# Diverging paths: How other countries have designed and implemented assisted dying

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The UK is among a growing number of countries that are debating or have recently legalised assisted dying, primarily in western democracies. While international experience has already informed the debate in the UK, comparisons have focused on specific country examples and a narrow set of legal differences.

This briefing provides a comprehensive review of international evidence from 15 jurisdictions in 9 countries to describe a wider range of practical and operational differences in how comparable systems have set up assisted dying. We also describe the uptake of assisted dying in different jurisdictions, and how policy has evolved changed over time in places with longer-standing laws.

The Nuffield Trust takes a neutral position on whether assisted dying should be legal. This review does not make a judgement about the effectiveness of different models.

**Main findings**

- There is a broad spectrum of legislation and practice across countries. Some systems apply more restrictive policies, while others have adopted more permissive frameworks, but the degree of restriction is not consistent. Some countries enforce more stringent safeguards in some areas of policy while allowing greater flexibility in others, making it difficult to categorise countries in a strictly linear way.
- People who do not have a terminal illness can access assisted dying in some countries, but not all. Of the systems we reviewed, we found no examples where eligibility became more narrow or restrictive over time, though some, such as Oregon in the US, have remained relatively consistent. Among some systems where assisted dying has been legal for over five years, eligibility criteria have expanded, notably in Canada, Belgium and the Netherlands.
- Regardless of eligibility criteria, the proportion of all deaths which were assisted deaths has increased over time in most countries, although assisted deaths make up only a relatively small percentage of total deaths in any given year (0.1–5.3% in 2023).
- In almost all systems, assisted dying is publicly funded and integrated into the health care system.
- Countries have all established clear processes and frameworks for managing assisted dying. However, safeguards and requirements vary – including how patient consent and decision-making capacity are assessed, how practitioners are trained, and which roles are permitted to provide assisted dying.
- Systems also vary in how they monitor and ensure compliance with regulations. Some countries require a review of assisted dying requests before they can be approved, while in other countries only a retrospective review of decisions is undertaken.

Differences between countries are not just procedural – they affect how individuals access and experience services, what roles and responsibilities professionals hold, and how safeguards are upheld. As assisted dying legislation is debated in the UK, the diverse experiences of other countries offer critical learning. Our future work will delve deeper into the operational and system challenges that jurisdictions have faced in implementation, with key lessons for the UK as it considers its own path.

## Introduction

The UK is among a growing number of countries that are debating or have recently legalised assisted dying, primarily in western democracies. This includes France, which introduced a bill in 2024 with parliamentary discussions ongoing, and Portugal, which voted to legalise assisted dying in 2023, pending further regulation. Various forms of assisted dying are already legal in several countries and jurisdictions, including Australia, Austria, Belgium, Canada, Colombia, Cuba, Ecuador, Germany, Italy, Luxembourg, the Netherlands, New Zealand, Spain, Switzerland, and parts of the United States.

In each of these places, the way assisted dying has been implemented varies considerably. This wide range of experiences offers important learning on the set of options and practical implications that need to be considered when deliberating how legalisation might affect individuals, families, staff, and health and care services in the UK.

While a wealth of international learning has already been drawn on to inform the debate in the UK, comparisons have primarily focused on specific country examples or a narrow set of legal parameters across jurisdictions, focusing on eligibility requirements for those wishing to access assisted dying. This briefing provides a comprehensive review of international evidence to describe a wider range of practical and operational differences in how comparable systems in nine countries have set up assisted dying. We also describe the uptake of assisted dying in different jurisdictions, and how policy has changed over time in places with longer-standing laws.

Methods and approach

This report is based on a structured analysis of official documents relevant to assisted dying practices in countries where it was legalised as of 2023, including Australia, Austria, Belgium, Canada, the Netherlands, New Zealand, Spain, Switzerland, and parts of the United States. We focus on high-income OECD countries or jurisdictions with populations over 3 million. This excludes some systems where assisted dying is legal (e.g., Luxembourg, Colombia, and some U.S. and Australian states). We also exclude countries where legislation has yet to be implemented (Portugal) or where legal frameworks remain ambiguous (Germany and Italy).

