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Palliative care and assisted dying

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Palliative care has become a key area of debate during the scrutiny of the Assisted Dying for Terminally Ill Adults (Scotland) Bill. This briefing provides an overview of palliative care in Scotland and provides further information on the relationship between assisted dying and palliative care in other jurisdictions.



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Summary

Introduction

The World Health Organisation defines palliative care as "an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual."

It may be delivered by specialist palliative care teams or in more generalist settings, such as by GPs and community nurses.

Palliative care need in Scotland

In 2021, an estimated 56,416 people in Scotland died with palliative care needs. This represented 90% of all deaths and is a figure projected to rise to 63,353 by 2040. This increase is driven by an ageing population and the growing prevalence of multiple long-term conditions.

Palliative care is required for a wide range of diseases, with global data showing the majority of adults needing care suffer from cardiovascular disease (38.5%), cancer (34%), and chronic respiratory conditions (10.3%), among others. In Scotland, the leading causes of death include heart disease (11.1%), dementia and Alzheimer's (10.6%), cerebrovascular disease (5.9%) and lung cancer (5.9%).

Common symptoms requiring palliative care include pain, breathlessness, fatigue, and complex issues such as delirium, nausea, depression, and bowel obstruction. An estimated 1 in 4 people who need it, do not receive palliative care—equating to around 14,000 individuals annually.

Reviews by Audit Scotland and Marie Curie highlight challenges in meeting palliative care needs, including:

- Unequal access to specialist services, especially for non-cancer patients.
- Geographic and demographic disparities, affecting rural communities, ethnic minorities, and those in deprived areas.
- Over-reliance on generalist staff, who often lack adequate training and support.
- Limited support for carers and poor service integration, particularly outside regular hours.

Scottish legislation and policy

Scotland currently has no specific legislation governing the provision of palliative care. Instead, the National Health Service (Scotland) Act 1978 places a general duty on Scottish Ministers to promote a comprehensive and integrated health service. There have been previous attempts to introduce Members' bills on palliative care, including a proposal last year from Miles Briggs MSP for a Right to Palliative Care (Scotland) Bill but, to date, none of these attempts have progressed into law.

In September 2025, the Scottish Government published its first formal palliative care strategy which contains two overarching aims:

1. Scotland is a place where people of all ages and their communities can help and support each other to live as well as possible with life shortening conditions, dying, death and bereavement.
2. People of all ages with life shortening conditions and their families and carers receive palliative care, care around dying and bereavement support based on what matters to them.

The strategy is underpinned by eight outcomes, covering supportive communities, adult and paediatric palliative care, future care planning, care around dying, education and learning, data use, and governance.

Service provision

In Scotland, around 90% of the last six months of a person's life are spent in community settings, a trend consistent from 2015 to 2025.

In 2022-23, deaths occurred primarily in:

- Hospitals: 45.8%
- Homes: 30.7%
- Care homes: 18.8%
- Hospices: 4.7%

Age and underlying condition influence a person's place of death with younger people (<69) more likely to die at home (43%) than older adults (27%). Dementia-related deaths are more likely in care homes, whereas deaths from cancer occur more often at home or in hospices.

A service mapping exercise by the Scottish Government found:

- Collaboration between NHS boards and Health & Social Care Partnerships (HSCPs) is variable and complex.
- Respondents highlighted a strong need for better integrated working and fair resourcing across all care settings for palliative and end-of-life care.
- Most (86%) HSCPs and NHS boards (78%) have nominated palliative care leads.
- Few detailed commissioning plans exist for general or specialist palliative care.
- Of 38 adult specialist services, 56.5% are third sector, 41% NHS, and 2.5% joint/other.
- Services are delivered across homes, hospitals, care homes, hospices, and outpatient settings.
- The workforce includes:
 - 138 whole time equivalent (WTE) community nurse specialists (2.5 per 100,000)

- 53 WTE hospital nurse specialists (0.98 per 100,000)
- 0.9 WTE palliative medicine consultants per 100,000; 3 NHS boards have none.
- 245 specialist inpatient beds across 18 units.
- Out-of-hours advice is available in 13 of 22 HSCPs and 8 NHS boards offer public advice lines.

Expenditure

There is a lack of up-to-date data on palliative care funding and expenditure in Scotland. The most recent official figures come from Audit Scotland (2008), which reported that in 2006-07, approximately £59 million was spent on specialist palliative care:

- £26.2 million from voluntary sector funding for hospices
- £17.3 million in NHS contributions to voluntary hospices
- £15.5 million in NHS funding for NHS-run specialist services

This breakdown shows that 44% of funding came from the voluntary sector, with 56% from the NHS. However, expenditure on general palliative care services was not identifiable.

More recent research estimates that £22 billion is spent annually across the UK on supporting people in their final year of life. In Scotland, the estimated total spend across all sectors is £2.29 billion, with costs distributed across health care, social care, and social security.

- Health care accounts for the largest share at 58% (£1.33 billion), followed by social security (22%) and social care (20%).
- The average spend per person in their last year of life is £36,590.

A detailed breakdown of health care expenditure reveals hospital care (planned and unplanned) is the most significant cost, totalling £1.13 billion. Other notable costs include prescribing (£60 million), GP contacts (£28 million), and community-based services (£30 million). Hospice care accounts for £39 million, with public funding covering approximately 48% of hospice expenditure—consistent with earlier findings from Audit Scotland.

