Title: Terminally Ill Adults (End of Life) Bill (as amended in the House of Commons) (v1.2) **IA No**: DHSCIA9682 **RPC Reference No**: N/A **Lead department or agency**: Department of Health and Social Care (DHSC) **Other departments or agencies**: Ministry of Justice (MoJ)	**Impact Assessment (IA)** **Date:** 26 June 2025 **Stage:** Development/Options **Source of intervention:** Domestic **Type of measure:** Primary legislation **Contact for enquiries:** TIABImpactAssessment@dhsc.gov.uk

Summary: Intervention and Options

RPC Opinion: Not Applicable

Cost of Preferred (or more likely) Option (in 2025/26 prices)

Total Net Present Social Value	Business Net Present Value	Net cost to business per year	Business Impact Target Status
N/A	N/A	N/A	N/A

What is the problem under consideration? Why is Government action or intervention necessary?

This Impact Assessment (IA) appraises the Terminally Ill Adults (End of Life) Bill as amended in the House of Commons. This is a private member's bill that was introduced to Parliament on 16 October 2024 by Kim Leadbeater MP. The Bill passed Third Reading in the House of Commons on 20 June 2025. The Government has a responsibility to ensure any legislation that passes through Parliament is workable, effective and enforceable. Therefore, it has facilitated the publication of documents that routinely accompany the introduction of legislation, including this IA.

What are the policy objectives of the action or intervention and the intended effects?

The Bill would allow terminally ill adults, subject to safeguards and protections, to choose to request and be provided with lawful assistance to end their own life. The policy objectives are: (i) to give adults who are already dying a choice over the manner of their death; (ii) for this choice to be part of a holistic approach to end-of-life care; (iii) to create a robust legal framework for this provision; (iv) to protect individuals from fear of and actual criminalisation where they provide such assistance in accordance with the provisions of the Bill.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option

The Government is neutral on the policy of assisted dying and the passage of this Bill. Therefore, this IA only appraises one policy option: the introduction of "voluntary assisted dying (VAD) services" in England and Wales. As per HM Treasury's Green Book[1] guidance, this policy option is compared to the current situation (also referred to as "Business as Usual (BAU)"). In this IA, BAU is the continuation of current arrangements whereby it is an offence under section 2(1) of the Suicide Act 1961 to intentionally assist another person to end their own life.

Will the policy be reviewed? Yes, if enacted. **If so, set review date:** 2030/31, if enacted in 2025/26.

Is this measure likely to impact on international trade and investment?				**No**
Are any of these organisations in scope?	**Micro** Yes	**Small** Yes	**Medium** Yes	**Large** Yes
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** N/A	**Non-traded:** N/A

I have read the Impact Assessment, and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Chief Economist: C. Mun Date: 26/06/2025

[1] HM Treasury, The Green Book (2022): appraisal and evaluation in central government (viewed in March 2025)

Summary: Analysis & Evidence — Policy Option 1

Description: FULL ECONOMIC ASSESSMENT

Price Base Year 25/26	Implementation Year 1 (half-year) 29/30	Time Period 10 years	Net Benefit (Present Value (PV)) (£m)		
			Low: N/A	**High:** N/A	**Best Estimate:** N/A

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	N/A		N/A	N/A
High	N/A		N/A	N/A
Best Estimate	N/A		N/A	N/A

Description and scale of key monetised costs by 'main affected groups'

This IA sets out, based on various assumptions, potential costs associated with: (i) information provision and training; (ii) health and social care staff time in delivering VAD services; (iii) the VAD Commissioner and Panels; (iv) reduced care home and domiciliary care provider profits for individuals no longer requiring this provision after their assisted death. These figures come with wide ranges attached as they are dependent on a range of factors including, for example, the amount of time required of different professionals to deliver the VAD service. The cost associated with the creation of new offences is assumed to be negligible.

Other key non-monetised costs by 'main affected groups'

A qualitative approach is taken to describe the reported disbenefits of such policies to individuals and specific groups of individuals, such as feeling pressured into have an assisted death. It is noted that while the Bill sets the parameters for a VAD service, some details about how it would work is to be set through secondary legislation. Where possible, international evidence has been cited to provide illustrative costs of, for example, the substance(s) used to end life. Should the Bill pass, further work would be required to estimate costs of set-up, delivery, monitoring and evaluation. This may include a New Burdens[2] assessment for local authorities. There may also be opportunity costs which are not quantified.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	N/A		N/A	N/A
High	N/A		N/A	N/A
Best Estimate	N/A		N/A	N/A

Description and scale of key monetised benefits by 'main affected groups'

This IA sets out, based on various assumptions, the estimated impacts if an individual, who chooses to have an assisted death, no longer requires after their death: (i) palliative and end-of-life care; (ii) private or local authority funded care home or domiciliary care provision. These figures come with wide ranges attached as they are dependent on a range of factors including, for example, the amount of time taken to complete the process (from preliminary discussion to assisted death) and when the individual would otherwise have died. It is noted that these impacts are not stated as the objectives of the policy.

Other key non-monetised benefits by 'main affected groups'

A qualitative approach is taken to describe the reported benefits of such policies to individuals and specific groups of individuals, such as giving terminally ill adults a personal choice over the manner of their death. This IA also considers potential wider impacts, such as an indication of changes to state pension and state benefit expenditure. However, social security payments are considered "economic transfers" in the Green Book[3], rather than an additional cost or benefit.

[2] MHCLG (2022), New burdens doctrine: guidance for government departments, (viewed in March 2025)

[3] HM Treasury, The Green Book (2022): appraisal and evaluation in central government (viewed in March 2025)

Key assumptions/sensitivities/risks	**Discount rate (%)**	N/A

This IA is based on a range of assumptions, which are described in more detail against each impact throughout this document. Key assumptions include, for example, that: (i) VAD services in England and Wales would become available from October 2029, meaning that Year 1 of implementation is half-a-year; (ii) the number of applicants would range from between 273 to 1,078 in Year 1 (half-year), to between 1,737 to 7,598 in Year 10; (iii) that 60% of applicants would complete the process, resulting in between 164 to 647 assisted deaths in Year 1 (half-year), to between 1,042 to 4,559 assisted deaths in Year 10; (iv) that information provision, training and service delivery would initially focus on the NHS.[4]

While some monetised impacts have been provided, these are for the most part uncertain with wide ranges attached. The upper bound of these ranges should not be interpreted as maximum values, nor as representative of the full range of potential costs, given there are significant aspects of the Bill that have not been possible to quantify at this stage. Adding only the quantified elements of this IA together would not give a comprehensive assessment on the net impact of the Bill because significant unquantified impacts would not be accounted for in that net figure.

A range of sensitivity analyses are presented in annexes to this IA. These examine, for example, the impact of changing when the service starts, the proportion of applicants completing the process, and assumptions around workforce time and pay.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			**Score for Business Impact Target (qualifying provisions only) £m:** N/A
Costs: N/A	**Benefits:** N/A	**Net:** N/A	

[4] See 'Version control table' at the end of this document.

Contents

1 - Introduction

1. This Impact Assessment (IA) appraises the Terminally Ill Adults (End of Life) Bill as amended in the House of Commons. This is a private member's bill that was introduced to Parliament on 16 October 2024 by Kim Leadbeater MP. The Bill passed Third Reading in the House of Commons on 20 June 2025. The primary objective of the Bill is to allow terminally ill adults, subject to safeguards and protections, to choose to request and be provided with lawful assistance to end their own life. It extends to England and Wales only.

2. This is a complex policy with strong views on both sides of the debate. The Government is neutral on the matter of assisted dying and the passage of the Bill. It has facilitated the publication of documents that routinely accompany the introduction of legislation (including this IA), to inform Parliamentary debate. The impact of the policy on an individual would vary depending on their personal views and circumstances, and as such have not been quantified. Furthermore, while the Bill sets the parameters for a "Voluntary Assisted Dying" (VAD) service, details about how it would work are to be set through secondary legislation. It is therefore not possible to robustly estimate an overall Net Present Value (NPV).

3. Where sufficient information and evidence is available, illustrative figures for some impacts have been provided. These quantified elements are for the most part uncertain with wide ranges attached but should allow for some indication of the order of magnitude. The upper bound of these ranges should not be interpreted as maximum values, nor as representative of the full range of potential costs, given there are significant aspects of the Bill that have not been possible to quantify. Adding only the quantified elements of this IA together would not give a comprehensive assessment on the net impact of the Bill because significant unquantified impacts would not be accounted for in that net figure.

4. Since publication of version 1.0 of this IA on 02 May 2025, some new data updates have been released (for example, NHS pay scales[5], NHS Workforce Statistics[6], and OBR's triple lock forecast[7]). The impact of updating the analysis for this new data has been considered and these updates were not considered material to the results. Therefore, taking account of the importance of consistency, quality assurance and speed to align with the Parliamentary process, the data used in this IA remains the same as version 1.0 and v1.1. A version control table is included at the end of this document for completeness.

[5] NHS Employers (22 May 2025), Pay scales for 2025/26, (viewed June 2025)

[6] NHS England (29 May 2025), NHS Workforce Statistics - February 2025 (Including selected preliminary statistics for March 2025), (viewed June 2025)

[7] Office for Budget Responsibility (OBR) (19 June 2025), Supplementary forecast information on Long-term economic determinants and personal independence payment policy costing, (viewed June 2025)

1.1 - Terminology

5. The Terminally Ill Adults (End of Life) Bill is referred to as “the Bill” throughout this document. This IA appraises the provisions of the Bill as amended in the House of Commons.

6. There is no consensus on which terminology to use when debating the issue of whether people should be legally permitted to seek assistance with ending their own lives. This document primarily uses the phrase “assisted dying” to reflect the wording of the Bill, though others may refer to this as “assisted suicide” or “voluntary euthanasia”. The terminology used in this document is not intended to endorse or reflect any stance on the debate about changing the law.

2 - Strategic case for proposed regulation

2.1 - International context

7. It is estimated that over 300 million people across the world have access to some form of assisted dying.[8] At the point of publishing v1.0 of this IA, 25 jurisdictions had been identified where assisted dying is legal and a formal system with regulated processes (such as an established application and approvals process) is in place.

8. These services vary both in terms of who can access them and how they are delivered. The main points of variation are:

    8.1. **age**: many jurisdictions limit access to adults aged 18 years and over, while in a few it can also include children under the age of 18 years with parental consent

    8.2. **underlying health condition**: some jurisdictions restrict access to people with a terminal illness (often requiring a medical professional to determine that they have a limited time left to live, for example, 6 or 12 months); in other jurisdictions, access is granted to those experiencing 'unbearable suffering' and/or those whose suffering arises from psychiatric illness

    8.3. **citizenship**: some jurisdictions restrict access to citizens or those who have been resident in the jurisdiction for a specified amount of time; in other jurisdictions, citizens from other countries and non-residents can access the service

    8.4. **delivery model**: in most jurisdictions where assisted dying is legal it is provided through the healthcare system, while in Switzerland, it is provided through independent clinics or organisations such as Dignitas; across all of these, some are free at the point of access, while others are paid for directly by the individual or via health insurance

    8.5. **administration of substance**: in most jurisdictions, the life-ending substance(s) must be self-administered by the individual, while in others, a medical professional ("physician") can administer the substance

    8.6. **safeguards**: the most common safeguards across jurisdictions to ensure compliance with the respective framework, are that the person must make repeated requests to access the service, that they are subject to various assessments to ensure they are mentally competent and not being coerced, and a period or periods of reflection between specific stages of the process, during which the person has to wait before proceeding to the next.

9. Of the 25 jurisdictions identified, **10 had comparable eligibility criteria** to this Bill. Specifically, all 10 jurisdictions limit access to mentally competent adults aged 18 or older, who have been diagnosed with a terminal illness from which they are expected to die within 6 months, and they cannot apply solely on the grounds of mental illness or disability. These "comparable jurisdictions" are California (USA), Colorado (USA),

[8] BMJ (2024), Assisted dying: balancing safety with access | The BMJ (viewed in March 2025)

Hawaii (USA), Maine (USA), New Mexico (USA), New Zealand, Oregon (USA), the District of Columbia (USA), Vermont (USA), and Washington (USA). Annex A sets this out in more detail.

10. VAD service uptake varies across jurisdictions. In 2023 for example, assisted deaths accounted for 0.3% of all deaths in California (USA), compared to 4.7% in Canada. This range is narrower across the 10 jurisdictions with eligibility criteria comparable to the Bill; in none of them did the number of assisted deaths account for more than 1% of total deaths in any year.

11. Factors influencing uptake over time may include, but are not limited to:

    11.1. the amount of time the service has been operational

    11.2. how broad or narrow the potential cohort of service users is

    11.3. how people access the service (from initial application to administration of the approved substance)

    11.4. changes to the eligibility criteria and/or service design

    11.5. reporting mechanisms and requirements (which may mean that in some jurisdictions, the reported level of uptake is lower than the actual level).

12. It is not possible to directly attribute any of the factors listed above to the behaviour of individual applicants.

13. Across the 10 comparable jurisdictions, none changed the core eligibility criteria (described in paragraph 9 above). In 2023, both Oregon and Vermont removed the residency requirements from their respective assisted dying legislation (thus enabling non-residents to apply to receive assistance).[9] Other small changes were made to the delivery model used by some schemes: for example, removing or reducing the waiting period where this is expected to exceed the applicant's life expectancy, and/or expanding the workforce permitted to deliver VAD services to include Advanced Nurse Practitioners.

14. While not considered in detail, it is acknowledged there are 5 further jurisdictions where assisted dying is not illegal, but where there are no, or not yet, any formal arrangements or supervision by the state health department[10]. These are Italy, Germany, Columbia, Montana (USA) and Ecuador. There are also other jurisdictions actively exploring legalisation, for example, Scotland and the British Crown Dependency of Jersey. At the point of publication, the British Crown Dependency of the Isle of Man had approved and passed the Assisted Dying Bill 2023, which grants terminally ill adults with a prognosis of 12 months or less the right to choose to die. The Bill will now proceed for Royal Assent.

[9] See 'Version control table' at the end of this document. In v1.1, paragraph 13 as shown here was clarified to explain that in 2023 the residency requirement was lifted from the assisted dying schemes in Oregon and Vermont. See Annex A for sources.

