

World Health Organization (WHO)



The question of the implementation and usage of palliative instead of curative medication

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Chair Introductory Letters

Parinlada Viktoria (Vicka) Wright

Hello delegates, it's a pleasure to meet each and everyone of you. My name is Parinlada Viktoria Wright, your chair for WHO, but you may call me Vicka! I am in Grade 12/Year 13 at RIS, and I plan to study in Europe for university; Psychology as my major. This marks my sixteenth conference overall and my eighth time chairing.

Outside of MUN, you will find me involved in many extracurriculars like Student Council and Red Cross, debating,

singing, and listening to my spotify playlists on repeat (If you like CAS, Slipknot, Queen, or Chappell Roan, please talk to me!!!).

Anyhow, please take the time to read the information. It will

serve as a useful guideline for your research, position papers, and most importantly, your resolution papers.
:D

If you have any questions, inquiries, or concerns, please contact me on instagram at @vicka.w or through email at viktoriawright26@gmail.com or refer to my co-chair. Good luck to all of you, delegates, both old and new.

Unn and I are looking forward to seeing you in October!!

Asiwan (Unn) Pasuwat

Hello delegates, my name is Asiwan Pasuwat (you guys can call me Unn Unn), I will be one of your chairs for the WHO committee for the Concordian MUN conference. I am very excited to be chairing you all with my co-chair Vicka. I am currently 17 years old and in grade 12/ year 13 at EIS. I plan to study in Australia for my undergrad majoring in finance. Outside of MUN you guys can find me crashing out over college apps or playing tennis. If any delegates have any questions regarding the conference feel free to ask me or my co-chair about it. Delegates can contact me through my instagram @unn_unn or through email at 05947@eis.ac.th, and I look forward to seeing you all in October!!



Committee Overview

The World Health Organization (WHO) is a specialized organ within the United Nations that serves as the primary international body for public health. WHO provides leadership on global health matters, shapes the health research agenda, sets norms and standards, articulates evidence-based policy options, provides technical support to countries, and monitors and assesses health trends. These acts are with a mandate, to ensure the highest possible level of health globally.

The organization focuses on a wide range of fields, including global health security to prevent contamination, outbreaks and pandemics, along with the advancement of universal health coverage to ensure access to quality health services for everyone, and the prevention and management of noncommunicable diseases such as cancer, diabetes, and heart disease. Additionally, WHO also plays a vital role in achieving the health-related Sustainable Development Goals, specifically SDG 3, which scopes on good health and well-being, and it works to strengthen our health systems worldwide, enhancing the capacity of countries to deliver essential health services to prevent further issues from escalating.

In the committee, delegates of WHO will debate in order to address the critical issues, including the implementation and usage of palliative instead of curative medication, and the legalization and regulation of euthanasia. Delegates should aim to address the complex ethical and practical considerations of these pressing healthcare challenges through fruitful debates within our committee sessions.

Topic Introduction

The topic for this committee scopes onto the discussion of the implementation and usage of palliative care in place of curative medications. Healthcare systems worldwide face a demanding challenge of balancing curative treatments – a form of medical care given to a patient in order to eliminate or cure a disease, injury, or illness – with palliative care, a treatment that aims to manage specific symptoms and improve the quality of life and overall comfort of a patient. Curative treatments may be traditionally prioritized, but palliative care has nevertheless been receiving growing attention and recognition, leading as a consideration in numerous healthcare treatments, specifically in cases where cures are unobtainable or costly. The World Health Organization reported 58.6 million people¹ annually require palliative care, a majority of people coming from low and middle-income countries. In conflict, it has also been reported that less than 14% of patients receive these palliative treatments. These disparities are high within economical classes; in high income countries, such as The United States, Canada, and Australia, usually integrate such treatments into their mainstream healthcare systems. Whereas in countries with limited resources and a shortage of trained professionals, many people are left with inadequate care and support.

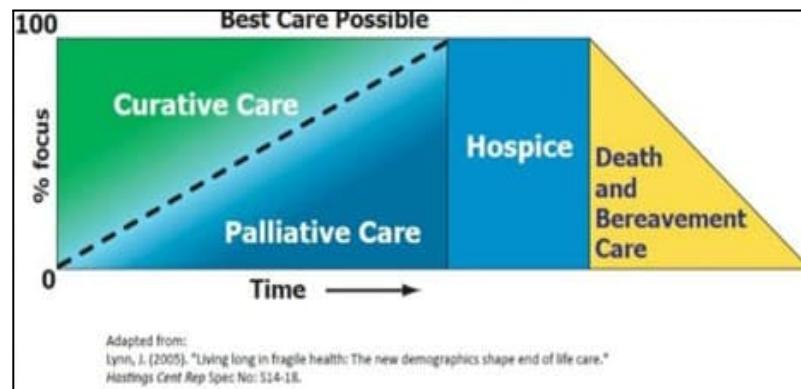
The debate over whether countries should prioritize palliative support over curative treatments raises countless concerns amongst many. It is important to recognize that in specific contexts, the investment in curative medications could be unsustainable and far too unattainable for patients from lower-income backgrounds. This is also the case for complex diseases, such as Parkinson's disease, Alzheimer's disease, and multiple sclerosis, all requiring comprehensive and well-rounded approaches like palliative care, which considers many factors and provides immediate relief.

