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**Article:**

Foster, L. [orcid.org/0000-0003-1471-842X](https://orcid.org/0000-0003-1471-842X), Woodthorpe, K. and Walker, A. (2017) From cradle to grave?: policy responses to death in the UK. *Mortality*, 24 (1). pp. 1-16. ISSN 1357-6275

<https://doi.org/10.1080/13576275.2017.1414776>

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## **From Cradle to Grave?: Policy Responses to Death**

### **Abstract**

While death features widely in various humanities and some social science disciplines, to date it has not been given the attention it deserves in social policy discourse or research. This paper sets out to begin to rectify that omission. Outlining a range of policy areas affected by death, it argues that budget and outcome-driven priorities in the UK have resulted in the evolution of disconnected and inconsistent policy responses to death. The paper begins by outlining death rates and characteristics of population ageing before focussing on social divisions in death and associated policies. It considers the death and UK social policy agenda before outlining the key characteristics involved in developing a coherent policy response and policy analysis in this field. It argues for a more comprehensive, consistent and joined up policy response to death, and corresponding academic study of death, which acknowledges and supports individuals preparing to die, when they die, and those left behind.

**Keyword: austerity, bereavement, death, demography, end of life, inequality**

### **Introduction**

Death and taxes are the only certainties in life – an aphorism commonly associated with Benjamin Franklin in 1789 (but coined by Daniel Defoe five decades earlier). For such an inevitability it is remarkable that death has been long neglected by social policy makers and policy analysts alike. This paper examines why this has been the case, specifically in the context of the UK where the establishment of the welfare state was clearly demarked as being

‘from the cradle to the grave’<sup>1</sup>. Through doing so the paper demonstrates that death presents the opportunity to bring together a sizable range of policy areas which are not usually considered together (Drakeford, 1998; Rowlingson, 2006; blinded for review).

At the outset it is important to note that policy responses to death are not just about dying, the moment of death, and bereavement. It is evident that individuals’ experiences of death and the situation of those ‘left behind’ are the products of decisions made *across* the life course and the impact of policies on these decisions. For instance, age at the point of death is connected to wider social policies which affect health, employment, income, participation, and individuals’ overall quality of life. Death can also be linked to various characteristics such as social class (Marmot, 2010), gender (Austad, 2006) and ethnicity (Holloway, 2007), all of which shape and contextualise people’s lives before they die.

Moreover, historical policy developments play a role in shaping communities’ and individuals’ experiences of death. These have an impact on the resources and quality of services available to dying individuals and those close to them, as well as on measures to prevent death (Monroe et al., 2011). In turn, these are shaped by the prevailing political ideology at any particular time. In policy terms, the prevailing political ideology has implications for how rights and responsibilities are conceptualised and operationalised; responses to times of crisis (including austerity measures); and the extent to which (financial) support is provided by the state or the market, or indeed whether it is provided at all. For instance, governments in the UK the last few decades have been dominated by neoliberal ideologies, which have promoted the role of markets in providing for individual needs, challenging whether the state should provide welfare

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<sup>1</sup> This was established in the 1942 Beveridge Report that became the basis for the establishment of the welfare state in the UK in the mid 1940s. The Report lauded the creation of an extensive system of social insurance that reached from ‘the cradle to grave’.

above a minimum level (blinded for review). As a result, policy not only affects the way people near the end of life are supported but also the financial circumstances of those left behind through factors such as Social Fund Funeral Expenses Payments and inheritance tax.

In short, policy is closely involved and intertwined in how death is experienced and our understanding(s) of death in the modern world. Given this, it is surprising that death is routinely overlooked within policy debates and literature in the UK and beyond (blinded for review). While any conventional social policy book for undergraduates will cover a range of issues associated with crime, health, poverty and welfare, it is rare that the death is acknowledged or explicitly mentioned beyond mortality rates. Certainly, mainstream social policy analysis has continued to neglect death beyond health policy specifically focused on palliative care/end of life care. As a result, the policy analysis of death has lagged behind other disciplines. For instance, within sociological inquiries there has been an increasing emphasis on attempting to examine the norms and social structures that aid in defining and managing dying and the consequences of death (Riley, 1983; Hunt, 2017), while in gerontology literature the dying process, end of life care, spirituality and bereavement have all been considered (Dickenson et al., 2000). Epidemiology has also explored death in relation to health-related factors and longevity (Marmot, 2010).