A 2011 UK Department of Health study estimated (at that time) that it would cost £144 million to extend palliative care to two-thirds of those in need in England, or £2,400 per person. Applying similar assumptions, the cost for Scotland was estimated to be £16.8 million. Despite high overall healthcare spending in the last year of life, specialist palliative care accounts for just 6% of formal healthcare costs. Evidence shows that integrated, multidisciplinary palliative care improves outcomes and reduces avoidable hospital use and costs.

Palliative care and assisted dying

During the course of the stage 1 evidence on the Assisted Dying for Terminally Ill Adults (Scotland) bill, many stakeholders raised the issue of palliative care. These issues were brought up by people on all sides of the debate and the concerns could broadly be divided into two main areas:

1. Whether inadequate palliative care will act as a driver of requests for assisted dying.
2. Whether assisted dying will erode the quality and availability of palliative care.

Palliative care as a driver to assisted dying

In jurisdictions that collect information on palliative care alongside assisted dying, the data tends to show that the majority of people (at least three quarters) seeking assisted dying are also in receipt of palliative care. Some suggest this shows people are not seeking assisted dying due to a lack of access to palliative care, but rather, they view it as an addition to their end-of-life care options. However, this data makes no assessment of the quality of care people are receiving.

Canada and Oregon also collect information on the concerns underpinning assisted dying applications. This data shows people citing concerns that are potentially amenable to palliative care, for example, 'inadequate pain control, or concern about it'.

The effect of assisted dying on palliative care

Effect on funding and service provision

The relationship between assisted dying legislation and palliative care funding and provision remains contested. Some commentators argue that assisted dying diverts resources away from palliative care, while others refute this claim. Practitioners in Canada have highlighted substantial increases in palliative care investment since the legalisation of Medical Assistance in Dying (MAiD), including expanded physician staffing, billions in home care funding, and growth in hospice beds and research initiatives. Similar claims have been made in other jurisdictions.

However, contrasting analysis suggests that jurisdictions with assisted dying have seen slower growth in palliative care provision compared to those without it. Concerns have also been raised about funding competition, noting that in some regions, increased investment in assisted dying coincided with cuts to palliative care budgets. Additionally, it has been claimed that promised funding for palliative care in Canada has not always been fully delivered, with a fraction of committed resources traceable over time.

Effect on individual care quality

An evidence review found that the impact of assisted dying on end-of-life care is mixed, with outcomes often shaped by how well assisted dying is integrated into broader care systems. In some jurisdictions, unclear policies regarding the role of hospices and care facilities have led to tensions. A lack of clear guidance may discourage individuals from disclosing their interest in assisted dying due to fears it might affect access to palliative care.

There is some evidence that where organisations are unsupportive or opposed to assisted dying, this has resulted in reduced communication, limited care options, and a perception that patients must choose between palliative care and assisted dying.

Conversely, research from Australia and Canada suggests that legalising assisted dying can act as a catalyst for improved end-of-life care, encouraging more open conversations about care goals and advance planning. Some studies found that physicians felt better equipped to support patients holistically, even when assisted dying was not pursued.

Palliative care laws alongside changes to assisted dying laws

Some countries have bolstered their laws around palliative care alongside changes to the law on assisted dying. This includes Belgium, France, and Germany.

Belgium enacted a law in 2002 guaranteeing universal access to palliative care, with funding more than doubling over the following decade. France recently committed over €1 billion in new funding to expand palliative services, aiming for equitable access across regions. Germany's 2015 Hospice and Palliative Care Act integrated palliative care into statutory health insurance at the same time as criminalising commercial assisted dying services. This came with an estimated €200 million in additional annual funding to support service expansion.

Introduction

What is palliative care?

Palliative care is commonly defined with reference to the World Health Organisation's description which is:

“ Palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual. ¹ ”

The Scottish Partnership for Palliative Care explains that what differentiates 'palliative care' from 'just good care' is the awareness that the person's mortality has started to influence clinical and/or personal decision making. They go on to say:

“ However, palliative care is not synonymous with death – it is about life, about the care of someone who is alive, someone who still has hours, days, months, or years remaining in their life, and about optimising well-being in those circumstances. ² ”

Palliative care services are often described as being either specialist or generalist:

- **Specialist palliative care** is provided through multidisciplinary teams which have undergone recognised specialist palliative care training and is provided in a variety of acute, hospice and community settings.
- **General palliative care** is also delivered in a variety of settings but is delivered by generalist professionals such as GPs, community nurses, allied health professionals, social workers, social carers and unpaid carers.

Services in Scotland are discussed in more detail in the section on [Service Provision](#).

Palliative care need in Scotland

An estimated 56,416 people died with a palliative care need in Scotland in 2021. However, this number is projected to rise to 63,353 by 2040. This accounts for 90% of forecasted deaths. ³

The increase has been attributed to Scotland's ageing population and the fact that people are living longer with multiple long-term conditions.

Palliative care is required for a wide range of diseases and global figures show the majority of adults in need of palliative care have chronic diseases such as cardiovascular diseases (38.5%), cancer (34%), chronic respiratory diseases (10.3%), AIDS (5.7%) and diabetes (4.6%). ¹

However, many other conditions may also require palliative care, including kidney failure, chronic liver disease, multiple sclerosis, Parkinson's disease, neurological disease and dementia.