¹ WHO. "Palliative Care." *World Health Organization*, 5 Aug. 2020,

Simultaneously, tensions also rise as member states are anxious that being over-reliant on palliative approaches in place of traditional long-term cures could raise the question of true equity in healthcare.²

Delegates of the WHO committee must carefully evaluate how to equalize the resources across both treatments, while also considering a country's available resources and economic status in order to promote a patient-centered healthcare on a global scale.

Fig. 1 - ‘Curative care is the initial focus for most cases, but palliative measures must be included.’



Definition of Key Terms

Key Term	Definition
Palliative Care	A biopsychosocial approach in healthcare, focusing specifically on improving a patient's quality of life and well-being; Examples of palliative care could be managing pain and other symptoms, while considering psychological, spiritual, and social support for the patient's environment.
Curative Treatment	A medical treatment meant for curing an illness or disease with the goal of a patient's full recovery, often through surgery, assigned medication, or specialized treatments like therapy.
Hospice Care	A type of palliative care, specializing in providing care to patients, those in their final stages of terminal illnesses. It focuses more on enhancing comfort and dignity rather than using aggressive treatments.
End-Of-Life Care	Healthcare services provided during the period when a patient is nearing death, which may include both palliative and hospice care, while controlling symptoms and providing emotional support.
Opioid Analgesics	Medications such as morphine and fentanyl, considered as essential by WHO for pain relief in palliative care.
Noncommunicable Diseases (NCDs)	Leading causes of death worldwide; Chronic illnesses such as cancer, cardiovascular diseases, diabetes, and chronic respiratory conditions.

² Akdeniz, Melahat, et al. “Ethical Considerations at the End-of-Life Care.” *SAGE Open Medicine*, vol. 9, no. 9, Mar. 2021, pp. 1–9,

Quality of Life	The primary aim of palliative care: A measure of overall well-being, encompassing physical, psychological, and social health.
Universal Health Coverage	An objective by WHO and the UN to ensure that all individuals and communities receive the health services they need without going through financial hardship.
Pain Management	The use of medications, therapies, and psychological support to reduce physical suffering in patients.
Advance Care Planning (ACP)	Advance care planning involves making a plan for future health and personal care should a person lose their decision-making capacity
Millennium Development Goals	Eight international development goals for the year 2015 created following the Millennium Summit, following the adoption of the United Nations Millennium Declaration

Key Stances and Parties

United States of America

The United States strongly advocates for the integration of palliative care across its national healthcare services. They support and implement both curative and palliative research as a balanced approach. Moreover, the U.S. highlights the importance of innovation, workforce training among professionals, and public awareness broadcasted on several social media networks and live television about end-of-life care. Even though access to palliative care is evolving, the access in states remains imbalanced, with barriers like a lack of employees, and reimbursement. Despite the challenges, the US has managed to advocate for the benefits of palliative care, such as improved quality of life, satisfaction from patients and their families, and managing overall symptoms.³

Canada

Canada remains as one of palliative care's strongest and early proponents. It has aimed to further advance palliative care through government policies and frameworks nationally, under the Palliative Care Act of 2017. Organizations rooted with the government, such as Pallium Canada are willing to educate healthcare professionals on palliative care, in hopes of expanding its access in various contexts, specifically home and hospice care. Canada recognizes the importance of integrating patient-centered care and improving the quality of life of patients. Furthermore, the nation strongly supports universal access to essential palliative treatments and necessary medications.

Germany

Prioritizing healthcare systems that include comprehensive approaches like palliative services, Germany has an extremely well-developed infrastructure for palliative-specialized care: hospitals, hospices, and a specialized professional team for emergencies.

³ Morrison, R. Sean. "Models of Palliative Care Delivery in the United States." *Current Opinion in Supportive and Palliative Care*, vol. 7, no. 2, June 2013, pp. 201–6, <https://doi.org/10.1097/SPC.0b013e32836103e5>.