It is within this context that this paper seeks to identify the limited (and overwhelmingly end of life care focused) discussions on death within social policy, and to make the case for a consolidated and consistent policy response to death, dying and bereavement. If this is to happen then policy requires a holistic account of death – as presented here - in order to make a convincing case for death to be allocated a higher priority by policy makers. Such an account requires an acknowledgement of the role of the life course in our understanding of death. This

need for such focus is enhanced by the ageing of the global population and projected increases in death rates meaning that the challenges for policy responses to death are likely to intensify and expand over the next 20 years.

Focused on the UK specifically, the paper begins with a very brief overview of the characteristics of population ageing before moving on to consider death rates, social divisions in death and associated policies. It discusses the death and social policy agenda before preparing the ground for the development of policy responses to, and policy analysis of, death.

## **Population ageing and death rates**

### *Ageing*

As with almost every country around the world, the UK population is ageing. In 2015 of the 65.1million UK population 11.6million (17.8 per cent) were aged 65 years and over. This proportion has increased between 1975 and 2015, from 14.1 per cent of the population to 17.8 per cent (ONS, 2017). At age 65, women can on average expect to live another 20.9 years and men 18.5 years (ONS, 2016a). Often referred to as the ‘Golden Cohort’, people aged in their 70s and 80s have seen the most improvements in mortality over the course of their lifetime (ONS, 2017). By 2015, there were estimated to be over half a million people aged 90 years or over. This represents a rise of 73 per cent over the last decade (ONS, 2016b). In the same year there were 14,570 people aged 100 years or older. This ageing of the population, and particularly the growth in ‘the oldest old’, shows no sign of slowing down. ONS projections indicate that of all those babies born in 2013, a third can expect to live to their 100<sup>th</sup> birthday and beyond (ONS, 2013).

### *Death rates*

One reason for the ageing of the population is the decline in the number of deaths per year as individuals benefit from enhanced diet, sanitation and medical treatment over the course of their lifetime. The number of deaths in the UK has fallen steadily since 2003, reaching a low in 2009 with 553,400 deaths. More recently there has been a slight rise again – to 603,000 deaths in 2015 – mostly because the number of deaths is affected by the increasing size of the population (ONS, 2017). Moreover we know that the death rate is due to rise: the ONS (2015c) has predicted that between 2014 and 2024 there will be almost 200,000 more deaths per year.

A rise in the number of deaths is directly related to an increase in the numbers of people dying at older ages due to the growth of the older population (ONS, 2017). Indeed, in England and Wales in 1963<sup>2</sup>, deaths were highest for males aged 70 to 74 years (15 per cent of all male deaths) whereas deaths were highest for females at ages 80 to 84 and 85 and over (each with 18 per cent of all female deaths). In the UK in 2013–2015, the majority of all deaths fell in the 80 and over age group, accounting for 57.4% of deaths for men and 68.8% for women in 2013–2015 (ONS, 2016a). The most common age at death in the UK in 2013 – 2015 was 85 for men and 89 for women (ONS, 2016b).

These demographic changes are not unique to the UK; such trends have also been witnessed across the western world where, according to global predictions, 91 million people will die in 2050 compared with 56 million in 2009 (Gomes et al., 2011). It is projected that Europe's population aged over 65 will rise over the next 50 years, with three times as many people aged 80 years and over in 2060 as in 2010 (Eurostat, 2014). Furthermore, it is predicted that from

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<sup>2</sup> UK data on death was not available until over a decade later.

2015 the number of deaths across Europe will start to outnumber the number of births (Eurostat, 2014).

