

FINANCING THE RIGHT TO DIE: COMPARATIVE STUDY OF INDIA AND NETHERLANDS

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ABSTRACT

Advances in medical technology and evolving societal views on autonomy and end-of-life care have brought deliberate life-ending decisions to the forefront of contemporary policy debates. Central to these debates are the distinctions between active and passive euthanasia, voluntary and non-voluntary choices, and related practices such as physician-assisted dying and the withholding or withdrawal of life-sustaining treatment. While these classifications carry significant clinical and legal implications, an equally critical yet understudied dimension concerns the role of insurers and financing systems. Whether euthanasia-related services are publicly funded, contractually recognized by private insurers, or excluded from benefit packages shapes patient access, incentives, and vulnerability to coercion or cost-driven pressures. This article examines “insurance for euthanasia” through a comparative study of the Netherlands and India. The Netherlands represents a statutory framework where euthanasia and physician-assisted dying are legally permitted under stringent safeguards and embedded within a mandatory basic health-insurance system. India, by contrast, relies on judicially crafted principles: courts have legalized the withdrawal of life-sustaining treatment and recognized advance directives, yet implementation is mediated by procedural requirements, a fragmented public-private financing landscape, and minimal insurer guidance. By juxtaposing these contrasting legal regimes and financing structures, the study highlights how statutory regulation versus case-law evolution—and centralized versus fragmented insurance systems—shape insurer behaviour, policy design, and patient outcomes.

Keywords: Euthanasia, Health Insurance, End-of-Life Care, Comparative Legal Analysis, India–Netherlands Policy Framework.

INTRODUCTION

Developments in medical technology and the ever-changing social attitudes toward autonomy and end-of-life care have placed choices regarding the deliberate termination of life on the outline of an immediate policy issue in most dominions. "Euthanasia" in general refers to the deliberate termination of a patient's life by another (usually a doctor), while related practices are those of physician-assisted dying and withholding or withdrawal of life-sustaining treatment (frequently mentioned to as passive euthanasia or 'letting die'). These differences, active vs. passive, voluntary vs. non-voluntary, are clinically and lawfully important since they decide both practice and regulatory reactions. Similarly major, though less researched, is how insurers and payment organizations involve with end-of-life decisions: whether euthanasia-related services are publicly covered, contractually addressed by private insurers, or taken out from benefit packages impacts access, incentives, and exposure to coercion or cost pressures.

This paper explores "Insurance for euthanasia" via a comparative approach to India and the Netherlands. The Netherlands symbolizes a statutory model in which euthanasia and assisted dying are allowed under stictly regulated circumstances and are rooted within a controlled health-insurance setting (a mandatory basic insurance system)¹. India provides a opposing case: the state's high courts and Supreme Court have acknowledged the legality of withholding and withdrawing life-sustaining treatment and have sanctioned advance directives (living wills)² in a sequences of landmark judgments, but enactment is mostly shaped by court procedure, a mixed public–private financing scene, and restricted insurer guidance. Relating these two jurisdictions hence irradiates how diverse legal regimes (statutory regulation vs. case-law evolution) and different financing structures (regulated basic insurance vs. fragmented private/public coverage) form insurers' roles, policy design, and patient results.

CONCEPTUAL FRAMEWORK AND LEGAL BACKGROUND

The premise of euthanasia includes a range of practices. In its most literal sense it is an act of permitted dying at the hands of a medical physician at the request of the patient when there is a direct administration of end-of-life medication. There is assisted dying as well where the medical physician orders a lethal dose that the patient self-administers. A dissimilarity is also drawn between "active" euthanasia, which involves optimistic steps to hasten death, and "passive" euthanasia, which comprises withdrawing or withholding life-sustaining treatment and letting death to occur naturally. These differences carry substantial legal and ethical concerns. In

1 Ministerie van Volksgezondheid, Welzijn en Sport, Is Euthanasia Legal in the Netherlands? (2025), <https://www.government.nl/topics/euthanasia/is-euthanasia-allowed> (last visited Sept. 13, 2025).