These infrastructures were able to be built and implemented under a framework called the Hospice and Palliative Care Act of 2015, also known as HPG. The framework has served not only as a structure for these facilities, but also added care into health insurance systems. Germany calls for standardized protocols and aims for training programs to be continuous, training professionals to handle specific cases that require care and providing comfort. Furthermore, Germany keeps an ultimate scope on equalizing the usage of both curative and palliative care.⁴

United Kingdom

The UK strongly stands for patient-centered palliative care, and has taken measures to combine curative medicine and treatments with palliative hospice programs. The Integrated Care Boards of the United Kingdom have been on legal duty to commission such healthcare services under the Health and Care Act, published in 2022.⁵ Additionally, it scopes for fair access for palliative treatments nationally and worldwide, in collaboration with other nations through the EMMS International project: Nepal, Malawi, Rwanda, and Zambia. Their ultimate goal is to dedicate time, respect, and holistic approaches to patients in need – regardless of their diagnosis.

India

India faces overwhelming challenges with access to medications and healthcare services across its nation. It faces a concerningly, growing need for palliative care, especially with less than 4% of the country's population getting equitable access to it. Due to its overpopulation, high amounts of poverty and limited access to opioids, India is held back from receiving full integration of palliative care within its country. But even with these issues, progress has been made through help from government initiatives in Kerala, like building government-based models and National Programs of Palliative Care. Legal policy changes have also led to increased access to pain medications, as well as education and awareness.

Kenya

Also aiming to expand palliative care nationally, Kenya faces a challenge of meeting the amount of demand for it due to scarce resources, a total of less than 800,000 patients receiving proper care annually. The Kenya Hospices and Palliative Care Association (KEHPCA), an organization by the Kenyan government, are working towards the goal of merging palliative care into new healthcare policies and services. Although this goal seems realistic, Kenya encounters numerous obstacles: lack of trained staff and misunderstandings from the public, confusing palliative care to undividedly provide for end-of-life care.

World Health Organization (WHO)

The WHO promotes palliative care as a key component for a comprehensive healthcare system and for universal health coverage. Its stance is supported by the 2014 international resolution, which strongly urged countries to fuse palliative care into primary healthcare settings, as well as settings among communities. The resolution also wanted countries to ensure access to medicine and training for healthcare workers and outreach teams. The

⁴ van Baal, Katharina, et al. "End-of-Life Care in Germany between 2016 and 2020 - a Repeated Cross-Sectional Analysis of Statutory Health Insurance Data." *BMC Palliative Care*, vol. 23, no. 1, 2024, p. 105, <https://doi.org/10.1186/s12904-024-01387-6>.

⁵ Khosla, Divya, et al. "Palliative Care in India: Current Progress and Future Needs." *Indian Journal of Palliative Care*, vol. 18, no. 3, 2012, pp. 149–54, <https://doi.org/10.4103/0973-1075.105683>.

organization provides technological guidance, assisting in medicinal production and lists essential for treatments, and supports policies and measures taken to ensure that patients have access to pain relievers and proper, professional end-of-life care.

United Nations Children's Fund (UNICEF)

UNICEF promotes palliative care for children and their families (family-centered care), as they view it as a vital element of a child's healthcare and future development, beginning at diagnosis, then treatment that focuses closely on biopsychosocial approaches to accommodate a child and make them feel comfortable and safe. UNICEF aligns with the principle where children should have the right to have an environment with support from their family. Hence, the organization works closely with developing resources and tools necessary for the training of staff, leading to the transformation of child care institutions to provide palliative treatments to children and their families.

Timeline Of Events

Date & Event	Description of Events
Founding of the Modern Hospice Movement 1967	In 1967, Dame Cicely Saunders, an English nurse and physician, founded the St. Christopher's Hospice in London. Her discovery led to a revolutionized approach to end-of-life care that effectively combined medical, psychological, and spiritual support to its patients, which marked the very beginning of palliative care and its recognition.
WHO's first definition of Palliative Care May 1986	In May of 1986, the World Health Organization, having dealt with national cancer control strategies, issued its first definition of palliative care as 'the active total care of patients' whose disease is not responsive to curative treatment'.
Cancer Pain Relief Guidelines set by WHO 1990	WHO published its first global guidelines in 1990, <i>Cancer Pain Relief and Palliative Care</i> , including the "WHO analgesic ladder," a framework for pain management in step-by-step format that remains widely used today.
Millennium Development Goals adopted by the UNGA September 2000	The United Nations General Assembly decides to adopt the MDGs, established in 2015, where curative measures were seen dominating global health priorities and palliative care barely mentioned, which showed the UN's focus on diseases was primarily on eradication rather than relieving symptoms.
WHO Re-defines Palliative Care 2002	During 2002, the World Health Organization released an official re-definition of palliative care by shifting its focus entirely and accurately in contrast to its first definition, stating it is 'an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering.'