The most common causes of death in Scotland are: ⁴

- Ischaemic heart disease - 11.1%
- Dementia and Alzheimer's disease - 10.6%
- Cerebrovascular disease - 5.9%
- Lung cancer - 5.9%
- Chronic respiratory disease - 5.5%

Pain and breathlessness are two of the most common symptoms experienced by people needing palliative care but there are many others symptoms that can benefit from the input of specialist and generalist palliative care providers, including: ⁵

- **Anorexia/cachexia** - loss of appetite with weight loss and/or muscle wasting.
- **Bowel obstruction** - from partial or complete mechanical obstruction causing a range of problems such as constipation, pain, nausea and vomiting.
- **Constipation** - may also be present due to other causes such as the use of opiate based painkillers or dehydration.
- **Cough** - common in lung cancers and in people with secondary infections.
- **Delirium and confusion** - can be common near the end of life and in dementia.
- **Depression and anxiety** - extremely common in people diagnosed with a life-limiting condition.
- **Diarrhoea** - can be a side-effect of medication, radiotherapy, constipation/bowel obstruction and pancreatic cancers.

- **Hypercalcaemia (raised calcium in the blood)** - most common in people with myeloma, breast, renal, lung and thyroid cancers. Can lead to delirium, seizures, drowsiness and coma.
- **Lymphoedema** - can happen in cancers which have spread to the lymph nodes and leads to a build-up of lymph fluid in the tissues.
- **Nausea and vomiting** - common in a wide range of life-limiting conditions.
- **Oral problems** - problems such as dryness and ulcers can be a common side-effect of many medicines, chemotherapy and radiotherapy. It can also be a problem in those who have trouble drinking.
- **Pruritis (itching)** - may be a result of medication side-effects or organ failure.
- **Seizures** - can be caused by primary or secondary brain tumours, cerebrovascular disease or biochemical abnormalities such as raised levels of calcium.
- **Sweating** - occurs in 10-20% of people with advanced cancer.
- **Weakness/fatigue** - common in progressive chronic disease and is often considered more distressing than pain.

Unmet Need

According to Marie Curie, around 1 in 4 people who need palliative care do not receive it.⁶ If applied to 2021 Scottish levels of need, this would equate to ~14,000 people with unmet palliative care needs each year.

There are no recent assessments of the state of palliative care services in Scotland, however an Audit Scotland review in 2008 found:

“ There is significant variation across Scotland in the availability of specialist palliative care services and how easily patients with complex needs can access these. People with a range of conditions need specialist palliative care but it remains primarily cancer-focused. Most palliative care is provided by generalist staff in hospitals, care homes or patients’ own homes. But palliative care needs are not always recognised or well supported. Generalists need increased skills, confidence and support from specialists to improve the palliative care they give to patients and their families. Palliative care needs to be better joined up, particularly at night and weekends. Family and friends caring for someone with palliative care needs also need support but this is not widely available.”

A later review of the evidence by Marie Curie found unequal access to services was more prevalent among particular groups, namely:⁷

- those with non-cancer conditions,
- people from black, asian or minority ethnic backgrounds,
- people in deprived areas,
- people in rural areas,

- older people,
- people living without a partner or spouse.

Similar findings were reached by the Scottish Parliament's Health and Sport Committee in its 2015 inquiry - 'We need to talk about Palliative Care'. One of the key conclusions of the inquiry was:

“ The Committee acknowledges that there is the need for access to palliative care to be more consistent across all conditions, ages and locations. ⁸ ”

Scottish legislation and policy

Legislation

There is no specific legislation relating to the provision of palliative care services in Scotland. Instead, the National Health Service (Scotland) Act 1978 (c 29) (the 1978 Act), contains a general duty on Scottish Ministers to 'promote a comprehensive and integrated health service'.

There have been some attempts over the years to legislate to ensure better provision of palliative care in Scotland but, to date, these have been unsuccessful. For example, in 2010, a Member's Bill entitled the [Palliative Care \(Scotland\) Bill](#), in the name of Gil Paterson MSP, was introduced but did not pass stage 1.

A proposal for a [Right to Palliative Care Bill](#), in the name of Miles Briggs MSP, was lodged in 2024 but has not yet been introduced as a bill.

Policy

In September 2025, the Scottish Government published its strategy on palliative care entitled [Palliative Care Matters for All: Palliative care strategy 2025-2030](#).⁹

Previous policy includes the [Palliative and end of life care: strategic framework for action](#).¹⁰

The strategy has two overarching aims:

“ **Enabling People and Communities** Scotland is a place where people of all ages and their communities can help and support each other to live as well as possible with life shortening conditions, dying, death and bereavement. **Strengthening Palliative Care** People of all ages with life shortening conditions and their families and carers receive palliative care, care around dying and bereavement support based on what matters to them.”

The strategy is also underpinned by 8 outcomes and was published alongside an initial [Delivery Plan \(2025-2028\)](#).¹¹ The outcomes are:

1. **Supportive communities** - People of all ages have the information and support they need to help themselves and others live well with life shortening conditions, and through death, dying and bereavement.
2. **Adult palliative care** - Adults of all ages with life shortening conditions and their families and carers receive general palliative care tailored to their needs, with specialist palliative care if required.
3. **Paediatric palliative care** - Babies, children and young people living with life shortening conditions, or those transitioning to adult services, and their families and carers receive paediatric palliative care tailored to their needs, with specialist paediatric palliative care if required.
4. **Future care planning** - People of all ages living with life shortening conditions, their families and carers are supported to have person-centred conversations themselves

and with their health and social care team about managing and planning for changes in their life, health and care.