We draw on a range of sources, including policy documents, official guidance, legislation, and data monitoring reports. Non-English sources were translated using DeepL Translator; translations were cross-checked against English-language literature to support accuracy and consistency (triangulation).

The briefing highlights key implementation examples rather than providing an exhaustive country-by-country review. While this output is primarily descriptive, a future publication will explore key lessons from international experiences and their implications for the UK.

The Nuffield Trust's position on assisted dying

The Nuffield Trust is an independent health think tank. We aim to improve the quality of health and social care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

The Nuffield Trust retains a neutral position on the ethics of whether or not assisted dying should be legalised, for whom, and in what circumstances. But we are committed to identifying evidence to support decision-makers in understanding the potential implications for health and care services. The focus of this briefing is not on the question of whether or not assisted dying should be legalised, but on the potential implications of a change in legislation on NHS and social care services and their workforce, as well as on patients and families.

The Nuffield Trust is well suited to take on this challenging topic, given our independence and our experience of drawing system-level lessons from international settings.

Terminology and definitions

A wide range of terminology related to assisted dying is in use, and definitions vary. In this study, we follow the approach of the Nuffield Council on Bioethics and use the term *assisted dying* as an umbrella term for a range of situations "involving healthcare professionals in providing lethal drugs intended to end a patient's life at their voluntary request, subject to a set of conditions". This includes both self-administration of lethal drugs required to die following prescription by a clinician at an individual's request (sometimes referred to medically assisted death or assisted suicide), and clinician administration of the lethal drug following a request from a patient (sometimes referred to as voluntary euthanasia).

Throughout the briefing, we use different terms for health professionals. We sometimes use the broader term 'health practitioner' to refer to the wider set of roles that may be

involved in the assisted dying process or end of life care more generally (e.g. allied health professionals). We use 'clinician' when referring to roles that require certain qualifications to be involved in assisted dying (e.g. nurses, doctors).

The terms 'review' and 'assessment' refer to different things as part of the assisted dying process. We use 'assessment' to mean the processes carried out by health practitioners to determine whether a person meets eligibility criteria for assisted dying before the service can be provided. This is distinct from 'review', which is typically carried out by specialised committees or oversight bodies to ensure laws have been followed correctly.

## Assisted dying practices across countries

The table below provides a comparative overview of how different systems have implemented assisted dying, highlighting key differences in legislation and practice. The spectrum and range of variation across approaches is broad – some systems have applied more restrictive policies while others have adopted more permissive frameworks.

The degree of restriction or permissiveness observed in different systems isn't always consistent across different aspects of policy. Some countries enforce more stringent safeguards in some areas while allowing greater flexibility in others, making it difficult to categorise countries in a strictly linear way. Nor has policy been static: while some systems have adopted broader policies from the outset, others have gradually evolved to become less restrictive over time. We discuss some of the main operational and practical differences across countries in the sections that follow. Where relevant, we identify key shifts in policy adoption since becoming legal.

Comparative overview of how assisted dying is designed and implemented across countries

| Domain | Feature of law and regulation | More restrictive approaches | More permissive / less restrictive approaches |
|---|---|---|---|
| Integration and funding | Integration with broader services | • Delivered separately from broader health and care services (e.g. through not-for-profit organisations) (**CH**) | • Delivered as part of state health and care infrastructure (**AU, BE, CA, NZ**) |
| | Reimbursement and payments | • Not covered by federal health insurance programmes or most private insurance policies (**US**[1]) | • Entitlement included in insurance/public benefits package[2] (**BE, CA, NL, NZ, ES**) |
| Eligibility | Prognosis | • Terminal conditions only where death is foreseeable (e.g. 6 months or less to live) (**AU**[3], **NZ**, **US**) | • Non-terminal conditions eligible where death is not foreseeable (**AT, BE, CA, NL, ES, CH**) |
| Assessment processes and requirements (e.g. | Consent and capacity | • Request must be confirmed in writing (**AU**[1], **AT**, **BE**, **NZ, ES**, **US**) | • Requests can be made orally and do not require witness (**NL**) |