Crucial Medicine Lists Expand March 2004	WHO includes morphine and other opioids into its list of Model List of Essential Medicines, noting these as necessary components of palliative treatments. However, in some low and middle-income countries, there is strict international drug control, which could pose risks and difficulties in integrating those substances into healthcare processes.
High-Level UN meeting on NCDs 19-20th September, 2011	In New York of 2011, UN member states gathered to discuss a critical global agenda concerning Noncommunicable Diseases, also known as chronic diseases. The summit's goal was to ensure commitment to preparedly confront four globally relevant diseases—cancer, cardiovascular disease, diabetes, and chronic respiratory disease. Moreover, the role of palliative care was acknowledged for the first time at a UN level, its role being vital in managing the diseases mentioned.
WHA Resolution on Palliative Care 23 May, 2014	Resolution WHA67.19 ⁶ was adopted by the World Health Assembly in 2014, which called for strengthening and using palliative care as a component in health systems globally, as well as universal health coverage. Moreover, it called for improving access to medications and training frontline workers for various processes.
Landmark Report Released 12 October, 2017	A Lancet Commission Report was published on October 12th, 2017, revealing that an estimate of 61 million people suffered critical health-related distress and symptoms without proper access to palliative care services. The report also highlights a key imbalance – where 90% of morphine consumption belongs to high-income countries.
UN Declaration on Universal Health Coverage 23 September, 2019	The United Nations Higher-Level Meeting in 2019 on the agenda of UHC, adopted a declaration, explicitly mentioning palliative care as a core component of universal health coverage, marking this meeting as the highest level recognition palliative care has received from the UN.
COVID-19 Pandemic with Palliative Care 2020	The COVID-19 pandemic in 2020 significantly increased the need for palliative care due to the complex needs of critically ill patients, including serious, different factors and levels of distress of being isolated in a quarantine setting.

⁶ Carrasco, José Miguel, et al. "Early Impact of the 2014 World Health Assembly Resolution on Palliative Care: A Qualitative Study Using Semistructured Interviews with Key Experts." *Journal of Palliative Medicine*, vol. 24, no. 1, Jan. 2021, pp. 103–6, <https://doi.org/10.1089/jpm.2019.0384>.

Key Issues

1. Unequal Access to Palliative Care Across Regions

Although awareness and integration of palliative care is widely used within healthcare systems in high-income countries, over 78% of people in low-income and middle-income countries remain unrecovered, as availability for resources and professional staff are scarce. The disparity and contrast between the economical classes raises points that situations like these are results from problems of equity and international responsibility. This could allow delegates to explore the possibilities of international assistance or cross-border cooperation playing a greater role in guaranteeing access.

2. Availability and Regulation of Opioids

International drug control laws in numerous countries prevent the use of morphine and other opioids, caused by national fears of the misuse and addition of these drugs. However, this also restricts access in several countries, ultimately creating a challenge to balance the safe regulation when focusing on a patient's needs. Delegates should consider the challenge, and how to strike a balance between preventing abuse of substances and ensuring that patients are not left to suffer without professional help.

3. Prioritization of Curative Treatment Funding over Palliative Care

Governments and donors often allocate resources primarily toward curative treatments as they're traditionally recognized, which could leave palliative services underfunded and overlooked. The discussion circulates on whether resources should focus on curing diseases or alleviating suffering, especially when cures are unavailable for complex, chronic diseases like cancer or cardiovascular disease. Delegates should analyze and decide whether these limited resources allocated by the government should go to potentially life-saving treatments, or should they be given to care that restores a patient's quality of life with no goal of 'cure'?

4. Global Policy and Coordination Gaps

Although there are passed resolutions by the World Health Assembly and the World Health Organization, the implementation remains inconsistent in countless countries, where intense suffering and battle occur to fight against these diseases. Currently, there is no binding international framework to guarantee access. Delegates must find or call for a creation of stronger commitments and frameworks – ones that have targets, mandatory reporting of progress, and the inclusion of all member states to unify and assist one another. This would ultimately seal the gap between recognizing the treatment and actually practicing it.

Past International Action

Name	Description

WHO defines Palliative Care	WHO issued the organization's first formal definition of palliative care in 1986, then reinforced it in their publication in <i>Cancer Relief and Palliative Care</i> in 1990. This officially introduced influential information on pain management and relief.
Inclusions in the Essential Medicines List	The World Health Organization added morphine and other pain relievers to its List of Essential Medicines, which emphasized the importance of pain relief and management as a fundamental and important concept for healthcare treatments. Unfortunately, access to these opioids in countries with low-to-middle income rates have been prohibited due to strict national control laws.
WHA Resolution 67.19	<p>The adoption of the World Health Assembly Resolution 67.19 in 2004, titled "Strengthening Palliative Care as a Component of Comprehensive Care." It called upon Member States to:</p> <ol style="list-style-type: none"> 1. Integrate palliative care into health systems on a national scale, 2. Ensure access to all essential palliative medicines, 3. Provide comprehensive training for healthcare workers, and 4. Support children, families, and caregivers. <p>Although this was marked as a milestone in progress for palliative care, implementation of its practices has remained inconsistent throughout the years.</p>
Universal Coverage Declaration by the UN	At the UN High-Level Meeting on UHC, Member States recognized palliative care as an essential part of Universal Health Coverage, which gave palliative care a push to the highest level of international political commitment.