5. **Care around dying** - People of all ages who are dying are cared for and comfortable wherever they die, with people close to them involved and supported.
6. **Education and learning** - Health and social care staff caring for people of all ages with life shortening conditions have access to recommended education and learning resources to support and enable them to provide palliative care, care around dying and bereavement support.
7. **Palliative care data** - National and local service providers gather, use and share palliative care data to inform service planning and delivery, monitoring, evaluation and reporting, including experiences of palliative care and care around dying.
8. **Governance** - Organisations responsible for health and social care work together and with third sector partners to improve planning, delivery, reporting and accountability for general palliative care and specialist palliative care services.

Service Provision

Where are people cared for in the final months of their lives?

People spend the majority of the final six months of their life at home or in a community setting and this trend has stayed largely unchanged over recent years.

Percentage of last 6 months of life spent at home or in a community setting Scotland 2015/16 to 2024/25 Public Health Scotland, 2025

Financial Year	Home/Community	Hospital
2015-16	87.0%	13.0%
2016-17	87.4%	12.6%
2017-18	88.0%	12.0%
2018-19	88.0%	12.0%
2019-20	88.2%	11.8%
2020-21	90.2%	9.8%
2021-22	89.7%	10.3%
2022-23	88.9%	11.1%
2023-24	88.9%	11.1%
2024-25 ⁱ	89.2%	10.8%

Source: Public Health Scotland (2025) [Percentage of end of life spent at home or in a community setting: Financial years ending 31 March 2016 to 2025](#)

Where do people die?

Of all the deaths registered in Scotland in 2022-23 (excluding sudden or accidental deaths) 45.8% took place in hospital (27,926), 30.7% at home (18,797), and 18.8% in care homes (11,529). Approximately 4.7% of deaths (2,882) were in a hospice or specialist palliative care unit.

However, there is some variation in place of death depending on age and underlying health condition.

For example, in 2022-23, 43% of deaths occurred at home in people aged under 69. This compares to 27% of deaths in people aged 70+. Similarly, 3.3% of deaths occurred in a care home for people aged under 69 compared to 23.4% for people aged 70+.

There is also some difference depending on the cause of death.

ⁱ Data for 2024/25 are provisional.

Proportion of deaths in each location by cause of death, 2022-23 Scottish Government, 2024

Cause of death group	Care Home	Home	Hospice/Palliative Care Unit	Hospital	Other
Cancers	12.1%	33.7%	86.7%	23.1%	14.3%
Circulatory System Diseases	20.3%	33.7%	4.0%	25.5%	25.7%
Nervous System Diseases	20.9%	4.3%	1.8%	4.9%	11.4%
Respiratory System Diseases	8.7%	9.0%	2.3%	14.8%	11.4%
Mental and Behavioural Disorders (inc Dementia)	21.2%	4.1%	0.3%	3.5%	17.1%
Other Causes	16.9%	15.3%	5.0%	28.3%	20.0%

Source: Scottish Government (2024) [Palliative care strategy - population data and research: overview](#).

Service mapping

As part of the development of its palliative care strategy, the Scottish Government undertook a [service mapping survey](#) of: ¹³

- Adult specialist services
- Paediatric services
- Health and Social Care Partnerships
- Territorial and special health boards

Key findings of the mapping exercise are outlined below.

Structures and Planning

- Collaborative relationships between Health and Social Care Partnerships (HSCPs) and NHS Boards are diverse and complex, with variation in how general and specialist palliative care services are managed and reported across and within NHS Board areas.
- Respondents highlighted a strong need for better integrated working and fair resourcing across all care settings for palliative and end-of-life care.
- Most HSCPs (86%) and NHS Boards (78%) reported having nominated palliative care leads, usually in clinical rather than executive roles.
- While most HSCPs included palliative care in their 2023-24 strategic plans, detailed commissioning or service delivery plans for general or specialist palliative care were rarely found in published documents.

Adult Specialist Palliative Care Services

- Of the 38 Adult Specialist Palliative Care Services (ASPCS) that responded, 56.5% described themselves as independent/third sector, 41% as NHS Scotland and 2.5% as 'other or joint funding'.
- Services reported providing specialist care at home, in hospital, in care homes, in outpatients and within hospices/ specialist palliative care units. Delivery varied in terms of resourcing, service models and provision.
- Community-based specialist care is available in all NHS board areas, although it varied in approach, structure and resourcing. It is led mainly by nurse specialists.
- Most NHS boards have specialist teams within hospitals but these varied in terms of team structure and resourcing, and fewer than half of boards responding had hospital inpatient palliative care beds.
- There were 138 whole time equivalent (WTE) community clinical nurse specialists (2.5 per 100,000 population) and 53 WTE hospital nurse specialists (0.98 per 100,000 population).
- There was an average of 0.9 WTE palliative medicine consultants per 100,000 population.
- 3 NHS boards had no palliative medicine consultants in their area but linked virtually with other board areas for support.
- There were 245 specialist inpatient beds across 18 units (4.5 per 100,000 population).
- There were 3,795 hospice admission reported in 2021-2022.
- 10 NHS boards offer outpatient palliative care clinics.
- 13 of 22 Health and Social Care Partnerships offer out-of-hours telephone advice for all care settings.
- 8 NHS Boards provide a public phone line for palliative care advice.

Babies, children and young people

- There were 359 referrals to Paediatric Palliative Care services in 2022-2023, and 80% of these referrals came from 3 services.
- 28 young adults transitioned from paediatric services in 2022-2023. Numbers are under-reported, increasing and cases complex.
- Only third sector services have dedicated transition teams. Partnership between third sector partners offers a transitions pathway in 4 NHS Board areas.
- The majority of specialist paediatric palliative care staff were funded by the third sector to deliver many services, particularly in the community, as well as bereavement support and transitions to adult services.
- There was large variation in referral patterns and referral routes in paediatric palliative care. Respondents mentioned the third sector as an important referral partner.