2. In Landmark Decision, Supreme Court Allows Passive Euthanasia, 'Living Will', Times of India, <https://timesofindia.indiatimes.com/india/in-landmark-decision-supreme-court-allows-passive-euthanasia/articleshow/63228731.cms> (last visited Sept. 13, 2025).

the Netherlands, both active euthanasia and physician-assisted suicide are controlled under the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001. In contrary, India, only passive euthanasia, defined as the withdrawal of artificial life support, has been judicially acknowledged, most remarkably through the Supreme Court's judgments in *Aruna Ramchandra Shanbaug v. Union of India* (2011)³ and *Common Cause v. Union of India* (2018)⁴. The comparative analysis in this paper therefore studies a statutory model of regulated euthanasia together with a case-law-driven model that authorizes only passive forms.

In the Netherlands, euthanasia has been assimilated into the health care system by statutory regulation. The 2001 Act, which entered into force in 2002, sets out a well-developed legal framework. Doctors can let life lapse on request or assist suicide if firm "due care" necessities are satisfied: the patient's request should be well-considered and voluntary; the suffering should be intolerable and not likely to change; no reasonable alternative should be available; at least one other independent doctor should be referred; and the act causing death must be done with medical care and attention. All requests need to be reported to regional review committees, who review compliance. The Act also gives legal effect to advance directives, allowing euthanasia where a patient has voiced such a desire in advance but later loses capacity. Professional practice is augmented by guidance from the Royal Dutch Medical Association (KNMG), which builds euthanasia as an extraordinary but morally acceptable component of medical practice subject to specified conditions.

Since Dutch citizens are legally made to buy basic health insurance (basisverzekering) from private insurers under state supervision, the matter is whether euthanasia is considered a reimbursed service. The Dutch right-to-die organisation NVVE firmly believes that euthanasia is covered by the basic package, notwithstanding whether the policy is a reimbursement (restitutiepolis) or in-network (naturapolis) product⁵. This infers that overall, insurers view euthanasia as an appropriate medical intervention, similar to palliative care or other end-of-life treatment. However, there is diversity in practice. Some insurers with a clearly stated religious or ideological profile, for example, Pro Life Zorgverzekeringen, have omitted euthanasia from their benefit package on grounds of conscience. Equally, euthanasia offered by the dedicated Levenseindekliniek, a stand-alone clinic that treats patients whose family doctors deny their request, has been subject to reimbursement controversy. Reports suggest that while some insurers, like Menzis, reimburse the cost of the clinic, others exclude them, leading to discrepancies in access based on the patient's selection of care provider. Therefore, as Dutch law

³ *Aruna Ramachandra Shanbaug v. Union of India* AIR 2011 SC 1290.

⁴ *Common Cause (A Regd. Society) v. Union of India*, (201208) 5 SCC 1.

⁵ NVVE, *Euthanasie*, <https://www.nvve.nl/informatie/euthanasie> (last visited Sept. 13, 2025).

codifies euthanasia as health care, the insurance facet brings out lingering tensions between universal legality and insurer discretion.

India has a very opposing picture. There is no statutory law in India concerning euthanasia, and active euthanasia continues to be a criminal offence under the Indian Penal Code. Legal tolerance of passive euthanasia stemmed from constitutional adjudication. In *Aruna Shanbaug* (2011), the Supreme Court allowed withdrawal of life support in extraordinary situations under the oversight of the High Courts. In *Common Cause* (2018), a Constitution Bench further protracted this acknowledgment, holding that the right to die with dignity is a component of the fundamental right to life under Article 21 of the Constitution. The Court acknowledged the legality of advance medical directives or "living wills," thus permitting competent individuals to identify the circumstances under which they would decline life-sustaining treatment in the future. In 2023⁶, the Court further updated procedural conditions by removing the necessity of magistrate sign-off and instead demanding notarization and attestation through witnesses, hoping to limit the hurdles that had rendered implementation complex.