[10] Health and Social Care Committee (2024), Assisted Dying/Assisted Suicide - Health and Social Care Committee (viewed in April 2025)

2.2 - Legislative framework in England and Wales

15. In England and Wales, suicide and attempted suicide are not in themselves criminal offences. However, under section 2(1) of the Suicide Act 1961[11] it is an offence for a person to intentionally encourage *or assist* the suicide (or attempted suicide) of another. Assistance includes helping a person from England or Wales to access an assisted dying service in another jurisdiction where it is legal. A person found guilty is liable to imprisonment for a term of up to 14 years.

16. There has been ongoing discussion of the policy options relating to assisted dying for many years, and this has included several attempts to change the legislation in England and Wales on assisted dying. The last Commons debate and vote on the law was in 2015 when, on a free vote, the Commons voted against the Assisted Dying (No 2) Bill 2015[12]. This was a Private Member's Bill, introduced by Rob Marris MP. Since 2020, six separate discussions related to assisted dying have taken place within Parliament.

2.3 - The Terminally Ill Adults (End of Life) Bill

17. The Terminally Ill Adults (End of Life) Bill was introduced to Parliament on 16 October 2024 by Kim Leadbeater MP, having been drawn highest in the Private Members' Bill ballot for the 2024-25 session. The Bill passed Third Reading in the House of Commons on 20 June 2025.

18. The Bill makes provision for adults who are terminally ill, subject to safeguards and protections, to request and lawfully be provided with assistance to end their own life. The Bill also makes clear that where a person provides assistance to a person to end their own life in accordance with the Bill; performs any other function under and in accordance with the Bill; or assists a person to seek to end their own life in accordance with the Bill (and in connection with the doing of anything under the Bill), they do not commit a criminal offence, including the offence of encouraging or assisting suicide under section 2 of the Suicide Act 1961. The Bill would also create a defence to the offence of encouraging or assisting suicide in cases where a person reasonably believes they were acting in accordance with the Bill and took all reasonable precautions and exercised all due diligence to avoid committing the offence.

19. The Government's position on the policy of assisted dying, and the passage of the Bill is neutral. While it is for the Bill's Sponsor to decide the policy intent, the Government does have a duty to the statute book to ensure any legislation that passes through Parliament is workable, effective and enforceable. Therefore, the Government has facilitated the publication of documents that routinely accompany the introduction of legislation. The Bill itself is a matter for Parliament.

[11] Suicide Act 1961

[12] Assisted Dying (No 2) Bill

3 - Objectives of the proposal

20. The policy objective of the Bill is to allow adults who are terminally ill, subject to safeguards and protections, to choose to request and be provided with lawful assistance to end their own life.

21. The main intended outcomes of the Bill, as described by Kim Leadbeater MP, the Sponsor of the Bill during its passage through the House of Commons, in their Explanatory Notes and at Second Reading, are:

    21.1. to give those who are already dying a choice over the manner of their death

    21.2. for the choice of assisted dying to be part of a holistic approach to end-of-life care, rather than a substitute for palliative care

    21.3. to create a robust legal framework for assisted dying to happen in a manner that is subject to strict eligibility criteria and multiple layers of checks and safeguards

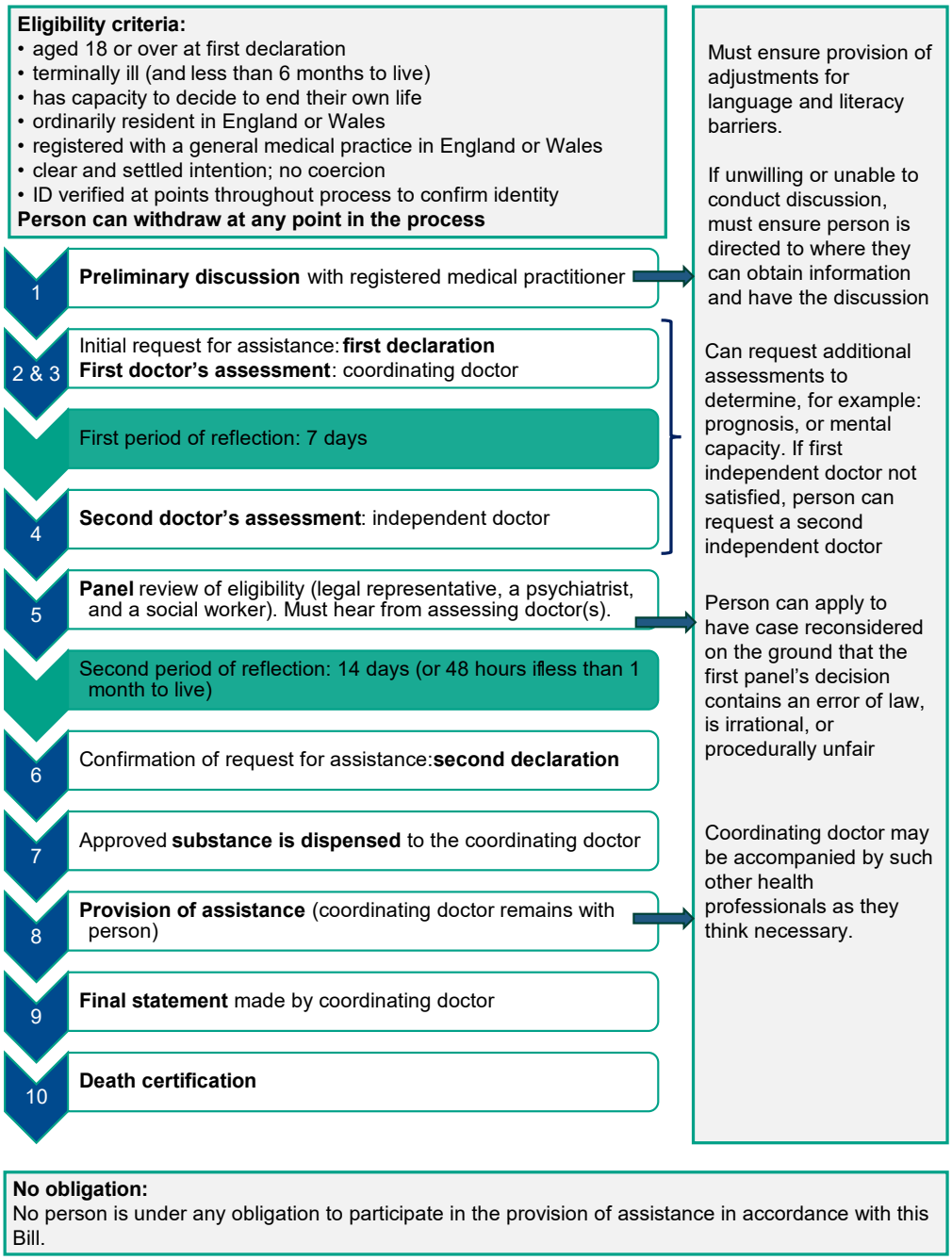
    21.4. to protect individuals from fear of and actual criminalisation where they assist another person to end their own life, in accordance with the provisions of the Bill.

22. Should the Bill pass, the provision allowing the Prime Minister to appoint the Voluntary Assisted Dying Commissioner comes into force after one year; other provisions come into force on such day or days as the Secretary of State may by regulations appoint; and any provisions not fully brought into force would come into force four years from Royal Assent. Provision about voluntary assisted dying services in Wales, and about providing for assisted dying services in Welsh, would come into force on such day or days as the Welsh Ministers may by regulations appoint.

4 - Description of proposed intervention

23. In line with the language used in the Bill, the proposed intervention shall be referred to as a "Voluntary Assisted Dying" (VAD) service. This would require primary legislation and is therefore subject to the Bill becoming an Act of Parliament and law. Figure 1 illustrates the main steps the applicant must follow to access a VAD service.

Figure 1 Overview of the main steps an applicant must follow to access a VAD service in England or Wales, should the Bill pass[13]



Note: Figure 1 represents the basic steps and further information about the process, roles and safeguards are to be found in the Bill.

[13] See version control table at end of document. In v1.2, Figure 1 was updated to reflect Bill amendment that "no person" is under any obligation to participate in the provision of assistance, rather than "no registered medical practitioner or other health professional".

4.1 - Eligibility criteria

24. To apply to access the VAD service, the applicant must meet all the following criteria:

    24.1. be terminally ill

    24.2. have the capacity to make the decision to end their own life

    24.3. be aged 18 years or over at the time they make their first declaration

    24.4. be ordinarily resident in England or Wales and have been so resident for at least 12 months ending with the date of the first declaration

    24.5. be registered as a patient with a general medical practice in England or Wales

    24.6. have a clear, settled and informed wish to end their own life, and have made that decision voluntarily, free from coercion or pressure by any other person.

25. The Bill defines a person as terminally ill if they have both:

    25.1. an inevitably progressive illness or disease which cannot be reversed by treatment, and

    25.2. their death in consequence of that illness or disease can reasonably be expected within 6 months.

26. [The Bill states that a person who would not otherwise meet these requirements shall not be considered to meet them solely as a result of voluntarily stopping eating or drinking.][14]

27. Furthermore, the Bill states that:

    27.1. treatment which only relieves the symptoms of an inevitably progressive illness or disease temporarily is not to be regarded as treatment which can reverse that illness or disease

    27.2. a person is not to be considered terminally ill only because they are a person with a disability or mental disorder (or both); however, having a disability or mental disorder does not prevent a person from being regarded as terminally ill if they meet the definition of terminally ill in Clause 2(1).

4.2 - Process and safeguards

28. The main steps and safeguards described in the Bill are summarised here.

29. **There is a three-stage approvals process.** The first is overseen by the “coordinating doctor”, the second by an “independent doctor”, and the third by a multidisciplinary “panel” comprised of a legal representative, psychiatrist, and social worker. At each stage, the doctor / panel must be satisfied that the person satisfies the eligibility criteria,

[14] See ‘version control table’ at end of this document. New text added to v1.2 to reflect new clause on voluntarily stopping eating or drinking.

has a clear, settled and informed wish to end their own life, and has not been coerced or pressured by any other person into doing so.

30. **Referral to an appropriate specialist can be made at each stage of the approvals process if there are doubts about the person's illness or mental capacity.** This might include, for example, referral to a medical practitioner with expertise in the specific disease, condition, or illness in question, or to a psychiatrist or other health professional who has experience of assessing mental capacity.

31. **The person must sign two written declarations to request an assisted death and can withdraw their consent at any time.** Both declarations must be witnessed and recorded, alongside any notice of cancellations, in the person's medical records. A proxy can be appointed by the person if they are unable to sign their own name (by reason of physical impairment, being unable to read or for any other reason).

32. **There are two 'periods of reflection' built into the process.** The first period of reflection is 7 days between the first assessment by the coordinating doctor and second assessment by the independent doctor. The second period of reflection is 14 days (reducing to 48 hours if the person has less than 1 month to live) between the certificate of eligibility being granted by the panel and the provision of the approved substance.

33. **The decision to self-administer the approved substance and final act of doing so must be taken by the person approved for an assisted death.** The coordinating doctor (or another authorised practitioner) must remain with the person until their death is confirmed, before issuing the "final statement".

34. **Each assisted death must be documented and reported for safety, monitoring, and potential research purposes.** Annual reports are to be published regarding implementation and the legislation would undergo a review after five years.

35. **Creation of new offences.** Two new offences have been created to ensure safeguarding and correct processes. These pertain to 'dishonesty, coercion and pressure' and 'falsification or destruction of documents.'

36. **Civil liability.** A provision has been included to provide clarity that persons who are (i) providing assistance in accordance with the Bill, (ii) performing a function under the Bill or (iii) assisting a person in connection with doing of anything under the Bill, will not, of itself, give rise to a civil liability. It provides that civil liability can still arise where an act has been done dishonestly, or in some other way done otherwise than in good faith or breaches a duty of care owed to that person.

37. **Free at point of access**. The Bill requires the Secretary of State to, by regulations, make provision securing arrangements for the provision of VAD services in England and similarly provides Welsh Ministers with the power to make regulations about provision of VAD services in Wales. The Bill goes on to state that these regulations must state that such services are to be provided free of charge, except where charging is expressly provided for in relation to commissioned VAD services.

5 - Description of shortlisted policy options

38. This IA considers the provisions of the Bill (the “proposed intervention”), in comparison to “Business as Usual” (BAU).

39. As defined in HM Treasury’s Green Book[15] guidance on appraisal and evaluation, BAU is the continuation of current arrangements, as if the proposal under consideration were not to be implemented. The purpose is to provide a quantitative benchmark, as the “counterfactual” against which all proposals for change are compared.

40. In this IA, BAU assumes that there are no changes to legislation in England and Wales on the matter of assisted dying, and that the legislative changes proposed in the Terminally Ill Adults (End of Life) Bill are not implemented.

41. Given that the Government remains neutral on the Bill and has not developed its own policy options, the IA does not propose or set out a range of alternative policy options.

[15] HM Treasury, The Green Book (2022): appraisal and evaluation in central government (viewed in March 2025)

6 - Appraisal of proposed intervention

6.1 - Summary of approach

42. This is a complex policy with strong views on both sides of the debate. The impacts of the policy to the individual would depend on the individual's personal views and circumstances and as such are not quantified. It is therefore not possible to robustly estimate an overall Net Present Value (NPV). Furthermore, while the Bill sets the parameters for VAD services in England and Wales, details about how it would work is to be set out after Royal Assent, through secondary legislation, codes of practice and guidance.

43. To inform parliamentary debate, this IA presents illustrative figures for some impacts - for Year 1 (which is half a year) and Year 10 of operation - where the level of detail contained in the Bill and existing evidence permits. This IA does not present the costs of the intermediate years. The figures that are presented are for the most part uncertain with wide ranges attached but should allow for some indication of the order of magnitude. The upper bound of these ranges should not be interpreted as a maximum value, nor as representative of the full range of potential costs, given there are significant aspects of the Bill that have not been possible to quantify at this stage.

6.2 - Core assumptions

44. This IA is based on the following core set of assumptions, developed in line with HM Treasury's Green Book[16] guidance. Other assumptions relating to specific impacts are set out in the corresponding section.

Coverage

45. Unless otherwise stated, it should be assumed that all described and estimated impacts of the Bill refer to England and Wales overall. In some cases, published data for Wales was limited, so it was assumed that trends observed in England would carry across.