| | | | |
|---|---|---|---|
| steps followed to determine whether a person is eligible for assisted dying) | | • Notary or witness required to validate written request (**AT**, **CA**[1], **NZ, ES**, **US**)<br>• Third clinical assessment needed if doubts about decision-making capacity or for non-terminal conditions (**AU**, **AT**, **CA**, **NZ**) | • No mandatory reflection/waiting period (**BE**[5] , **CA**[5], **NL**, **NZ**)<br>• Advance consent/ directives recognised[6] (**BE**, **CA**, **NL**, **ES**) |
| | Workforce requirements | • Only physicians can assess eligibility or administer the procedure (**AU**[1], **AT**, **BE**, **NL**, **ES**[1], **Oregon**)<br>• Practitioners must have expertise in relevant specialty or palliative medicine (**AT**, **BE**[7], **CA**[7])<br>• All practitioners must complete mandatory training to deliver assisted dying (**AU**)<br>• Health practitioners unable to initiate conversation about assisted dying with individuals (**AU**[1], **NZ**) | • Nurses can deliver some aspects of assisted dying services (**AU**, **CA**, **NZ**, **Colorado**, **Washington**)<br>• No requirement that a clinician has specialism in the individual's terminal condition (**AU**) |
| Administration / delivery (i.e. how life-ending medication is given or taken by the person who has been approved for assisted dying) | Clinician administration/ involvement | • Self-administration only, with no requirement that clinician be present (**AT**, **CH**[8], **US**[1]) | • Both self-administration and clinical administration (euthanasia) permitted (**BE**[9], **CA**, **NL**, **NZ, ES**)<br>• Practitioner administration allowed if person is unable to self-administer or if complications arise (**AU**[1]) |
| Data, monitoring and review (i.e. how processes are evaluated to ensure legal compliance) | Data collection and oversight | • Government agency specifically for monitoring and regulation of assisted dying established (**AU**, **CA**[1], **NL, NZ**)<br>• Requirement to collect and publish data including on number of people at different stages of the process (**AU**, **CA**[1], **NZ**, **Oregon**, **Washington**, **California**) | • No state or central regulatory body established specific to assisted dying (**CH**, **US**)<br>• Limited data collected or published (**AT**, **CH**, **New Jersey**) |
| | Committee / Board review arrangements | • Formal independent review required by board, committee or registrar before assisted dying can be administered (**AU**[1], **NZ, ES**) | • Retrospective review of cases only (**BE**, **CA**, **NL, CH**) |

Notes and sources: This table is not intended to be an exhaustive account of all dimensions of assisted dying policy or cross-country differences; rather, it highlights key areas of focus and notable points of variation across systems. The absence of mention of a particular country does not necessarily mean that measures were not taken in that country, only that limited information was available at the time of writing. All sources from country-level resources, legal documents, and reports. See reference list for full list.

[1] In some countries, notably Australia and the US (where it is legal), assisted dying has been legalised at the state-level, and there are some differences across jurisdictions in how laws have been set up and operationalised. In Canada and Spain, some policies are also decided and implemented at the province or state level so there may be different practices across jurisdictions. For instance, in Canada provinces differ in their approach to committee review and assurance, and review committees are established at the provincial level. Throughout the table, we refer to the whole country, but explicitly name US states where legal requirements differ between jurisdictions.

