. 2.² In stark contrast, the proportion of children under the age of 18 in poverty increased during since the 1970s, wavering around 20% for much of the late twentieth and early twenty-first centuries (U.S. Census Bureau, 2019).

This turn-around, whereby childhood poverty rates are substantially higher than old-age poverty rates, has sparked debates about public investments in social programs that benefit older adults relative to youth (Preston, 1984). Advocates for “generational equity” argue that per-capita spending on older adults is roughly twice that of comparable spending on youth in the United States (Isaacs, 2009) and that public supports for older adults necessarily transfer funds away from children and youth (Preston, 1984). These concerns are further exacerbated by compositional differences between older and younger populations in the United States today, such that younger populations include significantly higher shares of racial and ethnic minorities who are vulnerable to systemic racism

and economic disadvantage (Pew Research Center, 2018). Public discourse regarding generational equity often is counter-productive; however, maligning retirees as “greedy geezers” who are hoarding financial resources that could otherwise be directed to struggling children and youth (McConatha et al., 2003).

Debates regarding generational equity raise important and pressing questions. Should all older adults—even financially well-off persons—receive Social Security benefits, or should the program be means-tested such that only economically insecure persons receive benefits? What share of public funds should be dedicated to programs supporting younger versus older persons, given that both are considered economically dependent on working-age persons? These debates are more than just fiscal matters, they are informed by ethical concerns and reveal underlying disagreements regarding the core principles of distributive justice. Distributive justice models are concerned with the fair and ethical allocation of resources among members of a society or community (Irwin, 1996). Fair allocation typically takes into account the total amount of resources to be distributed, the logics behind that allocation, and the resource distribution that results. Because

² The average monthly Social Security benefit in 2022 was about \$1650.

resources are limited in most societies, establishing what is a “fair” distribution of benefits is a complex charge (Armstrong, 2012).

Theories of distributive justice emphasize five guiding principles which may be at odds with one another and may lead to different policy recommendations as rapidly aging nations face the dual challenges of providing income security to rising numbers of older adults, while also ensuring a sufficient material quality of life for younger persons. These principles are: *equality*, where all members of a society should receive an equal share of costs and rewards; *equity*, where one’s inputs would be proportional to their benefits; *power*, such that those with more authority, status, or control should receive more than those with less power; *need*, where resources are allocated most generously to those with greatest needs; and *responsibility*, where those who have the most resources are responsible for providing for those who have less (Forsyth, 2006). Recognizing the high costs of Social Security benefits, especially as the large cohort of Baby Boomers approaches their retirement years, potential policy solutions include increasing the minimum benefit received by low-income older adults yet limiting increases in benefits for retirees with richer resources (e.g., Herd et al., 2018). Prioritizing need among older adults could potentially free up funds to invest more heavily in young people with high levels of economic need. Sociologists of morality have the capacity to offer creative insights into policy agenda setting worldwide, underscoring the role of ethical principles in guiding fair and just distribution of public resources.

3.3 End-of-Life Medical Decision-Making

Decisions regarding end-of-life medical care, especially in the case of older adults with chronic illness, focus on what sociologist Roi Livne (2019) refers to as the “three quandaries of death.” Dying patients, their families, and health care providers must decide: (1) how far to go in prolonging life, (2) how much to spend to achieve

this goal, and (3) who precisely should make these decisions. For instance, dying patients and their families often must choose between hospice care versus curative care. Hospice is designed to provide comfort and relief to people with a life-limiting illness who have decided to stop curative treatments. Curative treatments, by contrast, focus on curing one’s underlying condition, with the goal of extending one’s life span. Yet many treatments that may extend one’s life span, most notably the use of feeding tubes, are considered “futile” because they provide no reasonable hope of a cure or benefit (Carr & Luth, 2019).³ Decisions regarding palliative versus curative care are guided largely by values regarding life extension versus the reduction of suffering, yet they also are guided by concerns regarding cost. Medical expenditures for care in the last year of life are exorbitant, accounting for an estimated 25% of all annual Medicare expenditures and 8.5% of total annual U.S. health expenditures (French et al., 2021). Hospitalizations, including intensive care unit (ICU) services, account for the bulk of these expenditures. Foregoing curative care for hospice care can save between 25 and 40% of health care costs during the last month of life (Emanuel, 1996).