Implementation year

46. In this IA, **Year 1** is set at **2029/30 (which is half a financial year),** and **Year 10** is set at **2038/39** for both England and Wales. This assumes that Royal Assent would take place in October 2025 and that all provisions of the Bill (if not already enacted) would come into effect 4 years after Royal Assent. This is contingent on the Bill progressing through all parliamentary stages in both Houses, and parliamentary timetabling. It is acknowledged that costs may be incurred earlier than 2029/30. For example, should the Bill pass, the provision allowing the Prime Minister to appoint the Voluntary Assisted Dying Commissioner comes into force after 1 year. It is also acknowledged that all other provisions may come into force on such day or days as the Secretary of State (except for powers about voluntary assisted dying services on devolved matters for Wales) or

[16] HM Treasury, The Green Book (2022): appraisal and evaluation in central government (viewed in March 2025)

Welsh Ministers (for powers about voluntary assisted dying services on devolved matters for Wales) appoint.

47. Annex H sets out a sensitivity analysis where Year 1 is set at 2028/29 (which is half a year) and Year 10 is 2037/38. This assumes that Royal Assent would take place in October 2025 and that all provisions of the Bill (if not already enacted) would come into effect 3 years after Royal Assent.

48. The assumed date of Royal Assent in the main body of this IA and Annex H is for illustrative purposes, to enable analysis to be conducted, and does not reflect any decisions about parliamentary timetables.

Price base year

49. The price base year is set at the current year, **2025/26**, as this is the earliest Royal Assent could occur. This is the year that prices used to calculate costs and benefits are taken from. Costs are adjusted to 2025/26 prices using the latest available GDP deflator unless otherwise stated[17].

Number of applicants

50. It is assumed that the number of people ("applicants") coming forward to use the assisted dying service across England and Wales would range from between 273 and 1,078 in Year 1 (October 2029 to March 2030), increasing to between 1,737 and 7,598 in Year 10 (April 2038 to March 2039).[18] See section titled "Cohort Estimates" for further information.

Number of assisted deaths

51. It is assumed that 3 in 5 applicants (60%) would complete the process and have an assisted death. The estimated number of assisted deaths across England and Wales ranges from between 164 and 647 in Year 1 (October 2029 to March 2030), to between 1,042 and 4,559 in Year 10 (April 2038 to March 2039).[19] See section titled "Cohort estimates" for further information.

Time to complete VAD process

52. The amount of time taken to complete the process, from preliminary discussion to assisted death, is uncertain. For illustrative purposes, this IA assumes that the process would take 2 months.

[17] HM Treasury (2025), GDP deflators at market prices, and money GDP March 2025 (Spring Statement & Quarterly National Accounts) (viewed March 2025)

[18] See ''Version control table' at the end of this document. In v1.1, Year 1 high scenario cohort estimates corrected from 1,311 to 1,078.

[19] See 'Version control table' at the end of this document. In v1.1, Year 1 high scenario cohort estimates corrected from 787 to 647.

Quality-Adjusted Life-Years (QALYs)

53. QALYs are not designed to quantify the health impacts of choosing to end life. Therefore, they have not been used in this IA and instead a more qualitative approach has been taken to describe the impacts on individuals.

54. While it is normal for wider health system costs and benefits (for example NHS staff time and expenditure) to be quantified in terms of their wider QALY impacts or opportunity costs, to ensure consistency throughout this assessment, we have expressed such impacts in financial, rather than QALY-value terms.

6.3 - Main impacts considered

55. The main quantified and unquantified impacts considered in this IA are summarised in Table 1 below and discussed in more detail in subsequent sections.

Table 1 Main quantified and unquantified impacts considered

Section	Overview of approach
Impacts on individuals and specific groups of individuals	This section provides a narrative overview of the potential impacts of the Bill on the following groups of individuals: terminally ill adults, relatives and friends, unpaid carers, health and social care staff, and staff working in the justice system. The Government has published a separate Equality Impact Assessment (EQIA) to aid parliamentary debate on the potential impacts of the policy on individuals with specific protected and other demographic characteristics.
The approved substance(s)	This section provides a narrative overview of the approved substance(s) used in other jurisdictions, and some of the considerations to be taken if this Bill should receive Royal Assent. Quantifying the impact is not possible at this stage, as provision about dispensing, transporting, storing, handling and disposing of approved substance(s), and what the approved substance(s) are, are to be set out in future regulations.
Information provision and training	This section sets out considerations for information provision and training on VAD across health and social care settings in England and Wales. It includes estimates relating to the cost of an initial education campaign to ensure health and social care staff are aware of the changes and what they mean. It also includes estimates for the cost of procured training based on assumptions around the size of the workforce cohort that would need to be trained, the type of training that would be required, and the potential opt-out rate among health and social care professionals.

Section	Overview of approach
	Annex B contains training cost sensitivities to consider the impacts of changing the workforce cohort and the number of people applying to use the service.
Health and social care staff time	This section sets out the potential impacts of delivering VAD services on health and social care professionals' time. The qualifications and experience these professionals must hold, the amount of time required at each stage of the process, and the number of applicants leaving the process at each stage are all uncertain. In this IA, clinician time costs have been estimated by assuming 6 NHS professionals would be involved in the process for 32 hours (the length of time each professional is involved varies). Based on salary data, an hourly cost is estimated for each professional and multiplied by the number of hours involved and cohort size. The cost for people who require an interpreter or advocate have been included and are estimated to be 2.5 times greater than individuals who do not require these reasonable adjustments. A range of sensitivity analyses have been run to consider the impacts of changing the amount of staff time and pay and are set out in Annex C.
Voluntary Assisted Dying Commissioner and Panels	This section outlines provisional estimates for the cost of funding the Voluntary Assisted Dying Commissioner and their office, and the estimated cost of each Panel. A sensitivity analysis is set out in Annex D to consider the impact of changing the average time per hearing and the number of applicants considered by the Panel.
Healthcare costs at end-of-life	This section sets out the potential impacts of delivering VAD services on healthcare costs at end-of-life. If it is assumed that the VAD process takes 2 months from preliminary discussion to assisted death, and that the individual would otherwise have lived for 6 months, then there would be up to 4 months of unutilised care. The average healthcare costs during the final 4 months of life have been estimated using an (as yet) unpublished NIHR-funded study[20]. This captures hospital (both emergency and non-emergency care), primary and community care, hospice, medicines and other care costs, but does not distinguish between funding avenues. It also considers variations in projected assisted death numbers (low, central, and high), and the amount of time care is no longer required for (ranging from the final 4 to final 1 month of life). It is

[20] Clarke, G., May, P., Cook, A., Mitchell, S., Walshe, C., Bajwah, S., Yorganci, E., Kumar, R., Fraser, L.K., Sleeman, K.E., Murtagh F.E.M. (2025). Costs and cost-effectiveness of adult palliative and end-of-life care. Evidence briefing summary. London: National Institute for Health and Care Research (NIHR) Policy Research Unit (PRU) for Palliative and End-of-Life Care. Summary accessed on 18/03/2025. **Full report is unpublished data – provided via personal communication.**

Section	Overview of approach
	unclear whether any reduction of expenditure would materialise if there were high levels of demand for palliative and end-of-life care. As a sensitivity, the impacts of changing the average healthcare costs are considered in Annex E.
Social care sector	This section sets out the potential impacts of delivering VAD services on the social care sector; specifically, care homes and domiciliary care. The Bill does not specify the setting from which assistance to end life would be provided. Published death registration data by place, for those who died from cancer in England, is therefore used to estimate the potential number of assisted deaths among people living in a care home or their own home. Further assumptions are made about the split of local authority and privately funded care arrangements, to estimate the impact of care no longer required for between 1 to 4 months. The quantified analysis of profit impacts assumes costs for the care home or domiciliary care organisation are flexible in the short term. However, care home organisations may fill vacant beds quickly in some cases, or domiciliary care organisations my take on new clients which may reduce the impact on profit, so this analysis should be considered as illustrative only. It is also unclear whether any reduction of expenditure by local authorities would materialise if there were high levels of demand for social care services in a that local authority.
Wider impacts on state pensions and state benefits	This section describes the potential wider impacts of VAD services on social security payments, specifically state pensions and state benefits. The number of people choosing to have an assisted death who would otherwise have been in receipt of a state pension or state benefits (under Special Rules for End of Life) is unknown. In addition, social security payments are considered 'economic transfers' in HM Treasury's Green Book, meaning they do not constitute a saving or cost for society. To give some indication of the scale of potential economic transfers, assumptions are made about the proportion of people having an assisted death who would have: 1) been in receipt of state pension and Attendance Allowance (AA); or 2) been in receipt of Personal Independence Payment (PIP). Forecast data from DWP is used to estimate the average weekly state pension, AA, or PIP entitlement, which is then multiplied by the estimated number of people who had an assisted death and no longer required each payment for between 1 to 4 months. There is a high degree of uncertainty in these estimates.
Wider impacts on the justice system, and death	This section provides a narrative overview of the wider potential impacts of the Bill on the justice system, as well as on death certification and registration processes, most of which are considered negligible.

Section	Overview of approach
certification and registration	
Implementation considerations	Further work would be required to estimate all costs associated with setting up, implementing, monitoring and evaluating the VAD service in England and Wales, should the Bill become law, and subject to further details being set out in regulation such as staff training requirements.
Monitoring and Evaluation	There are several provisions for monitoring and evaluation in the Bill, which have not been quantified at this stage. This section summarises provisions in the Bill relating to monitoring and evaluation. It describes in narrative form key considerations for data collection, process and impact evaluations.

7 - Cohort estimates[21]

7.1 - Summary

56. There are no official statistics in England and Wales on the number of terminally ill adults, nor the cost of their palliative and end-of-life care. As such, this IA looks at uptake of VAD services in other jurisdictions with comparable eligibility criteria to estimate the number of people choosing to request and proceeding to have an assisted death.

57. As shown in Table 2, it is estimated that the **total number of applicants** would range from between **273 and 1,078 in Year 1 (which is half a year)**, to between **1,737 and 7,598 in Year 10**.

58. The **total number of assisted deaths** is estimated to range from between **164 and 647 in Year 1 (which is half a year),** rising to between **1,042 and 4,559 in Year 10**.

Table 2 Estimated number of applicants and assisted deaths, by implementation year, for England and Wales overall [22]

Cohort	Scenario	Year 1 (half-year): 2029/30	Year 10: 2038/39
Number of applicants	Low	273	1,737
	Central	481	3,639
	High	1,078	7,598
Number of assisted deaths	Low	164	1,042
	Central	289	2,183
	High	647	4,559

7.2 - Availability of international data

59. To estimate the number of potential applicants and assisted deaths in England and Wales, published data from comparable jurisdictions has been considered.

60. A comparable jurisdiction has been defined as one where the person requesting assistance to end their own life:

    60.1. is an adult, aged 18 or above

    60.2. has been diagnosed with a terminal illness, from which they are expected to die within 6 months

    60.3. cannot apply solely on the grounds of mental illness or disability (as defined in the respective disability legislation in each jurisdiction).

[21] See 'Version control table' at end of this document. In v1.1, the estimated proportion of assisted deaths occurring under the high scenario in Year 1 was corrected from 0.13% to 0.11%. All numbers derived from this were also updated in v1.1 (and carried forward to v1.2). In this section of the IA, this included Year 1 high scenario values in Table 2, Table 4, Table 5, Table 9, Table 10, Table 11, Figure 4, Figure 5, and corresponding text.

[22] DHSC estimates based on figures found in Annex A and ONS (2025), National population projections (viewed in March 2025)

61. 10 jurisdictions were identified that met these criteria, but the availability of published data varied. As shown in Table 3, only 3 of 10 jurisdictions published annual data on the number of applicants, while 8 of 10 published data on the number of assisted deaths (though only 7 did so annually).

Table 3 Availability of published data on annual number of applicants and assisted deaths, across comparable jurisdictions[23]

Jurisdiction	Annual data published on number of applicants	Annual data published on number of assisted deaths
California (USA)	Yes	Yes
Colorado (USA)	Not found	Not found
Hawaii (USA)	Not found	Yes
Maine (USA)	Yes	Yes
New Mexico (USA)	Not found	Not found
New Zealand	Yes	Yes
Oregon (USA)	Not found	Yes
District of Columbia (USA)	Not found	Yes
Vermont (USA)	Not found	Partial (not annual)
Washington (USA)	Not found	Yes

62. Annex A contains a summary of data published in comparable jurisdictions on the total number of deaths and total number of assisted deaths.

63. There are a range of reasons uptake may still vary across jurisdictions with comparable eligibility criteria; for example, public health systems, population demographics, societal norms, length of time the service has been operational, design of the process, and mechanisms for reporting usage. However, it was observed that none exceeded an assisted death rate of 1% of total deaths in any reported year.

7.3 - Methodology for estimating the number of assisted deaths

64. In this IA, we set out a low, central, and high estimate for the potential number of assisted deaths in England and Wales.

65. The approach to calculating each scenario is described in turn below. The number of assisted deaths is estimated relative to the total number of projected deaths across England and Wales, taken from ONS projections[24] [25], and includes all persons (not just adults). For year 1, which is half a year, we have halved the full-year deaths in the ONS projections.

[23] For data sources, see Annex A

[24] Principle projection – Wales summary (2022 based edition), ONS (2025), (viewed in March 2025)

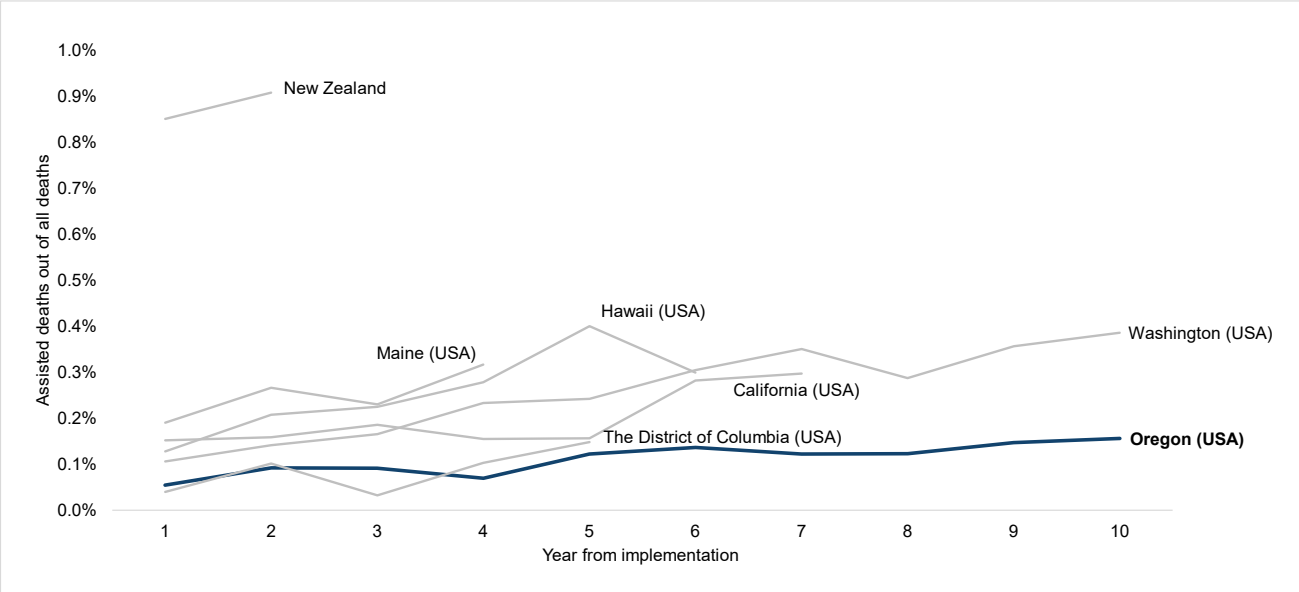
[25] Principle projection – England summary (2022 based edition), ONS (2025), (viewed March 2025)

Low estimate

66. The annual rate of assisted deaths **by implementation year** was compared across the 7 jurisdictions where data was available. Only 2 (Washington and Oregon) had been operational for at least 10 years, so the trend for most was limited. Oregon generally reported the lowest rate over the first full decade of implementation. See Figure 2.