Given that death is primarily associated with later life, there exists a risk that discussing policy responses may over-emphasize the false but still prevalent notion that old age is associated with continuous loss and decline – which has been termed the ‘burden of dependency’ thesis (blinded for review). Indeed, the social construction of later life dependency may be an influential factor in the neglect of death by policy makers and policy analysts, by portraying it as the inevitable result of decrecence. However, while the evidence overwhelmingly refutes this thesis (Townsend, 2007) and also demonstrates the major formal and informal roles older people play within society (Lain, 2016), it is the case that older people are *more likely* to experience co-morbidities and their illness trajectories are *more likely* to fluctuate than those of younger adults. They are also less likely than younger people to have access to wide(r) social networks, with fewer links within and beyond the local community (Thomas, 2015). They are also less likely to die in a place of their choosing (Seymour et al., 2005) as ‘very few people now live their lives to the end, in their own homes, without any recourse to formal health and social care services’ (Holloway, 2007: 21). For the majority of those dying in older age various service providers are involved in their lives and the lives of their families, and often intensively (Brown and Walter, 2014). Therefore, the way in which health and social care policy responses and services are structured and delivered can have profound effects on the experiences of death and bereavement for older people, their families and their friends.

### *Deaths before older age*

At the same time it is important to not overlook deaths that occur before people reach older age. While increasing mortality rates are largely a result of an ageing population, it is also the

case that death may be 'untimely'. 'Premature' mortality, in the form of deaths between the ages of 16 and 64, account for 16 per cent of deaths, with deaths in childhood accounting for 1 per cent in England and Wales (Victor, 2010). These deaths may be as a result of accident or injury, euthanasia or suicide, and not related to older age (Richards et al., 2013). The death may also be considered 'untimely' as a result of risk taking behaviours such as drug or alcohol use (Valentine and Walter, 2015). As such, policy in relation to death should not exclusively focus on the needs of the oldest proportion of the population; it needs to include services that may be accessed as a result of unexpected, abusive, or violent deaths.

### **The Social Division of Death**

Crucially, death is not experienced equally. It does not exist in a social, economic or political vacuum: it mirrors life, who we are and how we are able to live. Therefore, like life, death is characterised by one of the long-standing preoccupations of politicians and policy analysts alike: inequality. An example of this can be found in life expectancy: for example in England and Wales while average life expectancy has risen among all socio-economic groups, the disparities between these groups have actually widened. In 1982-86, life expectancy at birth for women who were employed in routine manual occupations was 77 years; Table 1 shows that by 2007-11 it had risen to 80.4 years (ONS, 2015a). While such trends are to be celebrated the equivalent figures for higher managerial/professional groups were 81 years and 84.5 years respectively, indicating significant variation in longevity according to occupational status. For men, life expectancy at birth for those taking up routine manual occupations rose from 70.5 years (1982-86) to 76.6 years (2007-11), while for those in higher managerial/professional occupations it increased from 75.5 years to 82.5 years respectively (ONS, 2015a). There is thus a remarkable 4.1 years for women and 5.9 years for men difference in their expected ages of death between those at the top and bottom of the occupational hierarchy. These occupational

differences are further replicated at age 65 for men and women. Table 1 indicates that the life expectancy of men and women at age 65 who had worked in routine manual occupations were 3.9 years and 3.1 years less (respectively) than those in higher managerial/professional occupations.

Insert Table 1

It is not only life expectancy that reflects the divided nature of UK society but also *healthy* life expectancy. In England, healthy life expectancy (defined by the World Health Organisation (nd) as the number of years a person can expect to live in ‘full health’, where they are not suffering from a disease or injury) at birth for women in social class V (manual) in 2001-3 was 68.5 years and 64 years for men in the same class. Compared with those in social class I (professional/managerial), where the figures were 80 years and 77 years respectively, this equates to a stark difference of 11.5 years for women and 13 years for men between the top and bottom social classes (ONS, 2010). Furthermore, healthy life expectancy at age 65 for women and men in social class V (manual) in 2001-3 were 13.5 years and 9.8 years respectively. Once again, there are considerable differences when compared with those in social class I (professional/managerial) where the figures were 19.5 years and 16.2 years respectively (ONS, 2010). This indicates that not only do those in the lowest social class die prematurely in comparison with those in higher classes but, also, their deaths are likely to be preceded by much longer than average periods of ill-health and/or chronic disability. Needless to say (almost all of) these expectations regarding longevity and healthy life will have a significant bearing on how the final event itself is approached and experienced.