In spite of all these legal progressions, inclusion of passive euthanasia in India's health financing is extremely uncertain. Health insurance policies do not mention euthanasia, whether active or passive. As passive euthanasia typically includes withdrawal of treatment instead of offering some new medical service, insurers need not "cover" some extra cost. The monetary implications are rather with regard to life insurance: would the death benefit be collectible if death results from withdrawal of life support under a living will?⁷ Industry view is that insurers would not be likely to veto such claims, mainly after the one-year contestability period typical of life insurance policies. Deaths due to passive euthanasia are dealt with in the same way to deaths due to natural causes instead of suicides or illegal doings. Though, the dearth of clear statutory or regulatory direction makes policyholders susceptible to doubt and probable litigation in the event insurers act restrictively.

INSURANCE PRACTICES AND IMPLEMENTATION

In the Netherlands, health insurance is universal, compulsory, and regulated around the basisverzekering (basic package). This package, as defined by the Health Insurance Act 2006, is uniform across insurers and controlled by the Dutch Health Care Institute (Zorginstituut Nederland). While private companies provide the insurance, the state proposes the content of coverage, guaranteeing that all citizens have access to necessary medical care. In compliance with the "Termination of Life on Request and Assisted Suicide Act 2001" a medical service done by physicians is

⁶ Vora, *Supreme Court Review 2023: Right to Life*, Supreme Court Observer (2023), <https://www.scobserver.in/journal/supreme-court-review-2023-right-to-life/> (last visited Sept. 13, 2025).

⁷ D. Mahapatra, *Living Wills Not Likely to Impact Insurance Payouts*, *Times of India* (Mar. 11, 2018), <https://timesofindia.indiatimes.com/india/living-wills-not-likely-to-impact-insurance-payouts/articleshow/63251033.cms> (last visited Sept. 13, 2025).

where euthanasia falls into this structure. Irrespective of whether the policy is organized as a reimbursement plan (restitutiepolis) or the in-network (naturapolis) the “NVVE (Dutch Association for a Voluntary End of Life)” endorses that euthanasia is reimbursed by the basic package. When we talk about the range of end-of-life care, this integration shows that euthanasia is not deliberated as an extraordinary service but is a part of it.

Nevertheless, for deciding the coverage for providers outside of the standard structure, there is some discretion that is allowed for insurers. A salient instance is the Levenseindekliniek, now known as the Expertisecentrum Euthanasie⁸, which stresses on the fact that doctors who reject to do the procedure, euthanasia is provided for them. Several insurers have declined to reimburse the costs of euthanasia through the clinic trials even though the same legal precautions are taken in general practice which is averaging over €2,500 per case. Insurers such as Menzis⁹ covers the general clinic services’ costs and some of them reject claims for reimbursement only because they think that euthanasia by a patient’s primary physician. Now there is a sensitive issue where at one end euthanasia is a legitimized medical act, at the other end it is that insurers retain their discretion in context with the reimbursement. The third perspective is where patients have a dilemma that since access to euthanasia lies on their insurer’s policies rather than only on legal prerogative.

Moral implications such as obvious religious or ethical positions also arises from insurers. Pro Life Zorgverzekeringen¹⁰, for instance, advertises itself as a Christian health insurer and dismisses euthanasia from its coverage. Policyholders pursuing euthanasia must therefore pay out of pocket or depend on on supplementary insurance. While such insurers are relatively small in terms of market share, their presence validates the ongoing contribution of conscience to structuring insurance practice even in a statutory organization of legalized euthanasia. Notably, the exclusion of euthanasia by such insurers has not been legally opposed, which may indicate that Dutch officials and courts have thus far housed a pluralistic method balancing rights on the individual level contrary to insurer conscience.