67. To produce our low estimate, the annual proportion of deaths for the first 10 full years of the scheme in Oregon (1998 to 2007)[26] was therefore applied to the projected number of deaths at population level in England and Wales.

Figure 2 Proportion of assisted deaths relative to total deaths, by jurisdiction, first (complete) 10 years of implementation



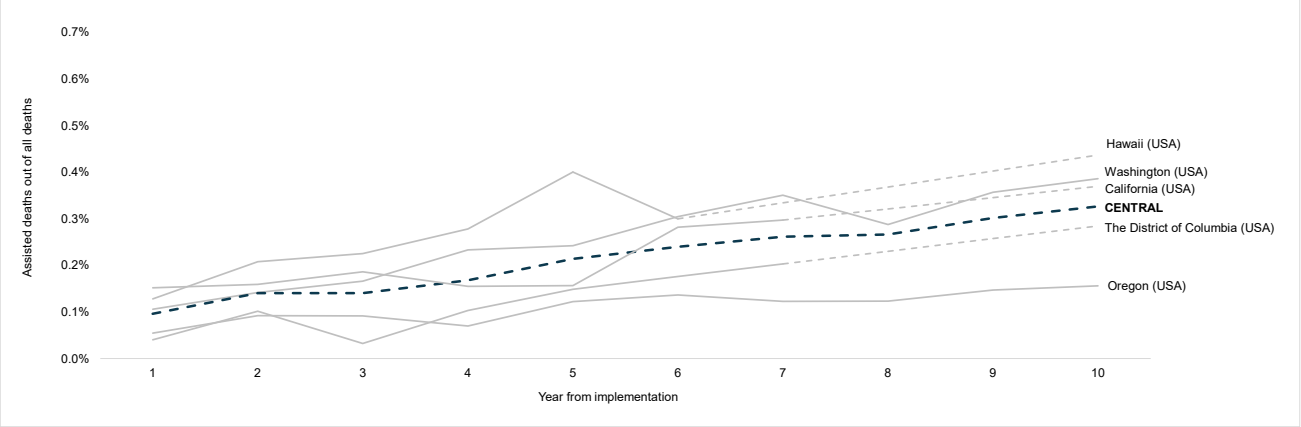
Central estimate

68. There were 2 comparable jurisdictions that had published data for the first 10 complete years of operation. There were a further 3 comparable jurisdictions that had published data for at least the first 5 complete years of operation (which is half of our 10-year appraisal period). For these 3, data was extrapolated up to year 10 to complete the series (this covered Years 6 to 10 in Hawaii, and Years 7 to 10 for California and the District of Columbia).

69. To produce the central estimate, the average actual and/or projected annual rate of assisted deaths across California, Hawaii, Oregon, the District of Columbia and Washington, for the first 10 years of implementation, was applied to the projected number of deaths at population level in England and Wales. See Figure 3.

[26] For data source, see Annex A

Figure 3 Actual and/or projected proportion of assisted deaths relative to all deaths, by jurisdiction, first 10 years of implementation



Note: in Figure 3, projected values are shown with a dashed line. Only jurisdictions with at least five years of complete data have been included.

High estimate

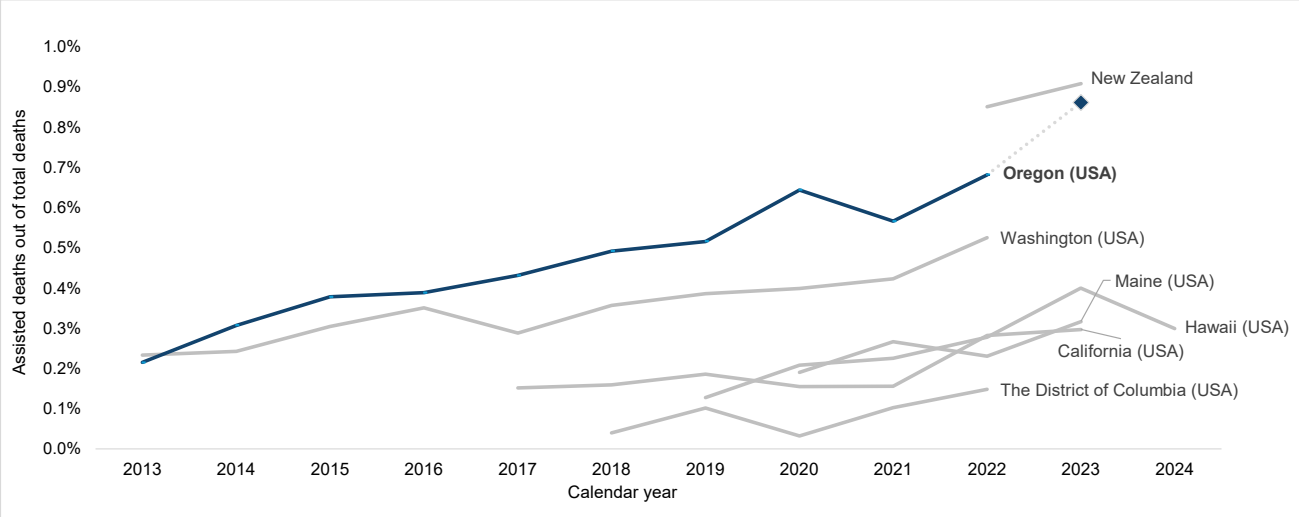
70. The annual rate of assisted deaths **by calendar year** was compared across the 7 jurisdictions where data was available. This comparison adjusts for the fact that each assisted dying service began at different points in time over the course of three decades, and that cultural and societal norms as well as public acceptance of these services might have shifted over time. See Figure 4.

71. To produce the high estimate, the proportion of assisted deaths in Oregon from 2013 to 2022 was used and applied to the project number of deaths at population level in England and Wales.[27] This was the 10 most recent and complete years of data for Oregon when the analysis for this IA was produced. While data has since been published to enable calculation of the assisted death rate for Oregon in 2023, this is not directly comparable to previous years due to a change in who could access the service (thus breaking the time series).[28] As the longest running scheme in our sample, Oregon seems like a plausible upper boundary.

[27] See 'Version control table' at the end of this document. In v1.1, point of clarification was made to paragraph 71 to explain that the high cohort scenario was derived from the proportion of assisted deaths in Oregon from 2013 to 2022, rather than 2014 to 2023 as previously stated in v1.0.

[28] On 27 March 2025, the Oregon Health Authority (OHA) published their '2024 Oregon Death with Dignity Act Data Summary'. This contained, for Oregon, the total number of deaths occurring in 2023 (42,592), from which the proportion of assisted deaths occurring in 2023 could be calculated. This is included for contextual purposes only in Figure 4 and is not used in the analysis for this IA. Oregon lifted the residency requirement from the Death with Dignity Act in 2023, meaning non-residents could access the service, thus breaking the time series.

Figure 4 Proportion of assisted deaths relative to total deaths, by jurisdiction, 2013 to 2024[29]



Note: In 2023, law amended in Oregon to allow non-residents to access the scheme, breaking the time series.

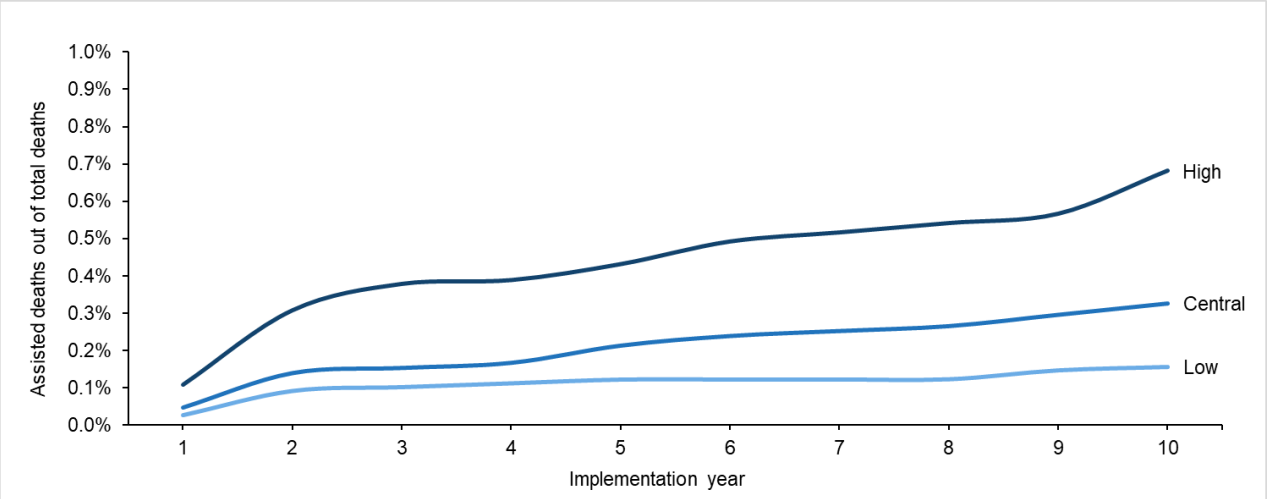
Low, central, and high estimates

72. For each of the low, central, and high estimates, the trend lines were smoothed to assume that the assisted death rate in England and Wales would remain stable or increase over time. See Figure 5.

73. The **estimated proportion of assisted deaths** out of the total number of projected deaths range between **0.03% to 0.11% in Year 1 (which is half a year)**, and between **0.16% to 0.68% in Year 10**. See Table 4.

74. This equates to an **estimated number of assisted deaths** between **164 and 647 in Year 1 (which is half a year)**, and between **1,042 and 4,559 in Year 10**. See Table 5.

Figure 5 Estimated proportion of assisted deaths as a proportion of total deaths per year, by scenario (low, central, high)



[29] See 'Version control table' at the end of this document. In v1.1, Figure 4 was corrected to include data points for 2013 and the format of trend line for Oregon was amended to reflect break in time series in 2023, when law was amended to enable non-residents to access the service.

Table 4 Estimated proportion of assisted deaths out of total deaths per year, by scenario (low, central, high)[30]

Year	1 (half-year)	2	3	4	5	6	7	8	9	10
	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37	2037/38	2038/39
Low	0.03%	0.09%	0.10%	0.11%	0.12%	0.12%	0.12%	0.12%	0.15%	0.16%
Central	0.05%	0.14%	0.15%	0.17%	0.21%	0.24%	0.25%	0.27%	0.30%	0.33%
High	0.11%	0.31%	0.38%	0.39%	0.43%	0.49%	0.52%	0.54%	0.57%	0.68%

Table 5 Estimated number of assisted deaths per year, by scenario (low, central, high), and territory[31]

Year		1 (half-year)	2	3	4	5	6	7	8	9	10
		2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37	2037/38	2038/39
England & Wales combined	Low	164	560	629	699	772	782	792	806	972	1,042
	Central	289	854	949	1,046	1,350	1,531	1,635	1,741	1,960	2,183
	High	647	1,870	2,328	2,421	2,722	3,143	3,338	3,542	3,747	4,559
England	Low	154	525	590	657	725	734	744	757	913	979
	Central	271	802	891	982	1,267	1,438	1,536	1,635	1,841	2,051
	High	607	1,756	2,186	2,273	2,556	2,952	3,135	3,326	3,519	4,282
Wales	Low	10	34	38	43	47	48	48	49	59	63
	Central	18	52	58	64	82	93	100	106	119	133
	High	40	114	142	148	166	192	204	216	228	277

[30] DHSC estimates based on figures found in Annex A and ONS (2025), National population projections (viewed in March 2025)

[31] DHSC estimates based on figures found in Annex A and ONS (2025), National population projections (viewed in March 2025)

Assisted deaths by terminal illness and age

75. In 4 comparable jurisdictions, data was published on the underlying terminal illness of those who had an assisted death. This suggests that a majority of assisted deaths occur among people with cancer. See Table 6.

Table 6 People with cancer as a percentage of assisted deaths in comparable jurisdictions[32]

Jurisdiction (year)	Number of assisted deaths	Number of assisted deaths with a cancer diagnosis	% of assisted deaths with a cancer diagnosis
California, USA (2023)	884	564	64%
Oregon, USA (2023)	367	242	66%
Hawaii, USA (2023)	76	57	69%
District of Columbia, USA (2022)	8	6	75%

76. In 6 comparable jurisdictions, data was published on the age of those who had an assisted death. This suggests that a majority of assisted deaths occur among people in older age categories (defined as those aged 65 and above, 70 and above, or 79 and above, depending on the jurisdiction). See Table 7.

Table 7 The distribution of assisted deaths by age band in comparable jurisdictions[32]

Jurisdiction (year)	Age band	Age band % of assisted deaths	% of overall assisted deaths overall
Oregon, USA (2023)	65-74	31%	83%
	75-84	32%	
	85+	20%	
Hawaii, USA (2024)	65-74	33%	90%
	75-84	39%	
	85+	18%	
Washington, USA (2023)	65-74	27%	83%
	75-84	33%	
	85+	23%	
New Zealand (2023/24)	65-84	59%	78%
	85+	19%	
California, USA (2023)	70-79	33%	76%
	80-89	27%	
	90+	16%	
District of Columbia, USA (2022)	79+	63%	63%

[32] For data sources, see Annex A

7.4 - Methodology for estimating the number of applicants

77. In the previous section, we described our approach to estimating the number of assisted deaths in England and Wales. In this section, we describe our approach to estimating the number of people expected to come forward and apply to use the assisted dying service.