As well as inequality being reflected starkly in the pathway to death's door and the passage through it, what is left behind at the individual's journey end is a product of unequal socio-economic status. Unequal lives result in wide disparities in bequests: one half of the UK population currently leaves nothing of any financial value when they die, with one in twenty leaving more than £500,000 (Rowlingson, 2016). In other words, the majority of people have nothing to fear from inheritance taxes (which currently begin at around £300,000), but there is almost universal abhorrence of their very idea (Rowlingson and McKay, 2005). This apparently deeply ingrained dislike of taxes on inheritance, or 'death taxes' as the tabloids call them at election times, represents a fundamental barrier to the creation of a more equal society, or even a less unequal one, where financial inequalities continue to widen through cycles of deprivation and affluence (Rowlingson and Connor, 2011).

#### *Death and austerity policies*

In the UK, government austerity policies have had an impact on this social division of death. Two major waves of neoliberalism since the 1980s have attacked the welfare state, first because it was said to cause economic harm (by 'crowding out' private investment) and, most recently, because it is blamed for the financial crisis in 2007/8. In both cases such claims have contributed to a political rhetoric which disguises a very simple ideological aversion to public provision, except where such provision subsidises corporations and the rich (Titmuss, 1958; Farnsworth, 2013). The enduring pain from resulting public expenditure cuts, particularly since 2010, commonly referred to in shorthand as 'austerity measures', have caused millions of people hardship - including hundreds of thousands who work for poverty level wages - and has been well documented (Bennett, 2014). Moreover, the implementation of such austerity measures has represented a major barrier to the development of fairer, more equitable, social policies (Farnsworth and Irving, 2015). Research in the USA has shown that economic

downturns in addition to a lack of generous employment benefits increase levels of suicide, especially among young men (Cylus et al., 2014). Austerity politics and reductions in services have also had a damaging impact on end of life care and the opportunities for the poorest members of society to die with dignity.

### *The Funeral Expenses Payment*

The generosity of state support in relation to funeral assistance also has implications for how death and its aftermath are experienced. The origins of the Funeral Expenses Payment (FEP) can be found in the establishment of the UK Welfare State in the late 1940s. In order to provide financial assistance for funeral provision a Universal Death Grant was introduced in 1949, set at £20 and available to all. In 1987, the then Conservative government withdrew the Grant as a way of curbing rising expenditure (Drakeford, 1998), replacing it with a means-tested FEP that was a part of the newly established Social Fund. This was, and continues to be, a conditional benefit to those eligible, with claims assessed on both the availability of resources, familial and close relationships, and the claimant's income. Introduced to 'target benefits on those most in need through a process of 'considered decision making', and to control expenditure more carefully' (Silburn and Becker, 2009: 66) for some time there have been concerns about how the FEP operates and the low level of the award (blinded for review). The costs associated with the funeral ritual and disposal are now in the region of £3,500 and are predicted to rise to between £4,500 and £5,000 up to 2020 (Royal London, 2014; Sunlife, 2014). Despite these substantial costs, in 2003 a cap of £700 for funeral director fees was introduced and has remained ever since, ignoring the Social Security Select Committee (2001) recommendation that the FEP cap should be annually reviewed.

As a result, the disparity between the average award and the current cost of a funeral means that, even if a claimant is successful, they are likely to face a shortfall. Moreover, the complex and invasive procedures that means-testing often entails has the effect of discouraging many potential beneficiaries from applying (Gugushvili and Hirsch, 2014). The Work and Pensions' Select Committee Inquiry into Bereavement Benefits (2016) recommended a review of the system of funeral payments. The benefit was devolved to Scotland as part of the Scotland Act (2016), and will be re-launched as the Funeral Assistance Payment in Scotland in 2019. In England, Wales and Northern Ireland, regulations are being changed but there is to be no lifting of the £700 cap at the time of writing.