Possible Solutions

Delegates should allow this part of the chair report to serve as a guideline when writing resolutions in your blocs.

1. Firstly, delegates should aim to urge and encourage member states to amalgamate palliative care into national healthcare systems, as well as UHC packages. This could include making collaborative models between nations, specialized teams, and working together to increase palliative training for all healthcare professionals. In cases where workers are limited, countries with an abundant amount of specialized staff could travel to provide training to nations that lack the availability to perform these programs.
2. Then, delegates must focus on the central concern of this topic: balancing curative treatments with palliative care. A method for this is the development of indicators that track how effective the balance is between both treatments in member states, such as a patient's access to either service, the overall validity of the treatment, and quality of life metrics. This plan could ensure that neither approach is completely neglected, and that the focus on both is equalized and plays an important role. It is imperative to recognize that health systems will prioritize curative treatments because they have more visible outcomes as they aim to cure diseases. Palliative care is seen as "unobtainable" in political views, making negotiation for such events to occur challenging.
3. Moreover, drug control regulations must be balanced with medical needs by revising and negotiating overly restrictive national laws on opioid distribution. This can be held through conferences and discussions with the government of a nation through help from the UN to facilitate progress and mediate potential conflict.
4. Delegates should also aim to increase the total national and international funding dedicated to palliative care. This could mean relying on the World Bank and UN development funds, or creating global mechanisms for funding used for HIV/AIDS and tuberculosis programs. However, do take note that relying solely on funds from international organizations can be unpredictable: global economic problems, donor priorities, and political tensions all lead to funding becoming unsustainable and lacking stability.
5. Lastly, delegates should confirm through discussions to clarify that palliative care is not a replacement for curative treatment, but it's more of a complementary factor. Campaigns and educational programs can be beneficial to families and communities to understand when and why both approaches may be necessary, which could possibly lead them to becoming more open minded about their views. However, taking precautions is necessary since some statements and misunderstandings could trigger the public or political opposition unless held as awareness campaigns.

Questions to Consider

1. How can member states balance investments between curative and palliative care treatments so that both methods are used when treating a patient?

2. How can low and middle-income countries overcome financial barriers when accessing medications and the necessary resources for palliative treatments?
3. What role can international organizations play in assisting nations in efforts to integrate palliative care into various healthcare systems?
4. Should palliative care be introduced early alongside curative treatment, or specially reserved for end-of-life care? What positive outcomes would this have and challenges would each approach face?
5. How can cultural attitudes and ethical concerns about death and end-of-life care be addressed among communities to encourage acceptance of palliative services? How can communication be maintained on a respectful level when being addressed?
6. What mechanisms can be used to ensure that vulnerable populations and underserved communities receive equitable access to both curative and palliative care?
7. To what extent should funding from international agencies be relied upon? Is this the most ethical decision when requiring funds for resources and medications?

Appendix

1. [Differences between Curative and Palliative Care \(Webpage\)](#)
2. [WHO overview on Palliative Care \(Article\)](#)
3. [Funding Models in Palliative Care \(Article\)](#)
4. [The Lancet Commission on Palliative Care and Pain Relief—findings, recommendations, and future directions](#)
5. [Translating research into program development in low- and middle-income countries \(LMICs\)](#)
6. [Hospice, Palliative Care and End of Life Dignity \(Video\)](#)
7. [WHO Guidelines for Integrating Palliative Care into Healthcare Systems \(Video\)](#)
8. [Discussing the Challenges of Integrating Palliative Care \(Video\)](#)
9. [Palliative Care for Children - WHO \(Website\)](#)
10. [Millennium Development Goals Report \(PDF\)](#)

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World Health Organization (WHO)



The Question of the Legalization and Regulation of Euthanasia

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Topic Introduction

Euthanasia, the act or practice of painlessly putting to death a person suffering from painful incurable diseases or incapacitating physical disorder, by allowing them to die by withholding treatment or withdrawing artificial life-support measures (Britannica, 2025). Euthanasia has been regarded as either suicide (if performed by the patient themselves), or either suicide (if performed by another person); due to the provision of it in most legal systems (Britannica, 2025).