[2] General user fees associated with standard health and care services and end-of-life care support may still apply

[3] 12 months for neurodegenerative conditions in some Australian states.
[4] Current policy, but currently under review with law expected to change in 2027
[5] For terminal cases only. Mandatory waiting period waits apply to other cases – see full text.
[6] Advance directives operate in different ways across systems. Where allowed, they tend to permit individuals to outline their wishes for assisted dying in case they lose decision-making capacity in the future, so long as all other criteria are met at the time of writing. As an extra safeguard, some systems require regular renewal of directives to ensure desire for request remains current.
[7] Only involving cases when death is not foreseeable
[8] In Switzerland, the absence of assisted dying legislation has meant that professional ethical bodies such as the Swiss Academy of Medical Sciences have played a significant role in formulating clinical guidelines for professionals.
[9] Self-administration is not explicitly legislated for as part of the Belgian Act of Euthanasia, but it is not prohibited and is accepted as legal by the Federal Control and Evaluation Commission.

| Country/jurisdiction | Abbreviation |
|---|---|
| Australia | AU |
| Austria | AT |
| Belgium | BE |
| Canada | CA |
| Netherlands | NL |
| New Zealand | NZ |
| Spain | ES |
| Switzerland | CH |
| United States | US |



### 1. *In almost all systems, assisted dying is publicly funded and integrated into the health system*

In most countries where assisted dying is legal, it is fully integrated into the broader health and social care system, meaning that it is publicly funded and provided within mainstream health care services as part of standard benefit packages.

There are some notable exceptions to this. In Switzerland, assisted dying is provided by independent, not-for-profit organisations like Dignitas, operating outside of the main health care systems. While Swiss doctors – working independently of these organisations – assess cases and prescribe medication, the assisted dying service is overseen by these not-for-profits, of which individuals must be a member and pay a fee. In the US, most government-run health insurance programmes and private health insurance policies do not cover assisted dying, though there are some exceptions (like state-funded Medicaid services in California which cover drugs used in assisted dying).

Even in systems where assisted dying is publicly funded and integrated into services, individuals may still face out-of-pocket payments, such as user charges for medication or doctor visits, under standard health care fee structures.

### 2. *People who do not have a terminal illness can access assisted dying in some countries, but not all*

A key distinction across countries is whether individuals with non-terminal conditions can access assisted dying, as is the case in Austria, Belgium, Canada, the Netherlands, Spain and Switzerland. In contrast, Australia, New Zealand, and US states restrict eligibility to those with terminal conditions, typically requiring a prognosis of 6 months or less (extended to 12 months for neurodegenerative conditions in most Australian states). Countries with broader eligibility criteria often impose additional safeguards to the assessment process – like requiring clinicians with relevant expertise to assess people's cases. Across systems, cancer is typically the most common clinical diagnosis for people accessing assisted dying.

There are some eligibility criteria that are more common across systems. For instance, nearly all jurisdictions we reviewed require that: individuals accessing assisted dying experience unbearable suffering that cannot be alleviated; have sound decision-making capacity; and are making an informed, voluntary request. This means requests must be seen to be free from coercion or outside pressure. Most systems also mandate that individuals are informed of alternative options, including palliative care and broader end-of-life care services to provide symptom alleviation, psychosocial and emotional support. However, how these criteria are assessed and the process each involves varies considerably across systems, as discussed in section 3 below.

*Key policy evolutions and trends*

In some jurisdictions where assisted dying has been legal for longer – such as Canada (9 years), Belgium and the Netherlands (23 years, respectively) – eligibility has expanded over time. Sometimes this has occurred through formal legislative changes, often prompted by legal challenges; in other cases, policies and the way legislation has been applied has evolved in line with changing societal expectations, acceptance and norms. Of the systems we reviewed, we found no examples where eligibility became more narrow or restrictive over time, though some, such as Oregon in the US, have remained relatively consistent.