In sum, despite the challenges presented by increasing mortality rates and increased life expectancy, alongside austerity measures in policy provision, death has remained largely absent from the social policy and policy analysis agendas. This has led to the development of policy responses in an ad-hoc, department-by-department basis (blinded for review). Such a silo approach has further consequences, with budget and outcome-driven priorities resulting in the fragmentation of separate tasks associated with dying, death and bereavement, as opposed to a focus on the whole person (Holloway, 2007). This has created a 'knowledge gap' at both an individual and societal levels as to how to handle, manage and prepare for death (blinded for review).

This lack of coherence and the way in which policy areas intersect and work together (or not) was recognised in the above mentioned Work and Pensions' Select Committee's Special Inquiry into Bereavement Benefits in 2016. It recommended that a holistic and department-wide review be undertaken of all policy areas associated with death, in order to ensure that the most vulnerable people in society have a robust, sustainable and consistent safety net at the end

of life. This recommendation was rejected by the Government the day before the 2016 UK Referendum on EU membership, and perhaps unsurprisingly has failed to gain traction since, despite repeated pressure for review (blinded for review).

### **Death and end of life care**

The one area of policy associated with death which has received consistent policy and academic attention is healthcare policy and, more recently, on managing the end of life. Yet despite the increase in policy on managing the end of life (blinded for review), there are shortfalls as ‘it is only recently that the realities of the sheer scale of the increasing numbers and proportion of older people in many Western societies has led to a focus on the deficiencies in the end of life care of many of them’ (Monroe et al., 2011: 5). Georghiou and Bardsley (2014) estimate that hospital costs in the final 90 days of life represent some of the largest cost elements in healthcare, averaging over £4,500 per person. The bulk of this cost is due to emergency hospital admissions, increasing rapidly in the last few weeks of life. Other potential costs include local authority funded social care, visits to the GP and seeing a community nurse. Within this, equitable access to end of life care remains a perennial issue, with the Health Select Committee report on Department of Health’s End of Life Care Strategy (DoH, 2015) citing a need to improve access to services for people with a non-cancer diagnosis, older people and individuals with dementia in particular.

Nearly a decade ago, seeking to address some of these deficiencies, and originating from over 50 years’ worth of developments in palliative and end of life care, the Department of Health’s End of Life Care Strategy (EOLCS) (2008) represented a milestone in aiming for consistent end of life care treatment across the UK. Such changes at a national level marked a radical departure from localised, often hospice-led, provision for end of life care (Reith and Payne,

2009) and was part of a positive recognition of the need to formalise holistic end of life care services within contemporary healthcare provision. These changes in approach to supporting people at the end of their lives have been transformative and ongoing (see for example Public Health England, 2013); however, it has resulted in the majority of policy and corresponding academic analytical work focusing on end of life care.

Moreover, a more holistic approach to healthcare at the end of life alone has not been problem-free; deficiencies in end of life care are still apparent in the application of the EOLCS (2008), which has, at times, failed to live up to expectations. For instance, whilst it was largely greeted as providing a positive vision for the future, there have been concerns about the role of choice (Randall and Downie, 2010) and how standards and tools – such as the Liverpool Care Pathway – have been implemented. There are concerns about whether it will remain on the policy agenda (Ellis et al, 2016), not least because end of life care is under considerable strain as a direct result of recent public spending cuts made in the name of austerity. Moreover, the four nations within the UK are now embarking on their own end of life care strategies, with Scotland leading the way in creating targets for accessible-for-all palliative care by 2021 (blinded for review).

### *Technology and preparation at the end of life*

The Dying Matters Coalition argues that a societal taboo surrounds death, resulting in many people not experiencing a ‘good death’ or suffering complicated grief (see Seymour et al., 2010). Given the significance of the medical profession at the end of life the idea of a good death may be at odds with some doctors who view ‘death as a failure’ of healthcare (Richards 2008). At the same time, technological developments that diminish the impact(s) of reaching old age mean that there has been a growing belief that we are able to control what happens as individuals near the end of their lives:

Society's ever increasing preoccupation with developing technologies to eradicate the effects of ageing, coupled with the omnipresent hope of mastery over death itself, encourages us all to view ageing, and by extension dying, as a phenomenon we have the potential to control (Gott and Ingleton, 2011: XVI).