However, physicians through the law may deem that it would be better for the patient's life to not prolong life in case of extreme suffering. The first countries to legalize euthanasia was the Netherlands in 2001 then followed by Belgium in the following year; although those who had deemed it unlawful had attempted to have it overturned (Britannica, 2025). The opinion that euthanasia is morally permissible is traceable back to Socrates, Plato, and the Stoics; they had rejected the traditional Christian belief, due to the Ten Commandments containing prohibition for murder (Britannica, 2025).

The debate has become more urgent with advancements in medical technology, which is able to prolong life, many times at the cost of immense suffering for a patient physically and emotionally and may cause significant financial and emotional strains on families.

Definition of Key Terms

Key Term	Definition
Euthanasia	An act performed by a physician to end the life of a terminally ill patient, at the patient's explicit request.
Assisted Suicide/Dying	An act of intentionally assisting someone in ending their life, most of the time by providing means of medication. However, the final action is done by the patients themselves, not the doctor.
Active Euthanasia	A form of euthanasia where the physician actively intervenes, for example, by administering a lethal injection.
Passive Euthanasia	A form of euthanasia where the physician withdraws life-sustaining treatment, such as turning off a respirator.
Voluntary Euthanasia	Euthanasia carried out with the full consent explicitly mentioned by the patient; typically used in cases of terminal illness or severe suffering.
Involuntary Euthanasia	Euthanasia performed against the patient's wishes, often considered illegal, morally and ethically unacceptable; also considered a violation to human rights and dignity.
Non-voluntary Euthanasia	Euthanasia that is performed when the patient is unable to give consent, which is promptly in serious cases of unconsciousness or incapacitation.
Palliative Care	A biopsychosocial approach in healthcare, focusing specifically on improving a patient's quality of life and well-being; Examples of palliative care could be managing pain and other symptoms, while considering psychological, spiritual, and social support for the patient's environment.
Sanctity of Life	A belief that human life is sacred and deserving of unconditional protection and respect. This is usually used as an argument against the use of euthanasia, claiming that life, as a sacred gift, should not be deliberately terminated.
Right to Die	The concept where individuals should have the right to choose the timing and manner of their death, especially in cases of terminal illness and intense suffering.
Advance Directive of Living Will	A document issued legally to patients to specify their medical preferences, which also includes end-of-life decisions, if there are cases where the patients will no longer be able to communicate their decision later.

Key Stances and Parties

The Netherlands

In 2002, The Netherlands was the first ever country to completely legalize the usage of euthanasia and physician-assisted dying. According to Dutch national law, it is stated that euthanasia, supervised with strict measures, is allowed for patients in severe suffering and with no signs of recovery. Additionally, this act can only be done voluntarily and with the patient's full consent, and careful documentation by professionals and physicians. The policy highlights the Netherlands and its aim to ensure human dignity and living rights, even for the terminally ill, and serves as an optional choice for them, if they go through intense suffering.

Belgium

Not long after the Netherlands, Belgium also legalized euthanasia in 2002, under the strict expansion of the treatment to include minors. The policy mainly stresses the importance of personal choices and extends the scope beyond terminal illness to include conditions like severe, non-curable psychiatric disorders. Given these terms, Belgium strongly supports the global influence of this, advocating for a widespread legalization of euthanasia, viewing it as a fundamental human right, where people should have the freedom to end uncontrollable suffering from a disease with no cure.

Switzerland

Switzerland supports the process of assisted suicide under strict supervision and protocols, and strictly allows it under a patient's voluntary approval. Dignitas, a Swiss non-profit organization, provides means to the patient, but the actual act is carried out by the individual themselves. However, no Swiss laws explicitly allow the implementation of euthanasia, to ensure that there are no selfish intentions involved. Switzerland is known for its country's personal freedom, hence its discussions with other nations to convince them to limit various forms of assisted dying and acts of euthanasia.

United States of America

Euthanasia is illegal in all fifty states in the United States, but physician-assisted deaths are permitted under state law. In certain states, such as California, New Jersey, Oregon, and Washington. However, these laws specify that assisted deaths can only be carried out with legal adults under some terminal disease. Overall, the US' stance is mainly neutral, as some states resist the legalization of assisted suicide due to religious beliefs, while progressive states advocate for autonomy and freedom over this.

Philippines

Euthanasia, also known as "mercy killing" in the Philippines, is illegal – with Catholic teachings citing the sanctity of life – that life is sacred and should remain protected from conception to natural death. The government is consistent with their stance, declaring that deliberately ending someone's life is morally and ethically unacceptable. Alternatively, it suggests providing palliative care to patients with terminal and chronic illnesses. Due to its nation's strong religious standpoints, the Philippines continues to resist legalization.