Expenditure

There is limited data on expenditure on palliative care in Scotland.

The most recent 'official' source of how much is spent dates back to 2008 and comes from [Audit Scotland](#). This audit found that, in 2006-07, £59 million was spent on specialist palliative care.¹⁴

This was broken down as:

- £26.2m voluntary sector funding of voluntary sector hospices
- £17.3m NHS funding to voluntary sector hospices
- £15.5m NHS funding to NHS specialist palliative care services

44% of funding for specialist palliative care came from the voluntary sector and 56% from the NHS. Expenditure on general palliative care services could not be identified.

However, more recently, the [Nuffield Trust and the Health Economics Unit](#) published research on behalf of Marie Curie which looked at how much public money is spent supporting people in their last year of life.¹⁵

Overall, it found that the total spend in the final year of life was £22bn across the UK. The report also sets out estimates of Scottish-specific spend and gives an estimated total spend across all sectors of £2.29bn per annum.

Estimated spend on people in the last year of life by sector, Scotland, 2022

Sector	Spend per person	£millions	% of overall spend
Health care	£21,170	1,327	58%
Social care	£7,240	454	20%
Social security	£8,180	512	22%
All sectors	£36,590	2,293	

Source: Nuffield Trust and Health Economics Unit (2025) [Public expenditure in the last year of life](#).

The report provides a further breakdown of the health care expenditure, including in generalist services. This shows the majority of healthcare spend in the final year of life was on hospital care.

Estimated spend on health care in the last year of life by health care service, Scotland, 2022

Setting	Subtype	Mean activity/event per person who died	Spend per adult who died (£)	Total spend (£millions)
GP Practice	Contacts	20.2	440	28
	Prescribing	-	950	60
	Subtotal	-	1,390	87
Community	Subtotal	10	470	30
Hospice care ⁱⁱ	Inpatient	-	320	20
	Community and outpatient	-	300	19
	Subtotal	-	620	39
Unplanned care out of hospital	Ambulance	1.7	620	39
	NHS 24	1.7	60	4
	Subtotal	-	680	43
Unplanned care in hospital	ED Visits	1.4	330	20
	Emergency admissions	1.6	12,220	766
	Subtotal	-	12,550	787
Planned care in hospital	Elective admissions	1.3	4,400	276
	Outpatient appointments	4.6	1,060	66
	Subtotal	-	5,460	342
Hospital care (all unplanned and planned care in hospital)	Subtotal	-	18,010	1,129
Health care	Total	-	21,170	1,327

Source: Nuffield Trust and Health Economics Unit (2025) [Public expenditure in the last year of life](#).

The report also found that public expenditure accounted for 48% of hospice expenditure in Scotland. This is in keeping with the findings of the earlier Audit Scotland report which found that NHS boards funded between 41% and 53% of the costs of voluntary hospices.

The cost of meeting unmet need

A study for the UK Department of Health Palliative Care Funding Review in 2011 estimated that it would cost just over £144 million to extend services to two-thirds of those in need of palliative care in England but currently not receiving any. At that time, this equated to around £2,400 per person.¹⁶

Applying similar cost assumptions to Scotland, the study suggested it would cost £16.8 million to extend 'specialist and core' palliative care to all of those who would benefit from it.

Although the Nuffield Trust review indicates a high level of expenditure on healthcare in the last year of life, one study found that specialist palliative care, comprising consultation teams in acute hospitals and specialist palliative care in the community and in hospices, accounts for just 6% of formal healthcare costs. These authors concluded:

ⁱⁱ NHS hospices and specialist services included in relevant sub-sector spend; service spend may not add up to sub-totals due to rounding.

“ This evidence briefing provides strong evidence that palliative care and end-of-life care delivered through multi-disciplinary teams, with specialist palliative care integrated alongside specialist and generalist teams, is effective, leading to improved outcomes for patients and their family caregivers. These services are associated with reduced avoidable healthcare utilisation and cost savings, including through reduced use of urgent and emergency care and reduced length of inpatient stays. ¹⁷ ”

Palliative care and assisted dying

During the course of the stage 1 evidence on the [Assisted Dying for Terminally Ill Adults \(Scotland\) Bill](#) ('the Bill') many stakeholders raised the issue of palliative care.¹⁸

These issues were brought up by people on all sides of the debate and the concerns could broadly be divided into two main areas:

1. Whether inadequate palliative care will act as a driver of requests for assisted dying.
2. Whether assisted dying will erode the quality and availability of palliative care.

In its [stage 1 report](#) on the general principles of the Bill, the Health, Social Care and Sport Committee recommended:

“ 110. Throughout its scrutiny of the Bill at Stage 1, the Committee has heard compelling evidence of the overarching importance, irrespective of whether or not the Bill becomes law, of ensuring that everyone who needs to is able to access good quality palliative care at the end of their lives. The Committee hopes that, regardless of the outcome, the current debate on assisted dying will provide a catalyst for further attention to be given towards improving the quality and availability of palliative care services in Scotland. 111. Should the Bill progress beyond Stage 1, the Committee highlights to the Scottish Government the importance of giving ongoing careful consideration to how the Bill, if it becomes law, will interact with all other key aspects of end-of-life care provision, including palliative care.¹⁹ ”

The following sections explore in more depth some of the evidence around the relationship between palliative care and assisted dying.