India is a diametrically opposite ground. Private health insurers control the insurance industry, accompanied by government programs like Ayushman Bharat. There is no direct discourse of euthanasia, active or passive, by any of these programs. As passive euthanasia more often than not includes the withdrawal of life-sustaining treatment rather than the commencement of new medical interventions, insurers are not required to "cover" extra expenses. Withdrawal of treatment does not constitute

⁸Voortbestaan Levenseindekliniek Wankel, Nationale Zorggids (2024), <https://www.nationalezorggids.nl/zorgverzekering/voortbestaan-levenseindekliniek-wankel/> (last visited Sept. 13, 2025).

⁹Menzis Gaat Euthanasie Bij Levenseindekliniek Vergoeden, Uitvaart.nl, <https://www.uitvaart.nl/nieuws/menzis-gaat-euthanasie-bij-levenseindekliniek-vergoeden/32590> (last visited Sept. 14, 2025).

¹⁰ L. van Lonkhuyzen & A. Sterk, Kamervragen over Christelijke Verzekeraar Pro Life, die geen abortus vergoedt, NRC(2024), <https://www.nrc.nl/nieuws/2021/11/08/kamervragen-om-christelijke-verzekeraar-pro-life-die-geen-abortus-vergoedt-a4064709> (last visited Sept. 13, 2025).

a billable service like physician-administered euthanasia in the Netherlands. Consequently, health insurance policies in India do not include or exclude euthanasia explicitly, but are instead quiet, treating passive euthanasia as external from the purview of insurance.

The more urgent challenge in India is with life insurance instead of health insurance. Financial protection for dependents would depend on whether an insurer categorizes death by passive euthanasia as a "natural death" under the policy conditions. Industry views are that they would pay out on such claims, mainly after the contestability period of one year in which they can investigate policyholder statements. Insurers look to regard passive euthanasia deaths as legally all-encompassing, separating them from suicides, which are most often omitted from the insurance cover for the first few years under a policy. But the lack of statutory or regulatory description leaves families open to unpredictable interpretation. Disputes could rise if insurers take on narrow interpretations of contractual terms, compelling dependents into litigation at exactly the moment when financial support is most immediately needed.

An additional test in India arises from the procedural obscurity of applying passive euthanasia. Even though the Supreme Court streamlined the system for living wills in 2023¹¹, the process is tremendously medicalized and legally managed with hospital ethics committees and adherence to court judgments. Procedural protections can cause postponement or difficulty in end-of-life decisions, indirectly increasing hospital expenses through drawn-out treatment before withdrawal. In such a case, insurance claims for hospitalization could be exaggerated due to the inefficiency in performing passive euthanasia. In contrary, where euthanasia can possibly decrease expenditure by acting as a proxy for expensive ongoing treatment in Netherlands, in India, funding and the added insecurity of the process could result in growing expenses for both, insurers and families.

A notable deviation is seen in the comparative analysis of this subject. Euthanasia is well embedded in the healthcare financing system as a reimbursable, regulated service although subject to distinction depending on the provider and the insurer in the Netherlands. Ensuring that insurers handle euthanasia as a valid medical act, this procedure is legal codified in their system, medically administered and is subject to external assessment. The codification of passive euthanasia in insurance law or practice does not exist except its judicial recognition in India. Life insurance policies acknowledge deaths that have happened due to natural causes but again with no clear directive, but, health insurance policies remain silent. Patients and families

¹¹ A. Hazarika, *Passive Euthanasia: Supreme Court Modifies 2018 Judgment, Does Away with Magistrate Nod for Living Will/Advance Directive*, *Bar & Bench* (2023), <https://www.barandbench.com/news/litigation/passive-euthanasia-supreme-court-modifies-2018-judgment-does-away-with-magistrate-nod-for-living-will-advance-directive> (last visited Sept. 13, 2025).

may face doubt and potential biases because of the silence of health insurance policies especially in situations where insurers can evade liability.