Indonesia

Euthanasia is prohibited in Indonesia, since it contradicts the declaration of human right laws in 1945. The word “euthanasia” is not explicitly mentioned in the country’s criminal code, but it is considered to have punishments to an equivalent degree and form as murder, mentioned in Article 344. Similar to the Philippines, Indonesia encourages palliative or end-of-life care for terminally ill patients. Its government claims that the usage of euthanasia would put vulnerable communities and their lives at risk.

United Nations

The UN has not taken a stance on euthanasia, with most of its decisions being left up to member states and their individual decisions. However, UN high-level meetings take place on topics circulating around palliative care, and the right of autonomy. Since the UN avoids authorizing global standards and commands, it mainly positions itself to focus more on state sovereignty in regulating euthanasia, and serves as an oversight for medical purposes and governance.

World Health Organization

The WHO doesn’t approve nor support the regulation of euthanasia, but focuses more on achieving palliative care access around the world. Its ultimate goal is to ensure the availability of pain relief medications, and integrating palliative care into public health systems increases. However, the WHO has released articles of university student debates on the topic of euthanasia.

Timeline Of Events

Event	Explanation
Early Debates circulate on Euthanasia 1930-1940s	Across medical and philosophical circles, debates began to rise in Northern America and Europe on euthanasia, with most discussions being on treating terminal illnesses and euthanasia, which was widely referred to as “mercy killing”. However, these concerns were unprioritized due to rising concerns over World War II and the unethical usage of euthanasia in Nazi Germany.
First Legal Assisted Suicide in US History 1973	In Michigan, Dr. Jack Kevorkian assisted the death of his patient, which raised questions, concerns, and sparked debates on a national and international level. This case eventually catalyzed public debates about the right to die and patient rights and dignity.
First US State to Pass Death with Dignity Act 1994	In 1994, Oregon passed the Death by Dignity act, which marked it as the first U.S. state to legalize the usage of physician-assisted dying in healthcare systems and processes. The law required extensive measures and strong safeguarding policies, and allowed adults to request for lethal injections.
Belgium and Netherlands Legalize Euthanasia 2002	The Netherlands became the first country to legalize Euthanasia, followed by Belgium shortly after; both countries followed strict measures to maintain autonomy and dignity, yet it also received controversial opinions from member states and nations with opposing laws and opinions.
Expansion of Euthanasia in Europe and Australia 2005-2010	After being introduced in the Netherlands and Belgium, countries such as Luxembourg, in 2009, and Australia, began implementing the strict regulation of euthanasia or physician-assisted dying, which meant that there was progress in the growing acceptance, while considering the protection and consistent oversight of vulnerable populations.
Canada Legalizes MAiD 2016	Following the Carter vs. Canada court case held by the supreme court, Medical Assistance in Dying was legalized in Canada in 2016. The law stated that eligible, legal adults could receive MAiD. Other evolutions to MAiD have been made, such as specific eligibility requirements being released, and safeguarding physicians and nurses practicing MAiD.
Global Debates and UN Involvement 2021-Onwards	There is no substantial legal framework on euthanasia specifically. The UN has not adopted resolutions or aligned with a stance, which left the drug's regulation to national decisions and law. On the other hand, the WHO prioritizes promoting awareness and the international recognition of palliative care integration rather than assisted dying into healthcare.

Key Issues

1. The Debate of Autonomy vs. Sanctity of Life

The most pressing issue of the usage of euthanasia lies between the debate of whether an individual has the rights to autonomy, and the religious, traditional belief of the sanctity of life. Nations that have legalized euthanasia argue saying that patients should have the right to choose how and when to die, while conservative countries like the Philippines, counter-argue by mentioning that life has a priceless value that should be protected, and should never be ended by unnatural circumstances.

2. How Can Vulnerable Communities be Protected?

Protecting vulnerable populations like the elderly, disabled, or mentally incompetent from pressure is a primary moral concern in the debate on euthanasia and assisted dying. Critics argue that it violates numerous ethical principles on human rights and the right to live, especially if an individual is deceived or encouraged to end their lives due to societal pressure, especially from a professional. Delegates should consider how safeguarding can be reassessed and strengthened for ensuring that decisions for such practices are truly voluntary.

3. Unequal Access to Palliative Care

Palliative care is closely tied to euthanasia treatments, or even assisted suicide. Although the WHO is working on the awareness and integration of palliative care to be widely used within healthcare systems in high-income countries, approximately 78% of people in low and middle-income countries do not have access to it, due to their lack of resources and essential medication. Unfortunately, in most cases, when an option for palliative care is scarce or unaffordable, euthanasia may appear to be the only option. The disparity and contrast between the economic classes raise points that situations like these result from problems of equity and international responsibility.