Please note that each of the jurisdictions mentioned in the following sections operate different models of assisted dying and therefore the data and evidence should be viewed in this context. For example, Canada and the Benelux countries have broader eligibility criteria for assisted dying than places like Australia, New Zealand and Oregon.

Palliative care as a driver to assisted dying

A key concern for some is whether people may opt for assisted dying because they feel it is their best option i.e. because they cannot access palliative care, or because their needs are not being met by palliative care.

Some jurisdictions with assisted dying legislation collect data on whether people making a request for an assisted death:

- were in receipt of palliative care at the time of their request, and/or
- the reasons underpinning their request.

This data has often been referenced during the debate on the Assisted Dying for Terminally Ill Adults (Scotland) Bill and is shown in more detail below for select jurisdictions with accessible data.

Assisted dying applicants in receipt of palliative care

Jurisdictions which collect data on whether assisted dying applicants are in receipt of palliative care or not include; Australia, New Zealand, Canada, Oregon, California and Washington. The data for each is shown below.

This data tends to show that the majority of people (at least three quarters) seeking assisted dying are also in receipt of palliative care. Some suggest this shows people are not seeking assisted dying due to a lack of access to palliative care, but rather, they view it as an addition to their end-of-life care options. However, this data makes no assessment of the quality of care people are receiving.

Australia

A report on 'The State of Voluntary Assisted Dying in Australia and New Zealand 2024' found 78% of people seeking assisted dying were in receipt of palliative care.

There was some variability among the Australian states. ²⁰

Proportion of applicants for assisted dying receiving palliative care, by Australian state.

Area (Date law commenced and time in operation)	% receiving palliative care (year to 30 Jun 2024)	% receiving palliative care (since law active)
Victoria - (Jun 2019 - 5 years in operation)	75%	79%
Western Australia - (July 2021 - 3 years in operation)	84%	85%
Tasmania - (Oct 2022 - 1 year 8 months in operation)	81%	NA
South Australia - (Jan 2023 - 1 year 5 months in operation)	80%	78%
Queensland - (Jan 2023 - 1 year 6 months in operation)	74%	75%
New South Wales - (Nov 2023 - 7 months in operation)	85%	85%

Source: Go Gentle Australia (2025) [State of VAD Voluntary Assisted Dying in Australia & New Zealand 2024 update](#).

A [review of the first 5 years of voluntary assisted dying \(VAD\) in Victoria, Australia](#) found:

“ VAD applicants in the first four years showed that 88% of rural and regional applicants and 83% of metropolitan applicants were accessing palliative care when they first requested VAD, suggesting that the higher rate of VAD uptake in regional and rural Victoria does not reflect difficulties accessing palliative care, and that VAD is appropriately being accessed alongside palliative care, rather than as an alternative to palliative care. ²¹ ”

New Zealand

According to the [Assisted Dying Service Annual Report 2024](#), 75.9% of applicants were in receipt of palliative care. ²²

Canada

The most recent report on Medical Assistance in Dying (MAiD) in Canada found that 75% of MAiD recipients accessed palliative care services and of those who required but did not receive palliative care services, for less than 0.1% of people, this was because care was not accessible. However, for 7.4% of recipients, it was not known whether they were in receipt of palliative care or if it was required. ²³

Requirement for, and duration and accessibility of, palliative care services among MAiD recipients

Requirement for, and receipt of, palliative care services	Number of persons	Percentage of all MAiD provisions (%)	Duration or accessibility of palliative care	Number of persons	Percentage of all MAiD provision (%)
Required and received	11,510	75%	Duration of palliative care for those who received it		
			Less than one month	4,792	31.2%
			One month or more	5,712	37.2%
			Unknown length	1,006	6.6%
Required, did not receive	431	2.8%	Accessibility of palliative care for those who did not receive it		
			Care was not accessible	6	< 0.1%
			Care was accessible	347	2.3%
			Unknown if care was accessible	78	0.5%
Other	3,402	22.2%	Unknown if required	1,139	7.4%
Total	15,343	100%	Did not require care	2,263	14.7%
				15,343	100%

Source: Health Canada (2024) [Fifth Annual Report on Medical Assistance in Dying in Canada, 2023](#).

Oregon

The most recent statistics for Oregon show that 92% of patients applying for assisted dying were enrolled in a hospice scheme. The average since the legislation came into operation is 91.1%. ²⁴

California

The [End of Life Option Act Report 2024](#) shows that since the law came into effect (9 June 2016 through to 31 December 2024) 91.9% of assisted dying recipients were receiving hospice and/or palliative care. ²⁵

Colorado

According to the [Medical Aid in Dying Report 2024](#) ²⁶, 84.1% of patients who died using MAiD were under hospice care.

Washington

The [Death with Dignity Act Report 2023](#) reports that 86% of people were enrolled in hospice care when they ingested the medication. ²⁷

Reasons underpinning requests for assisted dying

Canada and Oregon also record the nature of suffering amongst those seeking assisted dying, including some types of suffering that may be amenable to palliative care. For example, 'inadequate pain control, or concern about it' was reported by over half of applicants in Canada and around a third in Oregon.^{23 24}

The data is not broken down into whether the person is currently experiencing inadequate pain control, or if this is a concern they have for the future.