COMPARATIVE ANALYSIS: INDIA AND THE NETHERLANDS

First, the main point of difference is their origin and legality. The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001 is an inclusive statutory framework that has legalized euthanasia in Netherlands. This Act allows medical physicians to openly carry out physician-assisted suicide and euthanasia incorporating the said practice into their healthcare system under strictly controlled circumstances. On the other hand, through judicial pronouncements, passive euthanasia is permitted rather than any codified provisions in India. In the Aruna Shanbaug (2011) and Common Cause (2018) case the use of living wills and the withdrawal of life support were allowed. Due to the absence of a parliamentary Act, their implementation has been inconsistent and patchy. Between the lack of statutory clarity and judicial recognition, the insurance companies have been directly affected by it. With this Indian insurers are required to test a legal setting encompassed by case laws and evolving judicial procedures while Dutch insurers work in a codified system.

Secondly this distinction translates to the incorporation into the healthcare structures. In Netherlands, euthanasia is not considered as some outwardly act but within the range of medical aid that is reimbursable under the basisverzekering covered by the Health Insurance Act 2006. When euthanasia is carried out in accordance with the legalities in question, it is usually assumed that the patients' basic health insurance will pay for it. This generates predictability, ensures access, and prevents euthanasia from being a benefit of wealth. In contrary, India, health insurance policies are mute on the topic of passive euthanasia. Since passive euthanasia contains withdrawing treatment rather than delivering a new service, insurers are neither compelled nor prepared to reimburse it. Thus, patients and families get no insurance support for the act itself, though they may still have to bear the costs of drawn out hospitalization or treatment in the lack of timely execution.

Thirdly, variance arises from the role of insurers in determining access. Insurers have some discretion in specific circumstances where euthanasia is concerned even though it is completely legal in Netherlands. Patients may experience some kind of discrimination based on the insurers' willingness to pay for services such as this in the Expertiscentrum Euthanasie coverage. Faith-based insurers like Pro Life completely discount euthanasia forcing patients to look for alternate ways such as out of pocket expense to fund this aid. Such limitations, though legally acceptable can limit access to finance by insurers despite statutory ratification. In India, the problem is the conflicting: insurers have no clear role in euthanasia because the act produces no billable service, leaving families reliant on judicial and medical administration without financial lucidity.

Fourthly, financial implications of euthanasia within insurance system. Euthanasia can replace drawn-out, expensive medical care provided, which can result in lowered expenses borne by both insurers and family members in Netherlands. Thus coverage supports financial responsibility while respecting patient autonomy¹². There is a stark contrast when it comes to India where the lack of inclusion can increase the expenses. Patients who are awaiting court approvals for passive euthanasia are incurring more and more expense that would be paid by insurers who are required to cover the hospitalization costs while being critical and in the hospital during all this resulting in insurers increasing the costs while in comparison the Dutch model aims to prevent the additional costs.

There are instances where both India and Netherlands converge in their views concerning euthanasia and that is when they both place stress on procedural safeguards against abuse. In India the execution is closely supervised by courts or the medical ethics committee, whereas in Netherlands it is autonomous medical consultation. In both the structures medical professionals remain at the center of decision making which rely on ethical physician agreements. In India, there is disconnect between actual accessibility and legal recognition while ignoring this factor whereas financial access through insurance coverage is addressed in the Netherlands.

There is a broader analogy demonstrated in this comparative analysis: the recognized principle of euthanasia cannot be the only measurement of its efficacy. The true effectiveness can only be determined when the rights of the patients aren't affected by financial or institutional hindrances. Practical accessibility is a culmination of statutory transparency, insurance integration and regulated safeguards established in the Dutch model. Once again India's conflicting premise of judicial recognition without legislative or insurance follow-up leaves patients with an uncertain enactment resulting in a hypothetical right.