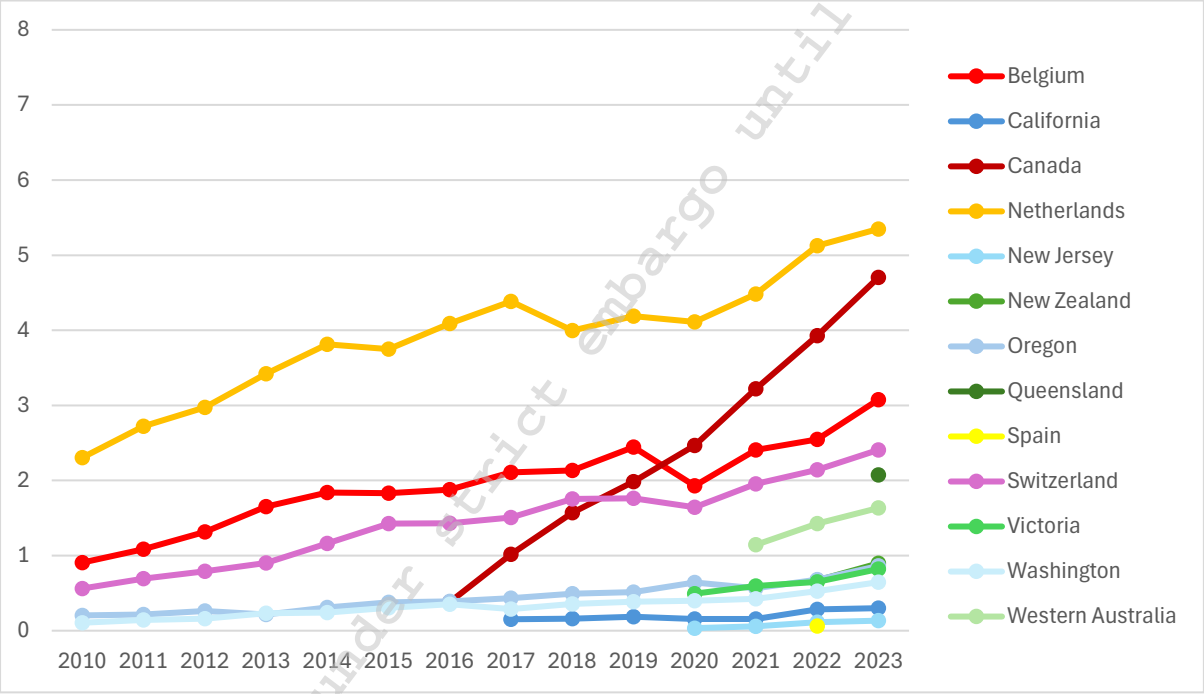
For instance, Canada – which legalised assisted dying in 2016 – broadened access to non-terminal conditions in 2021, following a legal case in 2019, and is preparing to allow assisted dying for people whose sole condition is a mental illness. Since this change, non-terminal cases have remained a small proportion of assisted deaths – 4% of assisted deaths (n=622) in 2023. However, in some other systems, the percentage has grown over time. In Belgium, where non-terminal conditions have been eligible since legalising assisted dying in 2002, the proportion has increased from 7% (n=24) in 2003 to 21% (n=718) in 2023.

Regardless of eligibility criteria, the proportion of total deaths which were assisted deaths has increased over time in most countries (see chart below), although assisted

deaths make up a relatively small percentage of total deaths in any given year (0.1–5.3% in 2023 across the countries we studied). Reasons for the increases and trends observed across systems are likely due to various factors embedded in the societal, ethical, political, and legal contexts of each country.

For instance, processes for assisted dying take time to establish, and for the public to have awareness of the law and their rights to request access. Variation may also reflect evolutions to practice that broadened eligibility and access over time, as discussed above, or changing social norms and attitudes towards assisted dying in each place. Approaches to reporting assisted deaths and data quality also vary and may be underreported in some places. In Colorado, for instance, confirmed assisted dying deaths are not reported.

Proportion of all deaths which were assisted deaths, by jurisdiction, 2010–2023




Note: Figures reflect the number of assisted deaths as a percentage of all deaths by jurisdiction, drawing upon routinely collected data regarding assisted deaths as well as annual or monthly mortality statistics. Where there are discrepancies between figures reported by year, we have used those which are most up-to-date. Care should be taken when comparing data by jurisdiction. For instance, some areas report assisted deaths by calendar year, whereas others run mid-year to mid-year. Viewing the data in isolation does not enable us to unpick specific causative factors to explain differences.

Most jurisdictions also impose residency requirements, limiting access to citizens or people who have been resident for at least one year, as a way of avoiding individuals travelling to or claiming residency in a place to access assisted dying. This raises further complications for countries where assisted dying is only legal in some states – like the US and Australia. Over time, some jurisdictions in these countries have eased restrictions or made exemptions – Australia, in part, due to broader legalisation across all six states, and to enable individuals to access the service closer to family.