78. There was a general scarcity of data on the number of people applying to use VAD services, with only 3 comparable jurisdictions reporting this information. In these jurisdictions, it was observed that the number of applicants was greater than the number of assisted deaths. It was reported that applicants may leave the process at different points and for a range of reasons, including, for example:

    78.1. the person changing their mind and choosing not to have an assisted death

    78.2. the person being assessed as ineligible by medical professionals

    78.3. the person being assessed as losing their mental capacity later in the process

    78.4. the person dying from their underlying terminal illness.

79. The average reported proportion of applicants who were certified as having an assisted death was 57%. This however ranged from 38% of applicants completing the process in New Zealand to 66% in Maine and California. See Table 8.

Table 8 Reported proportion of applicants who completed process and had an assisted death in comparable jurisdictions (2023) [33]

Jurisdiction	Number of applicants reported	Number of assisted deaths reported	Proportion of applicants completing process
California (USA)	1,272	835	66%
Maine (USA)	80	53	66%
New Zealand	914	344	38%
Average	/	/	57%

80. It is uncertain how this would translate across to England and Wales. For the purpose of this IA, **it is assumed that 60% of applicants complete the process** and proceed to have an assisted death. To estimate the number of applicants, the number of assisted deaths was therefore uplifted so that the number of people having an assisted death is 60% of the number of applicants (i.e. dividing the number of deaths by 0.6).

Estimates

The **estimated number of applicants** is between **273 to 1,078 in Year 1 (which is half a year)**, to between **1,737 to 7,598 in Year 10**. See Table 9.

[33] For data sources, see Annex A.

Table 9 Estimated number of applicants per year (assuming 60% complete), by scenario (low, central, high), and territory[34]

	Year	1 (half-year)	2	3	4	5	6	7	8	9	10
		2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37	2037/38	2038/39
England & Wales combined	Low	273	933	1,048	1,166	1,286	1,304	1,321	1,343	1,621	1,737
	Central	481	1,423	1,581	1,743	2,250	2,552	2,726	2,902	3,267	3,639
	High	1,078	3,116	3,880	4,035	4,537	5,239	5,564	5,903	6,245	7,598
England	Low	256	876	984	1,094	1,208	1,224	1,240	1,261	1,522	1,632
	Central	452	1,336	1,484	1,636	2,112	2,396	2,559	2,725	3,069	3,418
	High	1,012	2,926	3,643	3,788	4,260	4,919	5,225	5,543	5,865	7,136
Wales	Low	17	57	64	71	79	80	81	82	99	106
	Central	29	87	97	106	137	156	166	177	199	221
	High	66	191	237	247	277	320	339	360	380	462

[34] DHSC estimates based on figures found in Annex A and ONS (2025), National population projections (2022 editions) (see footnote 14 and 15) (viewed in March 2025)

7.5 - Cohort sensitivity analysis

81. There is significant uncertainty over how many people in England and Wales would have an assisted death. While the cohort estimates presented are based on data from jurisdictions with comparable eligibility criteria, their public health systems and population demographics may not be comparable to that of England and Wales, and quite a few have not been running for many years. Some of this uncertainty is accounted for by presenting a low, central, and high scenario for the number of assisted deaths over the 10-year appraisal period.

82. For each scenario, it is assumed that the number of assisted deaths **represent 60%** of the number of people who originally came forward to use the service. In other words, it is assumed that there would be a reduction of 40% between the preliminary discussion and assisted death. The number of people who would leave at each step of the process is not known, and this could be for a range of reasons (such as being assessed as ineligible or not mentally competent, deciding to withdraw from the process, or dying from their underlying terminal illness).

83. None of the jurisdictions analysed have a three-stage approval process, or one that involves an independent panel prospectively assessing the application. It is unclear if this difference, alongside the differences in health systems and population demographics, would impact the number of people that apply and are approved to use the service. To stress-test this assumption, a sensitivity analysis is set out below to show the effect of having a lower and a higher rate of people leaving the process.

84. If the estimated number of assisted deaths is taken, and it is assumed these **represent 80%** of the number of people coming forward (meaning there is a lower overall reduction rate of 20%), then the number of applicants changes to:

    84.1. between **205 to 808 in Year 1 (which is half a year)**, to between **1,303 to 5,699 in Year 10**, across England and Wales (Table 10)

85. If the estimated number of assisted deaths is taken, and it is assumed these **represent 33%** of the number of people coming forward (meaning there is a higher overall reduction rate of 67%), then the number of applicants changes to:

    85.1. between **497 to 1,960 in Year 1 (which is half a year)**, to between **3,159 to 13,815 in Year 10**, across England and Wales (Table 11).

Table 10 Estimated number of applicants per year, sensitivity analysis (assuming 80% complete the process instead of 60%)[35]

	Year	1 (half-year)	2	3	4	5	6	7	8	9	10
		2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37	2037/38	2038/39
England & Wales combined	Low	205	699	786	874	965	978	991	1,007	1,215	1,303
	Central	361	1,067	1,186	1,307	1,687	1,914	2,044	2,176	2,450	2,729
	High	808	2,337	2,910	3,026	3,403	3,929	4,173	4,427	4,684	5,699
England	Low	192	657	738	821	906	918	930	946	1,141	1,224
	Central	339	1,002	1,113	1,227	1,584	1,797	1,920	2,044	2,301	2,563
	High	759	2,194	2,732	2,841	3,195	3,689	3,918	4,157	4,399	5,352
Wales	Low	13	43	48	53	59	60	60	61	74	79
	Central	22	65	72	80	103	117	125	133	149	166
	High	49	143	178	185	208	240	254	270	285	346

Table 11 Estimated number of applicants per year, sensitivity analysis (assuming 33% complete the process instead of 60%)[35]

	Year	1 (half-year)	2	3	4	5	6	7	8	9	10
		2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37	2037/38	2038/39
England & Wales combined	Low	497	1,695	1,905	2,119	2,339	2,370	2,401	2,442	2,946	3,159
	Central	875	2,588	2,875	3,169	4,090	4,640	4,956	5,276	5,941	6,617
	High	1,960	5,666	7,055	7,336	8,249	9,525	10,116	10,732	11,355	13,815
England	Low	466	1,592	1,788	1,990	2,196	2,226	2,255	2,294	2,767	2,967
	Central	821	2,430	2,699	2,975	3,841	4,357	4,653	4,954	5,579	6,215
	High	1,840	5,320	6,623	6,888	7,745	8,944	9,499	10,079	10,664	12,975
Wales	Low	30	104	116	129	143	145	146	149	179	192
	Central	53	158	176	194	250	283	302	321	361	402
	High	120	346	431	448	504	581	617	654	691	839

[35] DHSC estimates based on figures found in Annex A and ONS (2025), National population projections (viewed in March 2025)

8 - Impacts on individuals and specific groups of individuals

8.1 - Summary

86. This section of the IA describes in narrative form the potential impacts of the Bill, as amended in the House of Commons, on the following groups of individuals: terminally ill adults, relatives and friends, unpaid carers, health and social care staff, and staff working in the justice system.

87. The Government is neutral on the policy of assisted dying. It is acknowledged that the views held by individuals and organisations on the potential impacts of the policy differ significantly. There are a range of materials and literature that have been published on the topic, including a report published by the British Medical Association entitled 'Key arguments used in the debate on physician-assisted dying'[36]. This IA refers to some of the main arguments put forward on both sides of the debate, which are based on assumptions and expectations that are complex to validate.

88. There are groups not referenced in this section that may be impacted by the policy, and the nature and extent of impacts may vary both within and across groups. The Government has published a separate Equality Impact Assessment (EQIA) to aid parliamentary debate on the potential impacts of the policy on people who share the nine protected characteristics set out in section 4 of the Equality Act 2010[37] (disability, sex, sexual orientation, race, age, gender reassignment, religion or belief, pregnancy and maternity, and marriage and civil partnership). The EQIA also sets out considerations for three additional dimensions not covered by the Equality Act 2010 (these are socio-economic background, geography, and mental health).

8.2 - Terminally ill adults

89. The proposed VAD service is aimed at terminally ill adults who have the capacity to decide to end their own life, are aged 18 or over at the time of the first declaration, are ordinarily resident in England and Wales (and have been so for at least 12 months) and are registered with a general medical practice in England or Wales.

90. The Bill defines a person as "terminally ill" if they have an inevitably progressive illness or disease which cannot be reversed by treatment, and if their death in consequence of that illness or disease can reasonably be expected within 6 months. A person is not considered "terminally ill" only because they are a person

[36] British Medical Association (2021), Physician assisted dying (viewed in March 2025)

[37] Equality Act 2010

with a disability and/or mental disorder, or solely as a result of voluntarily stopping eating and drinking. However, a person with a disability and/or mental disorder is not prevented from being considered “terminally ill” if they meet the definition in Clause 2(1).

91. One of the main reported benefits of such policies for terminally ill adults is personal choice over the manner of their death. In Oregon, research conducted with terminally ill adults prior to their assisted death found that “losing autonomy” was the most common end-of-life concern (reported by 88% of applicants in the 2024 annual report[38]). In the UK, evidence suggests that some people with severe health conditions and/or a terminal illness may seek ways to end their own life. For example, in 2023, 40 residents were reported to have travelled from the UK to Dignitas in Switzerland to end their life,[39] and experimental statistics published by the ONS found elevated rates of suicide among people with severe health conditions (compared to those without)[40]. The impact of VAD service provision in England and Wales on these outcomes is uncertain.

92. There are a range of reasons put forward to explain why some terminally ill adults may value having a choice over the manner of their death. For example, end-of-life concerns reported by assisted dying service users in the 2024 Oregon Annual Report included: being “less able to engage in activities making life enjoyable” (88%), “loss of dignity” (64%), “losing control of bodily functions” (47%), and “inadequate pain control or concern about it" (34%)[38]. It is acknowledged that having these end-of-life concerns does not mean every person would choose to have an assisted death, and that the extent to which these reasons would be cited by terminally ill adults in England and Wales is uncertain.

93. One of the main reported disbenefits of such policies for terminally ill adults is that they may feel pressured into have an assisted death. This concern has been cited by members of the public who support and who oppose legalisation of assisted dying in England and Wales.[41] There are a range of reasons put forward to explain why individuals might feel actual or perceived pressure to end their life. In Oregon, research conducted with terminally ill adults prior to their assisted death and published in the 2024 Annual Report showed “burden on family, friends/caregivers” (42%) and “financial implications of treatment” (9%) as end-of-life concerns[38]. In Maine[42], only 10 out of 34 hospitals reported having a palliative care programme, and it is not known the extent to which lack of access to palliative care may influence a person’s decision to have an assisted death.

[38] For data source, see Annex A

[39] Yang, J. (2024), Dignitas suicides from the UK | Statista (viewed in March 2025)

[40] ONS (2022), Suicides among people diagnosed with severe health conditions, England - Office for National Statistics (viewed in March 2025)

[41] King’s College London (2024), Assisted dying: two-thirds of public back legalisation within this Parliament, study finds | King's College London (viewed in March 2025)

[42] Maine Hospice Council and Centre for End-of-life Care (2024), Maine Palliative Care and Quality of Life Advisory Council (viewed in March 2025)

94. Public health systems and palliative care provision varies across jurisdictions. As such, the extent to which these end-of-life concerns would be cited by terminally ill adults in England and Wales is uncertain. The Bill aims to protect against the risk of coercion and pressure through the provision of various protections and safeguards. Additionally, as part of the assessment process, doctors are required to explain and discuss with the applicant any treatment available and all appropriate palliative, hospice or other care including symptom management and psychological support. It is acknowledged that there are high levels of demand for end-of-life and palliative care across England and Wales, including some unmet need and variation in quality of provision.[43]

95. HMT's Green Book[44] explains that health policies and interventions are usually assessed in reference to Quality-Adjusted Life Years ('QALYs'). This metric quantifies the potential for an intervention to lengthen and/or improve the quality of the person's life. Given that the intent of this Bill is to provide lawful assistance to terminally ill adults to end their life, and that this provision may be considered a benefit or disbenefit depending on individual views and circumstances, impacts have not been quantified in QALY terms.

8.3 - Relatives and friends

96. The Bill does not explicitly confer a role on the applicant's relatives and friends. The Bill defines a "relative" as: the person's spouse or civil partner; any lineal ancestor, lineal descendant, sibling, aunt, uncle or cousin of that person or the person's spouse or civil partner; or the spouse or civil partner of any relative listed here. However, the availability of a VAD service and the applicant's decision would still impact relatives and friends.

97. Relatives and friends can experience a range of emotions before or after their loved one has chosen to have an assisted death and self-administered the approved substance[45] [46]. An Australian study reports that for some relatives, a sense of meaning is derived from supporting a loved one to fulfil their wishes, striving for them to have a "good death" at end-of-life, and that it gives all involved more time to emotionally prepare for the death[47]. It is also reported that for some relatives, a loved one choosing to have an assisted death can present significant

[43] Association of Palliative Medicine and Marie Curie (2021), Association of Palliative Medicine and Marie Curie survey of palliative care practitioners 2021 (viewed in March 2025)

[44] HM Treasury, The Green Book (2022): appraisal and evaluation in central government (viewed in March 2025)

[45] Gamondi, C., Fusi-Schmidhauser, T., Oriani, A. and others (2019), Family members' experiences of assisted dying: A systematic literature review with thematic synthesis - PubMed (viewed in March 2025)

[46] La Brooy, C., Russell H., Lewis, S. and others (2024), The Impact of Voluntary Assisted Dying on Grief and Bereavement for Family Members and Carers in the Australian State of Victoria: A Qualitative Study - La Brooy - 2024 - Health & Social Care in the Community - Wiley Online Library (viewed in March 2025)

[47] La Brooy, C., Russell H., Lewis, S. and others (2024), The Impact of Voluntary Assisted Dying on Grief and Bereavement for Family Members and Carers in the Australian State of Victoria: A Qualitative Study - La Brooy - 2024 - Health & Social Care in the Community - Wiley Online Library (viewed in March 2025)

challenges for grief and bereavement, including the impact on familial relationships where personal views on assisted dying diverge.