In the United States and most wealthy nations, end-of-life decision-making is considered the domain of patients, often with the consultation of their family members and health care providers. The Patient Self-Determination Act (PSDA), enacted by Congress in 1990, requires that all federally funded health-care facilities provide patients the opportunity to execute an advance directive. An advance directive is designed to ensure that a patient’s treatment preferences are met at the end of life; it comprises a living will and a durable power of attorney for health care (DPAHC) designation. A living will articulates the specific treatments an individual would want or reject at the end of life, such as

³ Some scholars have argued that the use of feeding tubes is driven by “moral” rather than health-related concerns. Providing artificial nutrition and hydration, while not necessarily helpful, is viewed by families as a way to provide care and love through feeding (Gillick & Volandes, 2008).

ventilators or feeding tubes. A DPAHC legally designates an individual (also referred to as a surrogate) to make decisions on behalf of the patient should they become incapacitated (Carr & Luth, 2017). Additionally, as part of the Affordable Care Act in 2016, Center for Medicare and Medicaid Services (MCS) began reimbursing physicians for discussing end-of-life treatment preferences with Medicare patients at their wellness visits, in an effort to promote patient autonomy. Despite these policy interventions, slightly less than half of older adults in 2020 had an advance directive and only a small fraction of all Medicare patients discussed end-of-life planning with health care providers at their annual wellness visit (Palmer et al., 2021).

The end-of-life context is fraught with moral questions including the value of providing life-prolonging care that is neither cost-effective nor health-enhancing; and the ethics of entrusting a patient with a major health decision when they lack decision-making capacity or delegating this decision to a surrogate whose preferences may diverge from what the patient and other family members desire. Research on end-of-life decision-making often foregrounds legal, economic, or family-level influences, yet this literature would be enhanced with explicit attention to moral concerns (Moorman, 2020). Both social policies and popular understanding of end-of-life decision-making engage the moral concept of “death with dignity,” or the belief that a dying person should have a say in where, when, and how death occurs (Allmark, 2002). The ethical principles of autonomy or self-determination, as well as the principles of beneficence and nonmaleficence are especially useful in understanding end-of-life care (Akdeniz et al., 2021).

Autonomy refers to a patient’s right to self-determination; the use of advance directives, in theory, is a mechanism for promoting patient autonomy (or delegated decision-making) at the end-of-life. However, the limits of advance directives are well-documented, and even patients who articulate their preferences may not be fully informed about treatment options, the likely course of symptoms, and their prognosis for survival (Carr & Luth, 2019). Beneficence requires

physicians to defend and use the most effective intervention for each patient, whereas nonmaleficence emphasizes refraining from causing unnecessary harm. However, health care providers do not necessarily agree on the “best” care option, especially in the case of terminal illness. For example, doctors’ attitudes vary widely as to whether they are willing to provide care that is considered “futile,” and there often is not consensus as to what constitutes the least harmful or most effective course of treatment (Carr & Luth, 2019). Identifying the contextual and institutional factors that pose obstacles to the ethical delivery of end-of-life care is a critical goal. Sociological studies of morality in health care settings may be instructive for enhancing patient autonomy and health care provider beneficence at the end of life.⁴

3.4 Physician-Assisted Suicide

Physician-assisted suicide (PAS), also referred to as medical aid-in dying and passive euthanasia, occurs when “a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act” (AMA, 2012, p. 8). Debates about the morality of PAS have persisted for more than a century in the United States. In the early 1900s, advocates argued for legalizing euthanasia, invoking practical rather than religious or moral arguments. Debates were reignited in the 1980s when Michigan pathologist Jack Kevorkian provided dying patients the means to self-administer lethal medications. In 1997, Oregon became the first U.S. state to enact the Death with Dignity Act. This Act allows terminally ill individuals to end their lives through the voluntary self-administration of lethal medications, prescribed by a physician for that purpose. To be deemed eligible for PAS, patients

⁴ Such approaches should target domain-specific autonomy pertaining to health and medical care, rather than general trait-like autonomy. Prior studies of trait-like “personal mastery” find that it is not a significant predictor of advance care planning (Inoue, 2016).

must have an irreversible terminal illness, be of sound mind, voluntarily and repeatedly express their desire to end their life, and must take the specified legal dose by their own hand. As of October 2022, nine U.S. states (California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, and Washington) and the District of Columbia legalized PAS through legislation, and Montana legalized PAS via court ruling (Picón-Jaimes et al., 2022).