Reported nature of suffering by track Canada has a two track system for people seeking assisted dying. Track 1 is for those whose death is foreseeable. Track 2 is for those whose death is not foreseeable., Canada, 2023

Type of Suffering	Track 1 - where death is reasonably foreseeable (%)	Track 2 - where death is not reasonably foreseeable (%)
Loss of ability to engage in meaningful activities	95.5%	96.3%
Loss of ability to perform activities of daily living	87.3%	83.1%
Loss of dignity	64.9%	70.4%
Inadequate pain control, or concern about it	54.4%	58.5%
Loss of independence	52.8%	39.1%
Perceived burden on family, friends and carers	45.1%	49.2%
Inadequate control of other symptoms, or concern about it	41.8%	31.2%
Emotional distress, anxiety, fear or existential suffering	38.5%	35%
Loss of control of bodily functions	33.4%	32.2%
Isolation or loneliness	21.1%	47.1%
Other	3.6%	4.8%

Source: Health Canada (2024) [Fifth Annual Report on Medical Assistance in Dying in Canada, 2023](#).

Reported nature of suffering, Oregon, 1998-2024

End of life concerns	2024	2024	1998-2022	Total
Losing autonomy	87.8%	91.2%	90.2%	90.1%
Less able to engage in activities making life enjoyable	87.8%	88.6%	89.8%	89.4%
Loss of dignity	63.6%	63.5%	71.3%	69.4%
Losing control of bodily functions	46.8%	46.9%	43.8%	44.5%
Burden on family, friends/caregivers	42%	44%	47.7%	46.6%
Inadequate pain control or concern about it	34%	35%	28%	29.5%
Financial implications of treatment	9.3%	8.3%	5.1%	6%

Source: Oregon Health Authority (2025) [2024 Oregon Death with Dignity Act Data Summary](#).

An Australian study which [reviewed](#) the case notes of patients expressing an interest in assisted dying found that, on expressing initial interest, 57% of people were experiencing actual suffering, mostly existential in nature. However, the reasons differed depending on

whether the individuals proceeded with an assisted death or not.

“ The major reasons for seeking VAD [Voluntary Assisted Dying] for the cohort were a desire for autonomy (68%), actual suffering (57%) (mostly existential), fear of future suffering (51%) and social concerns (22%). Among those who died from VAD, the fear of future suffering (49%) was cited more commonly than actual suffering (45%). Among those who did not die by VAD, the primary reason for seeking VAD had been actual suffering (66%) more than autonomy (65%).²⁸ ”

The effect of assisted dying on palliative care

Another issue often raised in the debate, is the effect that the introduction of assisted dying may have on palliative and end-of-life care services.

Proponents for assisted dying argue that it can act as a complement to palliative and end-of-life care, rather than a substitute. These commentators often highlight an increase in funding for such services following the introduction of assisted dying and the successful integration of assisted dying into end-of-life care pathways, with increasing numbers of palliative care professionals being involved.

Those opposed to assisted dying argue it has a detrimental impact on palliative care services. This may occur at a population level, for example, through competition for funding, or it may have a direct impact on the care received at an individual level. These points are explored in more detail in the following sections.

Effect on funding and service provision

The impact of assisted dying legislation on the funding and provision of palliative care is subject to ongoing debate.

While some commentators have argued that assisted dying diverts limited resources away from palliative care, this is refuted by others. For example, in a submission to the Health, Social Care and Sport Committee, Prof James Downar, Head of Palliative Care at Ottawa University sought to counter claims made about what is happening in Canada in relation to palliative care:

“ Many Canadians have poor access to Palliative Care, as do many in the UK, but funding/support for clinical palliative care has increased dramatically in much of the country since MAiD became legal, including:”

- A large growth in funding and salaried positions for Palliative Care physicians. For example, in the past 4 years, the division I lead in Ottawa has almost doubled in size (to >40 physicians).”
- \$3 billion invested in home care in 2016, much of which went to palliative care services.”
- Millions of dollars invested in research at the federal and provincial levels, providing funding for the Pan-Canadian Palliative Care Research Collaborative in Ottawa, and the Palliative Care Institute in Alberta, and announcing dedicated research funding for palliative studies.”
- There has been a large growth in the number of funded community hospice beds in Canada in particular over the past 5 years, mirroring the rapid growth seen in the Benelux countries following MAiD legalization there.[1] In Ontario, for example, the number of funded hospice beds almost doubled (to 750) between 2016 and 2024.”

The Health, Social Care and Sport Committee also received evidence highlighting increases in funding for palliative care in other jurisdictions when assisted dying laws were changed, including the introduction of concurrent laws (see [Palliative care laws alongside changes to assisted dying laws](#)).

Similarly, the House of Commons inquiry into assisted dying/assisted suicide in 2024 concluded:

“ In the evidence we received we did not see any indications of palliative and end-of-life care deteriorating in quality or provision following the introduction of AD/AS [assisted dying/assisted suicide]; indeed the introduction of AD/AS has been linked with an improvement in palliative care in several jurisdictions. ²⁹ ”

However, this conclusion is disputed by others, including Anscombe Bioethics Centre whose analysis found:

- **Slower Progress in Palliative Care:** Between 2012 and 2019, European countries with legal assisted dying (e.g. Belgium, Netherlands) increased palliative care provision by 7.9%, compared to 25% in countries without it. Similar trends were observed in the U.S., where states without assisted dying saw faster growth in hospital palliative care teams.
- **Funding Competition:** In jurisdictions where AD/AS is considered part of end-of-life care, it often competes with palliative care for funding. For example, in New South Wales, increased funding for AD/AS was followed by significant cuts to palliative care budgets, impacting staffing and service delivery.
- **Unfulfilled Spending Commitments:** Promised investments in palliative care (e.g. Canada’s \$6 billion commitment) were often not ring-fenced, and actual allocations fell short. In Canada, \$184 million was traceable over five years.