One outcome of a growing reliance on technology to extend life is that the process and experience of dying in contemporary societies is *further* removed from everyday experiences and taken into specialist institutions (hospitals or nursing homes) to be supervised by professional personnel and managed by appropriate technologies (Hunt, 2017). Such technologies are not exclusively 'high tech' interventions and can include antibiotics, and assisted support for receiving nutrition and addressing breathing difficulties.

Thus the advance of medicine does not always represent inevitable progress and may actually promote a disengagement with death. The enormous advances in healthcare over the last 50 years have led to many of the challenges that affect people at the end of life arising from a failure to fit neatly into a way of framing and organising dying. Rather, people often die unpredictably and without any planning for the process (Samsi and Manthorpe, 2011). The unpredictability of death can mean that preparation for it is compromised. Using British Social Attitudes Survey data from 2009 and 2012, Shucksmith et al. (2012) found that less than a third of people had discussed any end of life plans (Table 2). Only 5 per cent had a living will or advance care plan and 11 per cent had written plans in place for their funeral (see also Public Health England, 2013). This lack of preparation was despite 70 per cent of respondents saying they felt comfortable talking about death, with the main reason given for not discussing end of life plans the idea that death was a long way off (43 per cent).

Insert Table 2

While death may seem like a long way off for some, it is not for others. Table 2 shows the likelihood of making plans does rise with age (45 per cent of 75+ year olds in 2012 compared with 23 per cent of those aged 18-34 had discussed end of life issues). There remains however a significant proportion of people aged 75 or over who have not made plans for the end of their life, be they health or financial, serving as another explanation for why policy interest and corresponding academic analysis has been lacking – it is simply not on the radar of many people, even those who are coming towards the end of their lives (blinded for review).

## **Towards a social policy of death**

### *Why a Social Policy of Death?*

This paper has so far shown that death has been vastly underrepresented in both official and academic policy discourses, with most attention concentrated on end of life care. Yet the impact of death is much wider than obviously death-specific policy. Death has implications for the workforce, including bereavement leave (Corden and Hirst, 2013), families (Valentine and Walter, 2015), financial services, pensions, and the distribution of housing (Rowlingson, 2016). As noted in this journal, it has further implications for land usage and environmental policy in relation to the disposal of remains (blinded for review). How it is approached and handled thus reveals much about the values a society espouses and upholds (Department of Health, 2008).

In the UK and at a time of austerity and population ageing, the issue of societal values has arguably never been more important. At stake is the very meaning of what it constitutes to be a citizen and a full member of society. In terms of death and dying, a fundamental question is raised concerning whether an individual should be responsible for their own circumstances at the end of life, or whether the state – and by implication everyone – has a responsibility to step in (blinded for review). For instance, official policies governing inheritance and taxation are major drivers of inequality and the ‘cycle of privilege’ (Rowlingson and Connor, 2011) whereas financial assistance for funerals through the FEP represents only very minimal redistribution based on (stigmatising) means-testing. Moreover, it is difficult to identify values when there is a relative dearth of policy responses, for example to the rising cost of cremation and burial, both of which contribute to funeral inflation (House of Commons Work and Pensions Committee, 2016). Similarly, bereavement provision has habitually not warranted much attention by policymakers and policy analysts (Croxall and Hillcoat-Nalletamby, 2007; blinded for review) with the literature on the availability of bereavement support tending to be restricted to a narrow range of issues such as spousal loss (Corden et al., 2008).

Why then do we need a coherent social policy of death? First and foremost, death throws up ‘a complex mesh of issues unique to the individual, yet shaped by prevailing social, political, legal, economic, philosophical, religious and cultural imperatives’ (Holloway, 2007: 1). Key to the case is that death touches the widest possible range of interests: the role of the state; national infrastructures; public health and sanitation; the individual in relation to whether they planned (and were able to plan for) death; their family, friends and wider networks; services provided by the third sector; the role of the commercial sector; policing; land availability; environmental policy and so on. This wide impact of death has not been grasped by policy makers nor policy analysts, and given the number of people it touches and the implications for

the state (blinded for review), policy responses and analysis should be *needs driven* rather than purely market driven and, ideally, underpinned by an equality and choice agenda.