98. In the Bill, some groups of people are disqualified from acting as the applicant's assessing doctor, witness, or proxy. This includes, for example: any relative of the person, anyone who would benefit financially or in any other material way from the death of the person, and any person who has not attained the age of 18. The purpose of this is to safeguard against the risk of actual or perceived coercion or pressure to have an assisted death.

99. It is not clear from the face of the Bill if a relative would be able to act as an "independent advocate" to provide support and advocacy to a qualifying person who is seeking to understand options around end-of-life care, including the possibility of requesting assistance to end their own life, to enable them to effectively understand and engage with all the provisions. The Secretary of State must by regulations make provision as to the appointment of persons as independent advocates including, for example, any training requirements. The impact of this provision on relatives has therefore not been quantified.

8.4 - Unpaid carers

100. The Bill does not explicitly confer a role on any unpaid carer of the applicant. An unpaid carer is anyone who cares or intends to care, unpaid, for a friend or family member. According to the 2021 Census, of the usual resident population aged 5 years and over, 9% in England and 11% in Wales reported providing unpaid care[48]; however, this may be an underestimate as some people who are objectively defined as an unpaid carer may not see what they do as 'looking after' or 'giving help or support'[49].

101. One of the reported benefits of VAD services to unpaid carers is the reduction in time spent providing care for the terminally ill adult who chooses to end their own life. Evidence suggests that providing unpaid care, particularly at higher intensities, is associated with negative physical and mental health outcomes, and employment impacts.[50] Providing unpaid care for someone who is terminally ill and at the end of their life, is likely to fall into the 'higher intensity' category. It is not possible to accurately quantify the reduction in time spent caring for someone who chooses to have an assisted death, as it is not known how long the process from initial application to assisted death would take, nor is it known when they would have died from their underlying illness.

[48] ONS (2023), Unpaid care by age, sex and deprivation, England and Wales - Office for National Statistics (viewed in March 2025)
[49] Carers Trust (2021), Factsheets for carers looking to get back into work or already in work - Resources - Carers Trust (viewed in March 2025)
[50] NHS England (2024), Health Survey for England, 2022 Part 2 - NHS England Digital (viewed in March 2025)

102. One of the reported disbenefits of such policies, alongside the emotional and psychological impacts as described for relatives and friends in the previous section, is the potential administrative burden on unpaid carers. Wider evidence on unpaid care suggests that many unpaid carers play an active role in coordinating services and supporting the person they care for to navigate and interact with health and social care systems.[51] It is not clear from the face of the Bill if an unpaid carer would be able to act as an "independent advocate" for the applicant. However, it is likely that an unpaid carer who would otherwise have supported the person to access and interact with health and social care services, may also require at least a general awareness of the VAD service and process.

103. It is acknowledged that some unpaid carers are children. According to the 2021 Census, there are approximately 120,000 unpaid carers under the age of 18 in England and Wales[52]. It is possible that the nature and extent of the impacts of the policy on young unpaid carers may be different to that of adults who are unpaid carers. People under the age of 18 are disqualified from being an "independent advocate", proxy or witness as described in the Bill.

8.5 - Health and social care staff

104. The Bill contains several provisions pertaining to the role of registered medical practitioners and other health professionals. For example, practitioners (meeting the training, qualification and experience requirements set through future regulations) may be responsible for (depending on their role) conducting a preliminary discussion with the applicant, assessing the applicant, answering questions asked by the Voluntary Assisted Dying Panel, preparing the approved substance for self-administration, and/or certifying the death. The Bill also states that the Panel must contain a psychiatrist and a social worker as two of its three members.

105. In the UK, most professional bodies have adopted a neutral position on assisted dying (see Table 12), though not in specific relation to the VAD service described in this Bill. This includes, for example, the British Medical Association[53], the Royal College of Nursing,[54] the Royal College of General Practitioners[55], and the Association of Palliative Care Social Workers[56]). This often reflects that their members hold a range of different views on the topic of assisted dying and/or whether they would be willing to actively participate in the provision of such a service. Other professional bodies have adopted a position of opposition (such as

[51] Fenney, D., Thorstensen-Woll, C. and Bottery, S. (2023), Caring In A Complex World: Perspectives From Unpaid Carers | The King's Fund (viewed in March 2025)

[52] ONS (2023), Unpaid care by age, sex and deprivation, England and Wales - Office for National Statistics (viewed in March 2025)

[53] British Medical Association (2021), Physician assisted dying (viewed in March 2025)

[54] Royal College of Nursing (2023), RCN position on assisted dying | Royal College of Nursing (viewed in March 2025)

[55] Royal College of General Practitioners (2025), Assisted dying (viewed in March 2025)

[56] See 'version control table' at end of this document. In v1.2, the position of the Association of Palliative Care Social Workers was corrected from opposed to neutral. Association of Palliative Care Social Workers (2024), APCSW Statements on Assisted Dying – November 2024 | Association of Palliative Care Social Workers (viewed in June 2025)

the British Geriatric Society[57] and the Association for Palliative Medicine of Great Britain and Ireland[58]).

106. Since first publication of this IA after Committee stage, the Royal College of Psychiatrists[59] has said they cannot support the Bill in its current form, although they remain neutral on the principle of assisted dying. The Royal College of Pathologists has also said that, whilst it has no position on the ethical issues relating to assisted dying, it does not support the role of medical examiners after an assisted death has taken place, as currently set out in the Bill.[60]

Table 12 Official positions of healthcare professional bodies on assisted dying

Organisation (year of publication)	Official Position	% Opposed	% Neutral	% For	% Undecided	Sample size
British Medical Association (2021)[61]	Neutral	33%	21%	40%	6%	28,986
Royal College of GPs (2025)[62]	Neutral	39%	61%	0%	Not known	8,779
Royal College of Physicians (2019)[63]	Neutral	43%	25%	32%	Not known	6,885
Royal College of Surgeons (2023)[64]	Neutral	25%	20%	52%	3%	3,268
Royal College of Nursing (2023)[65]	Neutral	Not known	Not known	Not known	Not known	Not known
Royal Pharmaceutical Society (2025)[66]	Neutral	Not known	Not known	Not known	Not known	Not known
Association for Palliative Medicine (2015)[67]	Opposed	82%	Not known	12%	Not known	387
British Geriatric Society (2024)[68]	Opposed	50%	Not known	33%	17%	775
Royal College of Psychiatrists (2024)[69]	Neutral[70]	45%	Not known	45%	Not known	1,474
Association of Palliative Care Social workers (2024)[71]	Neutral	Not known	Not known	Not known	Not known	Not known

[57] The British Geriatric Society (2024), BGS Position Statement on Assisted Dying | British Geriatrics Society (viewed in March 2025)

[58] The Association for Palliative Medicine of Great Britain and Ireland (2024), Position Statements | APM (viewed in March 2025)

[59] The Royal College of Psychiatrists (2025), The RCPsych cannot support the Terminally Ill Adults (End of Life) Bill for England and Wales in its current form (viewed in June 2025)

[60] The Royal College of Pathologists (2025), Royal College of Pathologists statement on the Terminally Ill Adults (End of Life) Bill (viewed in June 2025)

[61] See 'version control table' at end of this document. In v1.2 of this IA, the percentage "opposed" was corrected from 40% to 33%, and the percentage "for" was corrected from 33% to 40%. British Medical Association (2021), Physician assisted dying (viewed in June 2025)

[62] Royal College of General Practitioners (2025), Assisted dying (viewed in June 2025)

[63] Royal College of Physicians (2019), 2019 assisted dying survey results. No majority view moves RCP position to neutral | RCP (viewed in June 2025)

[64] Royal College of Surgeons (2023), Assisted Dying — Royal College of Surgeons (viewed in June 2025)

[65] Royal College of Nursing (2023), RCN position on assisted dying | Royal College of Nursing (viewed in June 2025)

[66] Royal Pharmaceutical Society (2025), Assisted Dying | RPS (viewed in June 2025)

[67] Association for Palliative Medicine of Great Britain and Ireland (AMP) (2015), Surveys of Palliative Medicine Clinicians' views about Assisted Dying (2015) (viewed in June 2025)

[68] British Geriatric Society (2024), BGS Position Statement on Assisted Dying | British Geriatrics Society (viewed in June 2025)

[69] Royal College of Psychiatrists (2024), RCPsych comments on vote for assisted dying Bill in England and Wales (viewed in March 2025)

[70] Royal College of Psychiatrists (2025), RCP position statement on the Terminally Ill Adults (End of Life) Bill, 9th May 2025 | RCP (viewed in June 2025). While neutral on the principle of assisted dying, they are opposed to the Bill in its current form.

[71] See 'version control table' at end of this document. In v1.2, the position of the Association of Palliative Care Social Workers was corrected from "opposed" to "neutral". Association of Palliative Care Social Workers (2024), APCSW Statements on Assisted Dying – November 2024 | Association of Palliative Care Social Workers (viewed in June 2025)

107. The Bill offers various protections and safeguards for registered medical practitioners and health professionals. For example, those involved in delivering the VAD service would not be held liable under criminal or civil law (if the provisions stipulated in the Bill are met). There is also no duty placed on any person to participate in the provision of assistance; meaning they can 'opt-out' of the process. Employers must not subject an employee to any detriment for exercising their right not to participate.

108. The Bill may have both direct and indirect impacts on health and social care staff. The nature and extent of these impacts would be influenced by a range of factors, such as whether they are actively involved in delivering the VAD service, their role, the number of applicants they are responsible for assessing or supporting (either as part of the VAD process or BAU health and social care provision), and their personal views. Some may value being able to support their patient's wishes at end-of-life. Others (including those who participate in the process) may experience impacts on their health and wellbeing[72]. There may also be an opportunity cost: if someone is involved in the VAD service as part of their ordinary employment, this redirects their resources from BAU activities to the VAD service; the impact of this on wider resourcing pressures is uncertain.

8.6 - Staff working in the justice system

109. Prison officers and probation officers may also be involved as the first point of contact for prisoners, before they are referred on to healthcare staff either located within the prison or outside. Prison chaplains may be involved in providing spiritual support to prisoners and/or their families. The Bill, as amended in the House of Commons, provides that no person is under any duty to participate in the provision of assistance in accordance with this Bill. This could mean, for example, that a prison officer could opt-out of escorting a prisoner to a setting for the provision of assistance. The Commissioner (who must have held office as a judge), and legal members of the panel would self-select for the roles. Differential impacts on members holding those roles are not expected.

[72] Sandham, M., Carey, M., Hedgecock., E. and others (2022), Nurses' experiences of supporting patients requesting voluntary assisted dying: A qualitative meta-synthesis - PMC (viewed in March 2025)

9 - The approved substance(s)

9.1 - Summary

110. This section provides a **narrative overview of the approved substances used in other jurisdictions** for the purpose of assisted dying, and some of the **considerations** to be taken if this Bill should receive Royal Assent. **Quantifying the impact is not possible at this stage of the Bill** as details about the approved substance(s) are still to be determined.

9.2 - Details pertaining to the substance in the Bill

111. The Bill, as amended in the House of Commons, provides for there to be approved substance(s) to be legally provided to people to assist them in ending their life in accordance with the Bill. It does not specify what the approved substance(s) would be on the face of the Bill. However, Clause 27(1) requires the Secretary of State to make regulations which specify one or more drugs or other substances which would be "approved substances" for the purpose of the Bill. Clause 37 provides that the Secretary of State must, by regulations, make provision about approved substances; including about the supply or offer for supply, or administration of approved substances; the transportation, storage, handling and disposal of approved substances; and the records to be kept in relation to the approved substances.

112. Clause 25(8) specifies the assistance the coordinating doctor may give to the person regarding self-administration of the approved substance. The coordinating doctor may (a) prepare the substance and (b) assist the person to ingest or otherwise self-administer the substance. Clause 25(7) specifies that an approved substance may be provided to a person by preparing a device, which will enable that person to self-administer the substance, and providing that person with the device. Additionally, Clause 25(9) specifies that the final act of taking the substance must be taken by the person. Further, Clause 39(1)(e) requires the Secretary of State to issue one or more codes of practice in connection with the arrangements for providing approved substances to the person for whom they have been prescribed, and the assistance which such a person may be given to ingest or self-administer them.

9.3 - International context

113. There is no single substance or combination of substances that is understood to be the most appropriate for assisting death[73]. In jurisdictions and countries with assisted dying policies, there are a wide variety of substances and combinations of substances that are used for assisted dying. A scoping review of the

[73] Worthington, A., Finlay, I. and Regnard, C. (2022), Efficacy and safety of drugs used for 'assisted dying' - PMC

substances used to end life between 1989 and 2020 in the Netherlands, the USA, Belgium, Switzerland and Canada found that a variety of substances are used including opioids, barbiturates, benzodiazepines and other sedatives[74].

114. The safety and efficacy of those substances used for assisted dying is currently difficult to assess. This is partially because clinician reporting is often very low in those jurisdictions where assisted dying is legal, or clinicians are not generally present when the person is ingesting the prescribed substance(s)[74]. Despite this, some evidence about complications is available from Oregon and Western Australia, where complications such as difficulties ingesting or regurgitating, seizures, and intravenous line complications are reported[74] [75].

Illustrative costs for one reported substance combination

115. VAD services in the USA report two main approved substance combinations. These are: 'DDMA' (diazepam, digoxin, morphine sulfate and amitriptyline) in New Jersey and Oregon; and 'DDMP' (diazepam, digoxin, morphine sulfate and propranolol) in Colorado and Hawaii[74].

116. As an example, Table 13 shows the substances used in the DDMP combination and indicative costs using NHS England reimbursement prices. These costs come with **significant caveats**, including:

116.1. it is not known whether these substances would be used as the approved substances in England and Wales and their inclusion in this IA should **not** be taken as an indication of potential future use

116.2. the prices relate to the average prescription cost for the individual substance, not the cost of the dose needed for use in assisted dying

116.3. the unit costs for existing use may not be a reliable indicator of the cost when used for assisted dying.