¹² Zorginstituut Nederland, Notitie – Verduidelijking Zorgverzekeringswet: Passende Zorg in de Laatste Levensfase, Thuis of Elders, <https://www.zorginstituutnederland.nl/documenten/2025/07/16/notitie-verduidelijking-palliatieve-zorg-laatste-levensfase> (last visited Sept. 13, 2025).

CONCLUSIONS AND RECOMMENDATIONS

First, legislative or regulatory elucidation that precisely acknowledges the status of deaths due to court-approved passive euthanasia or legally enforced living wills for insurance contract commitments should be considered by India. Such elucidation does not necessarily require private insurers to pay for euthanasia as a fresh billable therapy, passive euthanasia generally decreases, not increases the cost of care, but should remove ambiguity regarding the handling of ancillary claims. In specific, the regulators may deliver binding direction that deaths that occur after lawful withdrawal of life-supporting treatment or accurately implemented advance directives are to be viewed as lawful, non-suicidal deaths for insurance purposes in connection with life insurance policy payouts, so long as the removal is made in accordance with detailed procedural protections. This action would guard beneficiaries from disputed denials of death benefits and diminish the possibility for litigation that offends the dignity of the grieving.

Second, the guidelines of health insurance need to be altered to confirm coverage of palliative, hospice, and supportive services as they transmit to end-of-life decision-making. In reality, the cost to families generally does not result from withdrawal of treatment itself but from extended hospitalization, intensive care, or the need of palliative alternatives when withdrawal is lengthened. Regulators can order that health plans, public agendas and private products alike together with the clearly stated inclusion of palliative and hospice care as options rather than prolongation of life-sustaining cures, set up streamlined approval procedures for transferring from curative to palliative care once a binding living will or competent refusal has been documented¹³. By insuring these choices, insurers would eradicate perverse incentives to continue invasive treatments for financial motives and would endorse patients' autonomy in the choice of comfort-centered care.

Third, to avoid insurer discretion from generating de facto barriers akin to those witnessed in the Netherlands, India should order transparent contractual terms regarding omissions and conscience-based opt-outs. Any insurer looking for to refuse coverage for services bound to the use of a living will should be vital to disclose such omissions at the point of sale and to deliver an accessible instrument by which policyholders may gain alternative coverage or state-facilitated transmissions. Conscience-based omissions should be permitted when regulators must require insurers to pay for useful referral or switch services. This will prevent policymakers to make out of pocket payment or from having to manage intricate provider networks alone. Hence flexibility and transparency takes a domineering position in guaranteeing fair access to varied market aids.

Fourth, India needs to expedite the claims process while placing procedural safeguards against coercion. Minimal requirements for advance directive

¹³ Bhatnagar, As. *et al.* 'Institutional end-of-life care policy for inpatients at a tertiary care centre in India: A way forward to provide a system for a dignified death', *Indian Journal of Medical Research*, 155(2), pp. 232–242 (2022)

documentation should be specified for passive euthanasia in a statutory framework. Should mandate ethics committee evaluations or exclusive medical consultation in complex cases and while making claim decisions insurers can rely on a provided audit trail. To process death payments quickly while preserving safeguard mechanisms against undue influence, an audit trail would include doctor statements, certified living wills and ethics committee recommendations would be given. With this, to resolve disputes resulting from passive euthanasia claims insurer regulators would create quick-review tools in order to avoid drawn-out litigation.

To conclude, India would need a lot more than just judicially recognizing passive euthanasia to make it a viable and a morally acceptable notion in India. Amalgamation of procedural defenses, insurance assistance, palliative alternative coverage, and legal transparency are required for a logical integration. Taking an inspiration from Netherlands which embraces insurance incorporation and statutory lucidity while guarding against insurer discretion that leads to inequities. India can without subjecting people to coercion or financial hardship transition to a system that respects the right to dignified death.

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