### 3. *Countries have all established processes for managing assisted dying, but safeguards and requirements vary*

Every country where assisted dying is legal has established a structured process to assess eligibility and ensure consent. While these systems share common features, they differ in the specific safeguards used.

#### Consent and capacity

Most systems require multiple requests to confirm a patient's consistent desire for assisted dying. Spain mandates a repeated request, in writing both times, while Colorado requires three distinct requests – at least one of which must be in writing. In addition to two written requests, Canada also mandates that individuals give final consent immediately before receiving assisted dying (though some exceptions apply). Some countries have also added safeguards like witness signatures or notarisation to prevent coercion – Austria, for example, requires a standardised dying decree to be signed in the presence of a notary or legal patient advocate, and all requests must be submitted using a standardised, digital form. The Netherlands is distinctive for not requiring a written request or witnesses.

Most systems also enforce a waiting period – either between requests for assisted dying, and/or between the final request and the provision of assisted dying – ranging from seven to 14 days. New Zealand and the Netherlands are less restrictive in that they do not have a mandatory wait. Other systems adjust waiting periods based on prognosis: Belgium imposes a one-month wait for non-terminal cases, but none for terminal conditions, while Austria requires a minimum of 12 weeks for non-terminal cases and two weeks for terminal ones. And in Canada, when death is not considered reasonably foreseeable, eligibility assessments must take at least 90 days (there is no mandatory wait period in cases where death is reasonably foreseeable).

#### Workforce requirements

After an individual formally requests assisted dying, at least two independent clinicians typically assess their eligibility. Most countries only authorise physicians to conduct these assessments and administer the procedure, though Australia, Canada, New Zealand, and parts of the US permit a broader range of professionals to be involved. For instance, in some Canadian provinces nurse practitioners are permitted to both assess eligibility and administer assisted dying medication. And in New Zealand, nurse practitioners may assist with care planning and administer the medication (though only medical doctors are authorised to assess eligibility).

Additional safeguards exist in some jurisdictions, such as requiring a third assessment for individuals with mental health conditions or uncertain decision-making capacity. Some countries that allow assisted dying for non-terminal conditions, like Canada, Austria and Belgium, mandate that at least one assessor should either have expertise in the condition causing suffering, or in palliative medicine.

Australia and New Zealand are distinct in implementing formal training in assisted dying protocols for clinicians to be able to provide the service (although in New Zealand this is applied by training being a condition of receiving reimbursement for delivering assisted dying services, rather than in legislation). Parts of Australia have also introduced other minimum qualification standards – for example, requiring doctors involved in assessing or providing assisted dying to either hold specialist registration with at least one year of clinical experience, or, for general practitioners, to have at least five years of clinical experience. New Zealand and some states in Australia are also unique in prohibiting staff from raising assisted dying with their patients – only individuals considering assisted dying can initiate the conversation.

Countries with less restrictive workforce requirements have similar training programmes, but they tend to be voluntary, as in Belgium, or rely more on clinical guidelines and standards, as in Switzerland. The Netherlands relies on expert clinical networks to support and advise practitioners, having established formalised centres of excellence to provide second opinions to assessments, rather than enforcing qualification requirements.

Every system allows health care professionals to refuse participation in assisted dying, but countries differ in how they balance this alongside ensuring patient access. Most require objecting practitioners to refer individuals to an alternative provider or coordination service, though enforcement varies – some Canadian provinces, for example, have no referral mandate.

Spain has a distinct approach whereby clinicians can morally object, but they must formally register their objection with state boards – essentially acting as an 'opt-out' policy. Spain is also one of the few countries that explicitly prohibits institutional objection within the public health care system – meaning that state-funded organisations must ensure access to assisted dying for eligible individuals. This includes having systems in place to process requests and deliver assisted dying, even if this means bringing in external professionals or transferring individuals. Private institutions, particularly those with religious affiliations, have more flexibility to deny assistance. In most other systems, the right to moral objection only applies to individual practitioners.