Table 13 Average prescription cost by chemical substance (2023/24[76] and uplifted 2025/26 prices)

Chemical substance	Cost per Item (2023/24 prices)	Cost per Item (2025/26 prices)
Diazepam	£1.88	£2.00
Morphine Sulfate	£5.67	£6.04
Digoxin	£3.29	£3.50
Propranolol hydrochloride	£3.04	£3.24

[74] Worthington, A., Finlay, I. and Regnard, C. (2022), Efficacy and safety of drugs used for 'assisted dying' - PMC

[75] Government of Western Australia, Department of Health, Voluntary assisted dying board (viewed in March 2025)

[76] NHS Business Services Authority (2024), Prescription Cost Analysis – England 2023/24 | NHSBSA (viewed in March 2025)

117. Further costs would need to be considered depending on the methods used for transporting, storing, handling, disposing and ultimately taking the substance(s), including any equipment to do so. It is not possible to reliably estimate a total cost per patient without knowing the approved substance(s).

9.4 - Future considerations

118. Should the Bill receive Royal Assent, DHSC will consider further details on approved substance(s), such as:

118.1. the possibility that some suppliers may not wish to apply for an indication of assisted dying for their product, or, that suppliers may wish to restrict the use of their product for the purpose of assisted dying by other means. No assessment on the possibility of has been made to date.

118.2. the choice of the specific approved substance(s) to be used by a specific patient is likely to be determined by a clinician under consideration of the person's condition and preferences

118.3. DHSC currently assumes that, in the first instance, the approved substance(s) would *not* be licensed by the MHRA (Medicines and Healthcare products Regulatory Agency) specifically for the purpose of assisted dying, although this is subject to further consideration if the Bill were to obtain Royal Assent. Instead, DHSC currently anticipates that the approved substance(s) would be products already used in the UK health system for other purposes (in other words, authorised for other indications)

118.4. randomised controlled clinical trials to test the efficacy and safety of these substance(s) for the purpose of assisted dying are unlikely to take place in the immediate future, but further consideration is needed if the Bill were to obtain Royal Assent

118.5. evidence suggests that oral administration is the most likely method for self-administration, however, the use of devices is anticipated in the Bill in Clause 25. These medical devices could, for example, be a syringe or form of enteral access device, or software allowing the terminally ill person to self-administer.

119. A framework for monitoring efficacy, safety and adverse incidents would need to be put in place. Such a framework and the required systems and staff would also have cost implications, related to development and maintenance (including taking action based on signals).

10 - Information provision and training

10.1 - Summary

120. This section sets out considerations for information provision and training on VAD across health and social care settings in England and Wales.

121. The Bill does not specify where in England and Wales VAD services are to operate, but Clause 41 requires the Secretary of State to make provision securing that arrangements are made for the provision of VAD services in England (and Clause 42 provides that Welsh Ministers may make regulations about VAD services in Wales on devolved matters). VAD services could be provided through the NHS. **This Impact Assessment therefore assumes that information provision and training may initially focus on roll-out across areas of the NHS.**

122. The Bill does not specify who the registered medical practitioners responsible for delivering VAD services would be. However, the Bill requires the Secretary of State to make regulations which specify the training, qualifications and experience required to be a coordinating doctor (Clause 8(7) or an independent doctor (Clause 11(9)). This must include training about:

122.1. assessing capacity and assessing whether a person has been coerced or pressured by any other person

122.2. domestic abuse, including coercive control and financial abuse

123. reasonable adjustments and safeguards for autistic people and people with a learning disability. While training on such topics already exists in England and Wales, it is not in the context of assisted dying. **It is therefore assumed that, at a minimum, existing training provision would need to be modified and/or expanded**.

124. The Bill specifies that the assessing doctor(s) must explain to and discuss with the person:

124.1. their diagnosis and prognosis;

124.2. any treatment available and the likely effect of it;

124.3. any available palliative, hospice or other care, including symptom management and psychological support;

124.4. the nature of the substance that is to be provided to assist the person to end their own life (including how it would bring about death and how it would be administered); and

124.5. the person's wishes in the event of complications arising in connection with the self-administration of an approved substance (see Clause 12(2)).

125. **It is therefore assumed that training would also need to cover these topics (diagnosis, prognosis, treatment, palliative care, the substance), alongside process-specific points such as record keeping and preparation of the approved substance, depending on the practitioner's role**.

126. The estimated cost of an **initial education campaign** to ensure health and social care staff are aware of the changes and what they mean may cost in the region of **£550k to £850k**. This is intended to cover the cost of developing and testing a suite of materials, provision of online versions to be downloaded and printed locally, print and distribution of materials across the NHS, and provision of accessible, alternate format, and translated versions. It is estimated that there would be a recurring annual cost for routine updates and reprinting; for illustrative purposes this is assumed to be **£50k**. This is a partial estimate given that there would likely be a need to provide information to a much wider pool of people, including all professionals who are providing or have recently provided health or social care to the person, as well as family members, friends, unpaid carers, and other support organisations and charities.

127. The estimated cost of **training NHS staff** is between **£1.23m and £11.4m**[77] in **Year 1 (which is half a year)** and **£1.53m to £9.71m** in **Year 10**. This is based on various assumptions about the level of training different cohorts of staff would receive, potential opt-out rates, and how quickly it is delivered. This is a partial estimate. For example, it does not consider the impact of changes to the size of the NHS workforce over time, the need to train non-NHS staff, the opportunity cost if staff attend training instead of attending to their regular duties, and any New Burdens on local authorities.

128. Sensitivity analyses are set out in Annex B to set out impacts of varying who receives training and level of demand for the VAD service.

10.2 - Estimating the cost of information provision

129. In this IA, it is assumed that should the Bill pass, there would need to be an initial education campaign to ensure health and social care staff are aware of the changes to the law and what they mean. This is because even if a subsection of health and social care staff are responsible for actively participating in the VAD service, the assessing doctor(s) are required to make such enquiries, as appropriate, of the professionals who are providing or have recently provided

[77] See 'Version control table' at the end of this document. In v1.1, the estimated proportion of assisted deaths occurring under the high scenario in Year 1 corrected from 0.13% to 0.11%; all values derived from this were also updated. In this section of the IA, this included Year 1 high scenario values in Table 17, Table 18, and Table 20, and associated text. Corrections carried across to v1.2.

health or social care to the person. Those professionals would therefore need to be aware of the context in which they are providing this information and how it would be used. While provision of certain information to users or providers of services is permitted, the Bill requires the Secretary of State to make regulations about prohibiting advertisements whose purpose or effect is to promote a voluntary assisted dying service (clause 43). These regulations may contain exceptions, such as the provision of certain information to users or providers of services (see clause 43(2)).[78]

130. It is estimated, based on information from communications professionals, that an initial education campaign could cost in the region of £550k to £850k. This is uncertain and would depend on the scale and speed of the information campaign. The lower bound assumes that all campaign materials are made available to services and staff online, which they may then download and print locally. The upper bound assumes that campaign materials are printed and distributed to NHS services, and that accessible, alternate, and translated formats are also made available. It is further estimated that the annual recurring cost of routine updates and printing could sit at around £50k.

131. These costs are partial; for example, they do not account for the potential cost of any public or patient campaign to communicate the changes, or information provision to non-NHS services, such as the third sector and charities involved in supporting people with terminal illnesses, their families and carers.

10.3 - Estimating the cost of training

Training tiers and procurement costs

132. While the Bill states that a registered medical practitioner must undergo certain training, the level, content, and format of training is anticipated to vary according to the role and responsibilities of each practitioner.

133. There is existing provision of mandatory safeguarding training in the NHS[79], including content on assessing mental capacity[80]. Additionally, the Health and Care Act 2022[81] amended section 20 of the Health and Social Care Act 2008 to place a duty on the Secretary of State to make regulations to require service providers to ensure that health and social care providers receive training specifically on learning disability and autism appropriate to the person's role. This introduced a specific requirement to provide learning disability and autism training within the existing CQC regulated framework. The Oliver McGowan Mandatory

[78] See 'version control table' at end of this document. Text added to v1.2 to reflect new clause on advertising of VAD services.

[79] NHS, NHS safeguarding assurance - NHS Safeguarding (viewed in March 2025)

[80] NHS, Mental capacity - NHS Safeguarding (viewed in March 2025)

[81] The Health and Care Act 2022

Training (OMMT)[82] is the standardised training package that was developed for this purpose. However, it cannot be assumed that any existing training would be sufficient for assisted dying, and so at a minimum existing training would need to be adapted or expanded.

134. For illustrative purposes, **this IA draws on some considerations from the development of the OMMT package** which is being rolled out across the NHS on a tiered basis, to estimate the potential procured training cost for VAD staff. These training costs may differ if training was delivered in-house.

135. As shown in Table 14, it is assumed that there would be three training tiers, each building on the previous one:

    135.1. **Tier 1**: a 90-minute e-learning module and a 60-minute online interactive session with a facilitator, aimed at staff who require general awareness of VAD services. For example, staff who are already known to and/or likely to be a first point of contact for the person, prescribers of the approved substance, and staff involved in patient record keeping.

    135.2. **Tier 2**: a one-day in-person training session, aimed at staff who require more in-depth knowledge and training to deliver the VAD service. This may initially target, for example, hospital doctors specialising in oncology, neurology, geriatrics, and palliative care.

    135.3. **Tier 3**: an advanced two-day in-person training package, aimed at staff who are likely to lead the VAD service and act as the coordinating doctor.

136. It is assumed that those completing the training may need to repeat some or all of it at a specified point, to ensure their knowledge remains up to date. In this IA, the estimates have been constructed by first costing 1 “round” of training.

Table 14 Costs of training per tier and per person (1 round)[83]

	Cost per person 2024/25 prices	Costs per person 2025/26 prices	Additional cost compared to Tier 1
Tier 1	£25	£26	N/A
Tier 2	£118	£121	£95
Tier 3	£303	£311	£285

137. This only represents one part of the costs involved in designing, testing, delivering, monitoring, and evaluating a training package. There are a range of

[82] NHS England (2025), The Oliver McGowan Mandatory Training on Learning Disability and Autism | NHS England | Workforce, training and education (viewed in March 2025)

[83] DHSC estimates based on unpublished Oliver McGowan Mandatory Training figures and internal analysis

other direct and indirect costs that have not been possible to quantify in this IA. These include, for example:

137.1. the cost of staff time to procure the training, should there not be centralised provision

137.2. the cost of training and/or employing trainers and facilitators to deliver the training

137.3. the cost of travel to and from any in-person training sessions

137.4. the familiarisation costs associated with preparation time for training, reading, and understanding training content

137.5. the opportunity costs associated with attending the training, if during regular working hours, and backfilling of roles to maintain patient care

137.6. the cost of training further cohorts of NHS staff, or the impact of changes to the size of the NHS workforce over time.

138. It may be necessary to conduct a New Burdens assessment in the future, should the introduction of VAD services increase the cost of providing local authority services (for example, by requiring that local authority services procure a recommended training package for staff involved in VAD service delivery, and/or backfilling their daily roles to attend VAD training).

Number of practitioners and opt-outs

139. In this IA, it is assumed that health and social care professionals can opt-out of receiving training, if they also opt-out of participating in delivering the VAD service. The Tier 1 and Tier 2 training scenarios are based on the number of people working in specific professions across the NHS. For each, we provide estimates for the scenario where everyone completes the training – and then flex this to account for different opt-out rates.

Tier 1 (total cohort to be trained)

140. The Bill makes specific reference to certain groups of health and social care professionals, including registered medical practitioners, nurses, pharmacists and pharmacy technicians, social workers, and psychiatrists. The Bill also indirectly confers a role on Medical Examiners (as the person is not to be regarded as having died in circumstances which require a coronial investigation).

141. This IA considers a scenario where all these NHS professionals receive Tier 1 level training. The estimated overall size of this workforce cohort is 787k across England and Wales. This is based on rounded headcount data from 2024-2025 (and 2023-24 for social workers) and may not reflect the actual size of the cohort

at the point of implementation. Where headcount data was not available, FTE data was converted to headcount[84]. See Table 15.

142. It is likely the training would be delivered over a period of time and that some of these costs would be incurred prior to the VAD service being available to applicants. For illustrative purposes, it is assumed that approximately 50% of a round of training is undertaken in Year 1 (which is half a year). This equates to up to 393,700 people to be trained across England and Wales.

143. Beyond the initial wave of training, continued training will be needed to refresh people's skills and to train new people. As a broad approximation, we assume that the total annual coverage of future training will be 25% of an initial "round". This equates to up to 196,850 people to be trained across England and Wales in Year 10. For simplicity, we express this in terms of the same training provision and unit cost, though in practice there may be a combination of new training and top-up training.

Tier 2 (total cohort to be trained)

144. The Bill states that both the coordinating and independent doctors must be registered medical practitioners. Given that applicants must be terminally ill adults, and that many VAD service users in other jurisdictions are reported to have end-stage cancer and be older in age, it is assumed a group of specialist NHS hospital doctors would receive Tier 2 level training. This includes all grades of clinical and medical oncologists, geriatric and palliative medicine, and neurologists. The estimated overall size of this workforce cohort is 138k across England and Wales (See Table 15). As above, this is rounded and may not reflect the actual size of the cohort at the point of implementation.

145. For illustrative purposes, it is assumed that 50% of the round of training is undertaken in Year 1 (which is half a year). This equates to up to 6,900 people to be trained across England and Wales. It is then assumed that the total annual coverage of future training will be 25% of an initial "round". This equates to up to 3,450 people to be trained across England and Wales in Year 10.

[84] DHSC analysis uses the following multipliers to get from FTE to Headcount: 1.12 (England) and 1.16 (Wales). The multiplier is calculated from sources linked to in Table 15.

Table 15 Estimated headcount by profession, England and Wales

Tier	Profession	Headcount England	Headcount Wales	Total headcount
Tier 1	GPs [85] [86]	49,000	2,500	51,500
	NHS doctors (hospitals) [87] [88]	157,500	9,400	166,900
	Nurses (hospitals and GPs) [85] [89] [90]	428,100	29,100	457,200
	Pharmacists and pharmacy technicians [91]	77,900	4,500	82,400
	Social Workers [92] [93]	25,000	4,400	29,400
Tier 2 [94] [95]	Clinical Oncology	1,900	100	2,000
	Medical Oncology	1,700	100	1,800
	Geriatric Medicine	6,500	300	6,800
	Palliative Medicine	900	100	1,000
	Neurologists	2,100	100	2,200

Note: where headcount data was not available, FTE data was converted to headcount.[66]

Tiers 1 and 2 (with variations by potential opt-out rate)

146. No person, including a registered medical practitioner or other health or social care professional, would be under any duty to participate in the provision of assistance in accordance with the Bill. For this IA, it is assumed that practitioners not wishing to participate in the provision of assistance can also opt out of receiving training on the subject.