Effect on individual care quality

A review by the [Nuffield Trust](#) which looked at assisted dying in practice identified a small amount of evidence showing that the impact of assisted dying on broader end of life care experiences is mixed.³⁰

The integration of assisted dying with end-of-life care services seems to be a key factor when assessing impact. In some regions unclear policies regarding the role of hospices and care facilities in assisted dying have led to tensions, with some stakeholders advocating for assisted dying to remain distinct from palliative and hospice care. In New Zealand, a lack of clear guidance has reportedly discouraged individuals from disclosing their interest in assisted dying, fearing it might affect their access to palliative care.³⁰

Other evidence suggests that being on the assisted dying pathway may negatively impact end-of-life care, particularly in contexts where institutional objectionⁱⁱⁱ is permitted. Additionally, assisted dying can influence clinical conversations, with some practitioners reporting discomfort discussing palliative care and end-of-life planning, potentially reinforcing stigma.³⁰

The 5-year review of the assisted dying legislation in Victoria, Australia found:

“ Family members reported declines in the level of support from some palliative care services once VAD [Voluntary Assisted Dying] was mentioned. Where palliative care services did not support VAD, families reported that open discussions about palliative care treatment and options became limited and holistic and continuous care restricted. Some families reported patients had felt forced to choose between VAD and palliative care, a contravention of the principles of the Act.²¹ ”

In evidence to the House of Commons, Prof Katherine Sleeman of King's College London wrote:

“ Doctors report that MAiD legalisation [in Canada] paradoxically makes it more difficult to explore patients' suffering. MAiD clinicians report receiving referrals for MAiD, where careful exploration reveals that the patient "really ... wants palliative care".³¹ ”

Conversely, the Nuffield review highlights research from Australia and Canada suggesting that legalising assisted dying may enhance end-of-life care practices. It has been described by some as a catalyst for more open discussions about care goals and planning and they highlight:

“ ...a scoping review of health care practitioner and family experiences of assisted dying found that most studies conducted on physicians indicated that legalised assisted dying had improved their ability to provide better end of life care to patients who did not request assisted dying³⁰ ”

These mixed experiences were corroborated by the Australian study examining the effect of assisted dying on the quality of palliative care:

iii Institutional objection arises when a hospital, hospice, or care facility collectively chooses not to allow assisted dying services on its premises or through its staff. This is distinct from individual conscientious objection, which protects the rights of healthcare professionals to opt out based on personal beliefs.

“ VAD [Voluntary Assisted Dying] enquiries may encourage conversations, cohesion, therapeutic relationships and relieve suffering but also impact whole person care, cultural and spiritual perspectives and impart caregiver and staff distress. ²⁸ ”

Palliative care laws alongside changes to assisted dying laws

Access to good palliative care is viewed by many as a key consideration in the context of assisted dying. As a result, some countries have bolstered their laws around palliative care at the same time as changes to the law around assisted dying. These include Belgium, France and Germany.

Belgium

The Belgian law concerning palliative care was enacted in 2002 alongside its assisted dying legislation and gives every citizen the right to receive palliative care in a variety of settings. The law states (please note this is from a [translated version](#)):

“ Every patient suffering from an incurable illness must be able to benefit from palliative care. The arrangements for the provision of palliative care and the criteria for reimbursement of this care by social security must guarantee equal access to palliative care for all incurable patients, whether at home, in a nursing home, in a rest and care home or in hospital.”

Every hospital is supposed to have a palliative care team and palliative home care is to be available nationwide. Financial support is specified in regulations, and it has been widely reported that the resources accompanying the law led to a doubling of palliative care investment.

According to [one article](#), between 2002 and 2011, government expenditure for palliative care in Belgium rose from 89.77 to 186.98 million euros, an increase of 108%.

France

There have been previous laws enacted in France around access to palliative care but recently [legislation](#) was passed at the same time as assisted dying legislation and sets out:

“ ...the right to benefit from palliative support and care[...]is guaranteed to any person whose state of health requires it.”

The law commits over 1 billion euros of funding over the next decade to cover the following services:

- Day hospitals and short stays
- Stays in general medicine or surgery departments
- Stays in identified palliative care beds
- Stays in palliative care units
- The creation of palliative care units (including paediatric palliative care) in order to

achieve a minimum of 2 units per region by 2030

- Home hospitalisation
- Stays in medical and rehabilitation units
- Medicines dispensed in the community.

This funding is in addition to an estimated 1.6bn Euros of existing public funding for palliative care each year, meaning that by 2034, funding will have increased to 1.7 billion Euros per year.

A report on the Bill to the Social Affairs Committee detailed an estimated 50% of those in France who need palliative care receive it, with unmet need particularly evident at home.
32

Germany

In 2015, two different laws were adopted in Germany. One amended the criminal code to criminalise commercial, 'business-like' assisted suicides ([§ 217 German Criminal Code](#)) and the other aimed to improve hospice and palliative care in Germany.

The Hospice and Palliative Care Act 2015 aimed to develop and regulate the provision of palliative care in Germany.³³ The act did this by explicitly introducing palliative care as part of standard care within statutory health insurance.

In 2014, it was estimated that around 400 million Euros was spent annually on hospice and palliative care in Germany. This was made up of around 264 million Euros on Specialised Outpatient Palliative Care (SAPV) and between 140-150 million Euros on inpatient hospices and ambulatory hospice services

The Federal Ministry of Health estimated the Act would cost an additional 200 million Euros per year. This cost is borne by the health insurance companies.

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