*What would a coherent social policy of death look like?*

In preparing the ground for a coherent policy on death a ‘good death’ (itself a contested term) is best assured by, first of all, promoting a ‘good life’. While not diminishing the critical importance of debating precisely what that means in practice and how society may enable or prevent it (blinded for review), focus here is specifically on the inequalities that underlie premature death. Thus, the first priority of a policy response to death should be to ensure that its experience and aftermath are as equally distributed as possible in all but emotional terms. This requires a life course perspective and action to prevent premature death and disability.

While the evidence base for such action is very strong, for example with regard to the benefits of physical exercise (Marmott, 2010), the main challenge is the sheer scale of what is required to seriously reduce inequalities in life expectancy and healthy life expectancy. From the eradication of poverty and the promotion of healthy diets, to the transformation of the NHS from the treatment of sickness to the promotion of health, without such a programme to reduce inequalities death will remain fundamentally unequal.

Second, as noted earlier, it is important to recognise that the impact of death is often unpredictable. People have very different needs and experiences and, as such, require different levels of support or assistance. However, a lack of coherent policy responses in relation to death has resulted in a disjointed range of policies, practices and state provision, where national and local government can end up with competing interests. For example, there is limited consideration of long-term implications such as providing sustainable cemetery space and a

nation-wide cash benefit that can adequately absorb the rise in funeral service costs – which are in part driven by local authorities and their increases in cremation and burial fees. Nor is there recognition of the impact on carers of terminally ill people; the implications of experiencing bereavement in old age; or the vacuum of policy and guidance for public health funerals and how the uptake of these is affected by the FEP (blinded for review).

In practice, what this means is that national policy should be clear and coordinated, incorporating comprehensible working between various government departments and organisations in order to ensure that they operate in an integrated manner. Inter-professional and interagency communication, community and family support all need to be incorporated in assessments in order to provide a ‘whole person approach’ (Brown and Walter, 2014). Moreover, public services that are available at the end of life, or to recently bereaved people, need to be based on solid and sustainable financial and political foundations that reflect population demography and contemporary family structures. This last point is imperative given the projected rises in death rates, population growth and the ageing of the population, which have the potential to create considerable strain on individuals, families, organisations and the state as they try to meet these challenges.

### *The implications*

Given the policy void in this area, what are the implications for society’s understanding and handling of death more broadly? One significant consequence is the reinforcement of the individualisation and commodification of death. With little policy input the convention has become that death, with the exception of end of life care, is a private matter, of little consequence to the state. Sociologists and anthropologists have long been arguing this in this journal and beyond, but the case has not been taken up by complementary policy analysis.

While death is often an intensely personal tragedy for the family and friends of the deceased it can, as readers of this journal will know, also be an opportunity for public recognition and the expression of solidarity amongst the living. Without state intervention, potential financial pressures at the time of death can challenge this notion of solidarity (Corden et al., 2008). A rise in policy interest in death could therefore embrace consideration of the ways in which *the personal* and the social can be combined, for instance from the national allocation of resources and cost control to ensure at least an adequate funeral for everybody, and to enable the celebration of individual lives.

A coherent policy response to death should be further characterised by a joined-up approach where those individuals coming to the end of their life and those left behind are provided with the necessary state endorsed support, which in turn is not stigmatised nor provided in isolation from other public funded services. The World Health Organisation (2010) suggests that dying needs to be perceived as a ‘normal’ life event and process, and a support system offered to help dying people and their relatives, making use of available national, local and community resources. To enable this, communication between central government departments and clear signposting of services and resources associated with death and policy need to be readily available. There is potential for this to occur by bringing together existing services: for example while the Bereavement Service operated by the Department for Work and Pensions<sup>3</sup> provides some support, its remit is limited to those receiving social security benefits; at the same time, some hospices provide benefit information for dying people and their family but this is ad-hoc and dependent on the resources of the hospice itself rather than it being a systemic priority.

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<sup>3</sup> This is a telephone service that assists bereaved relatives in determining whether they are eligible for benefits after someone has died.