Debates will intensify in the coming years, especially as rising numbers of older adults suffer for protracted periods of time from chronic illness. This prolongation of life, despite its diminished quality, is particularly the case for Alzheimer's and related dementias (ADRD). Persons with Alzheimer's disease live between three and 11 years after diagnosis, on average, but some survive 20 years or more (Alzheimer's Association, 2020). These years, especially the later stages of disease progression, are marked by extreme memory loss, inability to communicate coherently, a complete dependence on caregivers for personal care, and steep declines in physical abilities. Persons with advanced dementia may become unable to walk, sit, or hold up their head without assistance. Muscles become rigid, and patients lose their capacity to swallow and control bladder and bowel functions. Most older adults do not want to live with this level of debilitation; surveys of U.S. adults' preferences for accepting or rejecting life-extending treatments show a stronger desire for rejecting life-extending treatments in the case of severe cognitive impairment compared to severe physical pain (Carr & Moorman, 2009). Dying patients also do not want to be a burden on their caregivers, recognizing that caregivers are at an elevated risk of depression, anxiety, physical health problems, and even hastened mortality (Richardson et al., 2013). Feelings of burdensomeness are associated with depression, anxiety, and a reduced sense of meaning in life among terminally ill older adults (Van Orden et al., 2012).

National opinion polls find strong support for PAS, with 72% of U.S. adults agreeing that doctors should be legally allowed, at the patient's

and family's request, to end a terminally ill patient's life using painless means (Brenan, 2018). However, medical, religious, and political opponents invoke "slippery slope" arguments, cautioning that increased availability of PAS could lead practitioners and health insurance providers to exert subtle pressure on vulnerable individuals to use this option, especially for oldest-old persons who are believed to have few remaining years of life, even in the absence of serious illness (Meier, 2010).

Debates regarding the morality of PAS are informed by suffering-focused ethics, a framework that gives moral priority to the reduction of pain, distress, and hardship. Suffering-focused perspectives encompass diverse positions, some of which can be used to support PAS on ethical grounds, and others used to oppose it (Mayerfeld, 2002). Negative consequentialism, which asserts that reducing suffering improves the human condition, is a moral claim underlying support for PAS (Sulmasy et al., 2016). Ponderate views counter that the reduction of suffering is more important than other values, yet other aggregated values are more important than the reduction of a certain amount of suffering. These other values might include the preservation of life at any costs, on the grounds that taking a life or hastening death is inherently immoral; thus, PAS would weaken the sanctity of life (Brock, 1985). Ideological and political battles regarding PAS will persist in the coming decades, as other states consider legislation to legalize PAS. Sociologists of morality can play a critical role in identifying political, cultural, and economic factors that influence public knowledge and perceptions, media framing, and both popular and institutional support of PAS.

4 Conclusion

The unprecedented increase in the number of older adults in the United States and worldwide has created new challenges for health care systems, governments, families, and the individuals who may live longer than ever anticipated. Population aging is linked with a

range of social challenges, most notably the long-term care crisis, the availability of adequate public income supports for older adults' decisions regarding the provision of ethical and effective medical care at the end-of-life, and debates regarding physician-assisted suicide. We have described these challenges, and underscored how each challenge—while typically studied as a policy or practice issue—is deeply moral at its core. Moral concerns regarding the fair and equitable distribution of public resources, suffering, the value of human life, the appropriateness of particular care ethics, and the practical limits of self-determination are particularly important against a backdrop of population aging, increased longevity, and the widespread availability of high-tech treatments that extend the length although not the quality of human life.

The sociological study of morality has high potential for shedding new insights into the ethical challenges associated with population aging, and can provide deep understanding into the complex ways that values intersect with policy agendas to affect the well-being of older adults and their families. We encourage such a research agenda to directly address the moral concerns raised by vastly disparate experiences among older adults. Older adults whose lives have been marked by economic disadvantage and racial oppression have higher rates of late-life poverty, food insecurity, residence in substandard housing, disease and disability, premature mortality, lower rates of hospice and palliative care use, less autonomy in end-of-life decision-making, lower rates of advance directive use, and a greater reliance on unpaid family caregivers who themselves are vulnerable to physical and emotional distress (Carr, 2019). Understanding these disparities, which will continue to grow alongside population aging and rising economic inequality, will require scholarly attention to the moral principles of justice, and how policies can be designed so that the least advantaged members of society enjoy a suitable standard of living in old age.

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- Deborah Carr** is a Professor of Sociology and Director of the Center for Innovation in Social Science at Boston University. Her research focuses on health and aging over the life course, with an emphasis on dying, bereavement, and end-of-life issues. She is a former editor-in-chief of *Journal of Gerontology: Social Sciences* (2015–2020) and a current editor of *Journal of Health and Social Behavior* (2022–2025). Her recent books include *Golden Years? Social Inequality in Later Life* (Russell Sage, 2019) and *Aging in America* (University of California Press, 2023).
- Elinore Avni** is a PhD student in the sociology department at Boston University. She obtained a master's degree in Sociology from Tel Aviv University. Her research interests include intergenerational relationships, aging and the life course, medical sociology, international sociology, and quantitative methodology.