4. Ethics in Medical Professions

The medical profession views euthanasia and assisted suicide unethical, viewing them as incompatible with the physician's role as a guide to heal and a violation of trust between a patient and the physician. According to the American Medical Association for example, physicians should preserve life, yet advocates for euthanasia argue that it serves as a form of compassionate care, because it would mean ending a patient's intolerable suffering.

Past International Action

Name	Description
Legalization of Euthanasia in the Netherlands	The Netherlands became the first country in early 2002 to legalise both euthanasia and assisted suicide. It created a strict set of conditions: the patient must be suffering unbearable pain, their illness must be incurable, and the demand must be made when the patient is fully conscious and aware of the situation.
U.S. State-Level Legislation	In the US, there was a strong opposition towards euthanasia, but for physician-assisted deaths, Oregon was the first US state to legalise assisted suicide. This led to other states to follow up with similar laws, which meant that even though euthanasia was nationally banned, it remains an exception for very specific situations.
Canadian Medical Assistance in Dying	Canada legalized Medical Assistance in Dying (MAiD) in 2016, allowing adults in Canada to request medical assistance in dying, meeting the following eligibility criteria: <ul style="list-style-type: none"> ● Must be 18 years of age or older and have decision-making capacity ● Must be eligible for publicly funded health care services ● Able to make a voluntary request that is not the result of external pressure ● Give informed consent to receive MAID, meaning that the person has consented to receiving MAID after they have received all information needed to make this decision ● Have a serious and incurable illness, disease or disability (excluding a mental illness until March 17, 2027)
Germany and Switzerland Court Rulings	At a court ruling at the Federal and Constitutional Court in Germany, 2020, a judgement on assisted suicide was carried out. It primarily brought up ‘business-like’ assisted suicide was unconstitutional and unethical. Switzerland, on the other hand, has long permitted suicide over a long period of time under specific conditions, allowing organizations such as Dignitas to function on legal grounds.

Possible Solutions

1. Delegates may consider a possibility: If proper palliative care is issued to a patient, it is possible that euthanasia may not be necessary to occur. This is because palliative care focuses on connecting with patients on physical, emotional and even spiritual levels. It's a very patient and family-centered treatment, which gives a patient proper emotional care and support. Competent palliative care may, on its own, be enough to prevent a person from feeling the need for euthanasia.
2. Delegates should also consider addressing the inequalities of palliative care worldwide, as well as expanding its use to countries with lower income. Creating financial initiatives for training programs and necessary resources would be beneficial for treatments and healthcare programs worldwide. This also ensures that patients have choices beyond euthanasia, which reduces the risk of it becoming the “primary outcome” for the terminally ill.
3. Next, minimum safeguards could be established and recognized for countries that already legalize euthanasia. Some measures that can be taken are mandatory evaluations from psychiatrists, and clear documentation and data collection for future development of guidelines and job profession. Moreover, the sovereignty of a nation is to be respected, so such policies can be developed with UN organs that specialize in medicine or health.
4. Lastly, there should be national and regional encouragement to voice the public’s opinion. Some states find that regional consultations can lead to a more democratic way in making decisions. This is to be inclusive and create legitimacy before creating new policies or measures to avoid possible backlash. Delegates can aim to apply this practice to other democratic systems.

Questions to Consider

1. To what extent is it ever right to end the life of a terminally ill patient who is undergoing severe pain and suffering?
2. What safeguards and policies should be strengthened to prevent misuse of euthanasia?
3. What role can international organs like the UN and WHO play in monitoring or regulating euthanasia?
4. How should countries with opposing stances on euthanasia interact? How can tensions be de-escalated?
5. How can palliative care become more accessible to potentially become a better alternative to euthanasia and physician-assisted deaths?
6. How can national sovereignty be respected and maintained with approaches involving international law?
7. How can medical professionals and their rights be protected? Do they willingly perform euthanasia on their patients?
8. How can cultural and religious differences be addressed when making policies? How can we be considerate to all beliefs while also creating universally applicable standards?

Appendix

1. [Relationship of Palliative Care with Assisted Deaths \(Article\)](#)
2. [Euthanasia: Right to Die with Dignity \(Article\)](#)
3. [Oxford Debates: Euthanasia SHOULD be Legalized \(Youtube\)](#)
4. [Oxford Debates: Euthanasia SHOULD NOT be legalized \(Youtube\)](#)
5. [Difference between Euthanasia and Assisted Suicide \(Youtube\)](#)
6. [Religions on Euthanasia \(Article\)](#)
7. [An Ethical Review of Euthanasia and Physician-Assisted Suicide \(Article\)](#)
8. [Countries that Allow Euthanasia and Assisted Suicide \(Article\)](#)

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