Moreover, systems for the administration of state support should be systematically reviewed on a regular basis to ensure they operate in an effective manner; the ‘hangover’ of policy response and the ongoing fragmentation of benefits and services cannot be permitted to continue. A principle concern is that where infrastructure associated with death and policy is inconsistent, allowed to wither, or if provision is cut, there is a greater likelihood of discrimination and inequity emerging between particular groups, relationships and individuals. For example, in the newly implemented Bereavement Support Payment, marriage or civil partnership are the only grounds on which a widowed spouse can claim for state support following a bereavement; co-habiting couples are not considered eligible for the benefit. Conversely, cohabitation is recognised as a legitimate relationship in FEP claims. Elsewhere, the eradication of derived benefits in the state pension system is likely to adversely affect a greater number of women than men given their increased likelihood of having interrupted work histories as a result of caring responsibilities and reliance on spouses’ pensions (Price, 2007). A reduction in the financial support associated with death is thus likely to magnify inequalities and increase reliance on other means-tested benefits such as pension credits.

A more holistic policy approach that brings together disparate policy areas is thus required, one which takes into account diverse life course experiences, and contemporary relationship patterns. While policies associated with children and childcare, employment and pensions have received considerable attention over recent years, those associated with death require a greater role on the policy agenda.

## **Conclusion**

Reflecting the recommendation made by the Work and Pensions’ Select Committee (2016) for a review of funeral, crematoria and cemetery policy and provision across the UK, clearer policy

and a more comprehensive infrastructure are required to support the potential growth in the number of people requiring state funded support or services, either in preparation for death or in response to it. This can be done in a number of ways.

First, a new policy framework for death could start from a life course perspective and endeavour to prevent as much inequality as possible in terms of life expectancy and healthy life expectancy. Second, the infrastructure around death should be informed by evidence generated by policy analysts regarding the most efficient means of provision so that public services that are available at the end of life or to recently bereaved people are based on solid and sustainable foundations. Third, policy responses must recognise the impact of inequity in access to resources and the need for provision which takes into account the diversity in individuals' circumstances and contemporary relationship patterns. These challenges are especially important at a time of economic uncertainty where, in addition to ageing populations, 'every society has to make complex, rational, yet pragmatic decisions that translate the rhetoric of progress and choice and the realities of health economics into appropriate service delivery for all groups and communities of the dying' (Monroe et al., 2011: 5).

Policies related to death face the twin challenges of increasing financial demands (linked to increases in mortality rates) and the pressure to provide services that adequately meet the needs of those dying and the people left behind. These need to be delivered with attention to respect and dignity. Improving daily living conditions, and tackling an unequal distribution of power and resources, all have an impact on longevity and reducing inequalities. At the same time, services for dying and bereaved people need to contend with the consequences of people's life experiences of poverty and inequality (Payne, 2011). While the life course approach to death is critical because it recognises that death is influenced by social policies which affect peoples'

circumstances throughout their lives, there is also an urgent need to deal with the challenges of those dying and those left behind. As this paper has shown, the universal nature of death and the aspiration of cradle to grave welfare in the UK mean that it should be *central* to social policy.

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**Table 1 - Life expectancy at birth and at aged 65 by NS-SEC class, 2007 to 2011 in England and Wales**

Class	Class Label	Life expectancy			
		at birth		at 65	
		Men	Women	Men	Women
1	Higher Managerial and Professional (HMP)	82.5	84.5	20.3	22.5
2	Lower Managerial and Professional (LMP)	80.8	84.0	19.3	21.9
3	Intermediate	80.4	83.4	18.7	21.7
4	Small Employers Own Account Workers (SEOAW)	80.0	82.8	18.7	21.9
5	Lower Supervisory and Technical (LST)	78.9	81.2	18.0	20.1
6	Semi-Routine	77.9	81.2	17.5	20.4
7	Routine	76.6	80.4	16.4	19.4

Source: ONS (2015a) using ONS Longitudinal Study

**Table 2 - Discussing end of life issues with someone, by age, 2009 and 2012**

Discussed	Year	
	2009	2012
	%	%
18-34	26	23
35-44	25	28
45-54	27	33
55-64	32	39
65-74	36	35
75+	39	45
All	29	31
Number	1350	2145

Source: Shucksmith et al. (2012) using BSA Data