*Key policy evolutions and trends*

A key tension that systems have had to manage is balancing adequate safeguards against ensuring timely access. This has led some jurisdictions – like Washington in the US – to broaden the range of professionals authorised to assess and oversee assisted dying requests to include physician assistants and advanced nurse practitioners. The state legislator enacted this change partly in response to concerns from advocates that individuals in rural areas struggled to access assisted dying due to limited numbers of physicians in these areas. Similar policies have been introduced in Colorado.

Other systems have reduced the mandatory waiting period, as in California – which reduced its 15-day waiting period between requests for assisted dying to 48 hours in 2022 – and Colorado, which halved its waiting period between requests from 15 to 7 days in 2024, and allowing providers to waive it entirely if death is imminent. Following a legal case and public consultation, Canada amended its law to remove the 10-day reflection period requirement for people whose natural death is reasonably foreseeable.

To ensure individuals are better informed about their options, some systems have also introduced requirements for health care institutions, like hospices, to publicly disclose their assisted dying policies. California recently adopted this approach, and it is under consideration elsewhere. Belgium took a further step in 2020, banning institutional objection to euthanasia, and strengthening requirements for objecting professionals to inform individuals of their options and refer to alternative providers.

Data is limited, but where available[1] it shows general practitioners as the most common staff group involved in assisted dying. Generally, it seems that most clinicians participate in only one or two cases a year, while a small group is then responsible for a significant proportion. For instance, in 2023 in Canada, just 4% of practitioners (89 in total) handled 64% of all cases (providing assisted dying 31 or more times each). Likewise, in Oregon in 2023, 77% of physicians that had prescribed medication for assisted dying wrote only one or two prescriptions.

### *4. The emphasis on prospective versus retrospective review differs across countries*

Many systems have established formal boards and committees to provide oversight and assurance to assisted dying decisions, though there are differences in how these bodies function and at what stage they fit into the process. Likewise, countries vary in what data is required to be recorded about assisted dying, and if and how this is integrated with existing death registration processes.

While many systems have a form of retrospective review, the Netherlands is distinct for the pivotal role it gives to this process. Other systems tend to combine stricter upfront procedures and processes alongside retrospective reviews as safeguards, where the Dutch model primarily relies on thorough oversight after the fact to ensure ethical and legal compliance. In the Netherlands, all assisted deaths must be reported to a municipal coroner, who forwards cases to regional committees composed of lawyers, doctors and ethicists. These regional committees review every case to ensure adherence to all legal and ethical standards, and that practitioners demonstrated full

[1] Data collected regarding workforce participation in assisted dying services varies by locality and the information captures reflects the distinct models of assisted dying as well as formal reporting requirements (or lack of them). The sorts of information provided include the number and role of staff involved at different points in the assisted dying pathway, as well as the number of staff who complete assisted dying training.

duty of care. Although Belgium, Spain, Canada and New Zealand also use retrospective review, the scope and approach varies – for instance, Ontario in Canada has set up an enhanced review committee that focuses on complex cases, while New Zealand primarily checks for administrative and operational compliance.

In Spain, New Zealand, and some Australian states, the entire case must first be considered by a registrar, review board or committee before medication can be administered and final approval given. These independent boards are often also tasked with data collection and monitoring uptake of assisted dying, as well as compliance with legislation.

## Conclusion

The debate on assisted dying is often shaped by selective interpretations of international evidence, with the same country's experience used to argue both for and against legalisation. This review does not make a judgement about the effectiveness of different models, but rather highlights the vast variation in how assisted dying has been implemented, reflecting each country's unique ethical, political and legal landscape.

These differences are not just procedural – they affect how individuals access and experience services, what roles and responsibilities professionals hold, and how safeguards are upheld. As assisted dying legislation is considered in the UK, the diverse experiences of other countries offer critical learning. Our future work will delve deeper into the operational and system challenges that jurisdictions have faced in implementation, with key lessons for the UK as it considers its own path.