147. The level of opt-out is uncertain. However, a survey of over 26,000 British Medical Association (BMA) members in 2020 reported that 47% of respondents would not be prepared to actively participate in any way, if the law were changed so that doctors were permitted to prescribe drugs for patients to self-administer to end their own life[96].

[85] NHS England (2025), General Practice Workforce, 28 February 2025 - NHS England Digital (viewed in March 2025)

[86] StatsWales (2025), Number of GPs employed in general practices (headcount and full-time equivalent), by GP type and area (viewed in March 2025)

[87] NHS England (2025), NHS Workforce Statistics - December 2024 (Including selected preliminary statistics for January 2025) - NHS England Digital (viewed in March 2025)

[88] StatsWales (2025), Medical and dental staff by specialty and year (viewed in March 2025)

[89] NHS England (2025), NHS Workforce Statistics - December 2024 (Including selected preliminary statistics for January 2025) - NHS England Digital (viewed in March 2025)

[90] StatsWales (2025), Nursing, midwifery and health visiting staff, by grade and area of work (viewed in March 2025)

[91] General Pharmaceutical Council (2025), GPhC registers data | General Pharmaceutical Council (viewed in March 2025)

[92] Skills for Care (2024), The state of the adult social care sector and workforce in England (viewed in March 2025)

[93] Social Care Wales (2023), Data and information on the social care workforce… | Social Care Wales (viewed in March 2025)

[94] NHS England, NHS Workforce Statistics - December 2024 (Including selected preliminary statistics for January 2025) - NHS England Digital (viewed in March 2025)

[95] StatsWales (2025), Medical and dental staff by specialty and year (viewed in March 2025)

[96] British Medical Association (2020), Surveys of Palliative Medicine Clinicians' views about Assisted Dying (2015) (viewed in March 2025)

148. The proportion of respondents saying they would not be prepared to actively participate varied significantly by profession, ranging from 35% to 76%, see Table 16. In addition, some respondents were undecided, which may increase this upper bound. For example, 76% of respondents specialising in palliative medicine said they would not actively participate, and 14% said they were undecided, giving a maximum opt-out rate of up to 90%.

149. In this IA, a range of opt-out rates are considered: zero, 33%, 50% and 90%.

Table 16 Proportion of BMA members who would actively participate in any way, if the law were to change so that doctors were permitted to prescribe drugs for patients to self-administer to end their own life, by profession (2020)[97]

Profession	Base	% yes	% no	% undecided
Palliative medicine	604	10%	76%	14%
Clinical oncology	205	23%	60%	17%
Geriatric medicine	725	26%	56%	18%
Medical oncology	149	30%	52%	18%
Respiratory medicine	376	30%	51%	19%
General practice	9,525	32%	50%	18%
Cardiology	301	37%	49%	14%
Neurology	193	36%	48%	16%
Old age psychiatry	296	35%	47%	17%
General (internal) medicine	490	34%	46%	20%
Occupational medicine	141	35%	45%	20%
General surgery	683	39%	44%	17%
Public health medicine	330	41%	43%	16%
General psychiatry	927	37%	42%	20%
Emergency medicine	755	47%	35%	19%
Intensive care medicine	423	45%	35%	19%
Overall	**26,357**	**35%**	**47%**	**18%**

Tier 3

150. It is assumed that at a minimum, the coordinating doctor will require Tier 3 level training. It is not known how many applicants each individual coordinating doctor might oversee. This is likely to vary according to a range of factors such as demand for and location of VAD services across England and Wales, and the availability of practitioners.

151. It is assumed here that each coordinating doctor oversees one applicant per year, and that 2 times as many coordinating doctors need to be trained (to account for a range of factors including staff churn and availability and post-

[97] British Medical Association (2020), Surveys of Palliative Medicine Clinicians' views about Assisted Dying (2015) (viewed in March 2025)

training opt-outs). The number of people receiving Tier 3 training is therefore estimated to range from between 546 to 2,156 people in Year 1 (which is half a year), to between 3,475 and 15,196 people in Year 10. See Table 17.

Table 17 Estimated workforce numbers undertaking training in Year 1 (half a year) and Year 10, by tier and opt-out scenario[98]

	Year 1 (half year)				Year 10			
	No opt-out	33% opt out	50% opt out	90% opt out	No opt-out	33% opt out	50% opt out	90% opt out
Tier 1	393,700	263,779	196,850	39,370	196,850	131,890	98,425	19,685
Tier 2	6,900	4,623	3,450	690	3,450	2,312	1,725	345
Tier 3 (low)	546				3,475			
Tier 3 (central)	962				7,278			
Tier 3 (high)	2,156				15,196			

Estimated partial training costs

152. Based on the above numbers of people trained, the following estimates show the partial procurement costs for training, adjusted for different rates of opt-out. Since details pertaining to training requirements would be determined through regulations, it is uncertain to what extent the costs would align and as such these costs should be considered illustrative only.

153. Table 18 shows the range of estimated training costs in **Year 1** by tier. The costs for tier 1 range from £1.01m to £10.1m depending on opt-out rates; the costs for tier 3 range from £156k to £614k depending on the cohort size.

Table 18 Estimated training costs by tier, Year 1 (2029/30, half a year), (values are based on previously rounded figures)[99]

	Year 1 (half year)			
	No opt-out	33% opt out	50% opt out	90% opt out
Tier 1	£10.1 m	£6.77 m	£5.05 m	£1.01 m
Tier 2	£655 k	£439 k	£328 k	£65.5 k
Tier 3 (low)	£156 k			
Tier 3 (central)	£274 k			
Tier 3 (high)	£614 k			

[98] DHSC estimates based on figures found in Table 15 and Table 16. Values are based on previously rounded figures. As discussed, for Tier 1 and Tier 2 this assumes half a round of training in year 1 and a quarter of a round in year 10. For tier 3, the number of people undertaking training is 2 times the assumed number of applicants in that time period.

[99] DHSC estimates based on figures found in Table 14 and Table 17

154. Table 19 shows the range of estimated training costs in **Year 10** by tier. The costs for tier 1 range from £505k to £5.05m depending on opt-out rates; the costs for tier 3 range from £990k to £4.33m depending on the cohort size.

Table 19 Estimated training costs by tier, Year 10 (2038/39), (values are based on previously rounded figures)[100]

	Year 10			
	No opt-out	Assume 33% opt out	Assume 50% opt out	Assume 90% opt out
Tier 1	£5.05 m	£3.38 m	£2.53 m	£505 k
Tier 2	£328 k	£219 k	£164 k	£32.8 k
Tier 3 (low)	£990 k			
Tier 3 (central)	£2.07 m			
Tier 3 (high)	£4.33 m			

155. Table 20 shows the low, central and high estimates of training costs for Year 1 (which is half a year) and Year 10. In **Year 1 (half year)**, the total costs range from **£1.23m to £11.4m**. In **Year 10**, the total costs range from **£1.53m to £9.71m**.

Table 20 Total estimated training costs by scenario (values are based on previously rounded figures) [100]

	Year 1 (half year)				Year 10			
Scenario	No opt-out	33% opt out	50% opt out	90% opt out	No opt-out	33% opt out	50% opt out	90% opt out
Low	£10.9 m	£7.36 m	£5.53 m	£1.23 m	£6.37 m	£4.59 m	£3.68 m	£1.53 m
Central	£11.0 m	£7.48 m	£5.65 m	£1.35 m	£7.45 m	£5.68 m	£4.76 m	£2.61 m
High	£11.4 m	£7.82 m	£5.99 m	£1.69 m	£9.71 m	£7.93 m	£7.02 m	£4.87 m

156. Sensitivity analyses are set out in Annex B to set out impacts of varying who receives training and level of demand for the VAD service.

[100] DHSC estimates based on figures found in Table 14, Table 15, Table 16, and Table 17

11 - Health and social care staff time

11.1 - Summary

157. This section sets out the potential impacts of delivering VAD services on health and social care professionals' time.

158. The Bill requires the Secretary of State to make regulations securing arrangements for the provision of VAD services in England (Clause 41) and similarly gives Welsh Ministers the power to make regulations which make provision about VAD services in Wales on devolved matters (Clause 42). The Bill also describes the procedure, safeguards, and protections to be followed by "registered medical practitioners" and others in providing VAD services.

159. The length of time from the preliminary discussion to the assisted death is uncertain. None of the jurisdictions that are comparable to this Bill in terms of eligibility criteria, have a three-stage approval process with an independent panel that prospectively assesses and confirms eligibility. As such, the amount of time required of health and social care professionals to deliver the VAD service in England and Wales is based on policy assumptions. Details pertaining to the training, qualifications, and experience held by these professionals are largely to be set out in future regulations. As such, assumptions are also made about the seniority (and associated pay rate) of each professional.

160. Specifically, it is assumed:

160.1. that **6 health and social care professionals** would typically be required for **32 hours in total**, to complete the main activities associated with **10 core steps** of the VAD process (described in Table 21)

160.2. that these are **NHS employees** who do not opt-out of the process

160.3. that the panel decides to hear from both the coordinating and independent doctor

161. It is also assumed that various proportions of applicants would withdraw between the preliminary discussion and self-administration of the approved substance; that 1.8% of applicants would require an interpreter and each step involving an interpreter would take 2.5 times as long; that 2.5% of applicants would require an independent advocate and each step involving an advocate would take 2.5 times as long.

162. The estimated cost of **staff time to deliver VAD services in England and Wales** ranges from **£412k to £1.63m[101] in Year 1 (which is half a year)**, to between **£2.62m and £11.5m in Year 10**. This includes adjusted costs for 1.8% of applicants requiring an interpreter and 2.5% of applicants requiring an independent advocate. This excludes any additional fees paid to panel members, as this is considered separately in the 'VAD Commissioner and Panel Approval' section.

163. A range of sensitivity analyses have been run to consider the impacts of changing the amount of staff time and pay. These are set out in Annex C.

11.2 - Estimated time required

164. This IA focuses on 10 core steps that are led fully, or in part, by health and social care professionals. At each step, it is assumed that there are no professional opt-outs, that no additional referrals are required to assess the applicant's eligibility, that the Panel grants the certificate of eligibility, and the applicant self-administers the approved substance and has an assisted death.

165. The assumed time for each step and staff member(s) involved are summarised in Table 21. It is important to note the time estimates are for the most part uncertain, and would vary according to a range of factors, such as: the applicant's terminal illness and prognosis, whether the applicant requires an interpreter or the support of an independent advocate, the setting(s) in which the service is delivered and associated staff travel time, the approved substance to be used and whether any complications arise as a result of self-administering the substance, and the specific requirements of the step itself (for example, guidelines on conversations to be held or record keeping).

[101] See 'Version control table' at the end of this document. In v1.1, the estimated proportion of assisted deaths occurring under the high scenario in Year 1 was corrected from 0.13% to 0.11%; all values derived from this were also updated. In this section of the IA, this included Year 1 high scenario values in Table 25 and Table 26, and associated text. All corrections carried across to v1.2.

Table 21 Summary of 10 core VAD service steps and assumed time per step [102]

Step	Description	Hours per step	Number of staff (role)	Total staff hours per step
1	Preliminary discussion	2	1 (coordinating doctor)	2
2 & 3	First declaration and first doctor's assessment	4	1 (coordinating doctor)	4
4	Second doctor's assessment	4	1 (independent doctor)	4
5	Multidisciplinary panel assessment	3	4 (coordinating doctor, independent doctor, psychiatrist panel member, social worker panel member)	12
6	Second declaration	1	1 (coordinating doctor)	1
7	Dispensing the approved substance	1	1 (pharmacist)	1
8	Provision of approved substance	4	1 (coordinating doctor)	4
9	Final statement	2	1 (coordinating doctor)	2
10	Death certification	2	1 (Medical Examiner)	2

Step 1: Preliminary discussion (Clause 5)

166. A registered medical practitioner may have a preliminary discussion with a person who indicates that they wish to seek assistance to end their own life in accordance with the Bill. The practitioner:

166.1. is not under any duty to raise the subject of assisted dying.

166.2. must first ensure provision of adjustments for language and literacy barriers.

166.3. must explain to the person their diagnosis and prognosis, available treatments and likely effects, and appropriate palliative, hospice, or other care, including symptom management and psychological support, and offer to refer the person to a specialist in such care.

166.4. must record the discussion in the person's medical records.

167. It is assumed Step 1 would take 2 hours of the coordinating doctor's time.

Steps 2 and 3: First declaration (Clause 8 and 9) and first doctor's assessment (coordinating doctor) (Clause 10)

168. The first doctor's assessment must take place as soon as reasonably practicable after they have witnessed the first declaration made by the person.

[102] The time taken for each step is unknown, these figures are based on assumptions relating to the type of staff needed and the amount of time each step would take.

This doctor must ascertain whether, in their opinion, the person meets all eligibility criteria and that their first declaration was free from coercion or pressure by any other person.

169. This doctor must make a report about this assessment and provide copies to all person(s) as set out in the Bill. If satisfied, the doctor must refer the person to another registered medical practitioner who is able and willing to carry out the second assessment.

170. It is assumed Steps 2 & 3 would take 4 hours of the coordinating doctor's time overall (see notes below).

Step 4: Second doctor's assessment (independent doctor) (Clause 11)

171. The second doctor's assessment must take place as soon as reasonably practicable after the first period of reflection (7 days beginning with the date of the coordinating doctor's report). This doctor must independently undertake the same assessment as the first doctor.

172. The independent doctor must make a report about the assessment and provide copies to all person(s), including the coordinating doctor, as set out in the Bill.

173. It is assumed Step 4 would take 4 hours of the independent doctor's time (see notes below).

Notes on Steps 3 and 4

174. It is reasonable to assume that Steps 3 and 4 could take longer than Step 1, because in completing their assessments the doctors' must:

174.1. examine the person and their relevant medical records.

174.2. where appropriate, make enquiries of professionals who are providing or have recently provided health or social care to the person.

174.3. explain to and discuss with the person being assessed their diagnosis and prognosis, available treatments and their effects, and any available palliative, hospice or other care including symptom management and psychological support.

174.4. explain the nature of the substance that is to be provided (including how it would bring about death and how it would be administered).

174.5. discuss the person's wishes in the event of complications arising in connection with the self-administration of the approved substance, inform

the person of further steps in the process and that they may decide at any point not to take any of those steps.

174.6. advise the person to inform a registered medical practitioner at their GP practice that they are requesting assistance to end their own life.

174.7. if appropriate, advise the person to consider discussing the request with their next of kin and other persons they are close to.

Step 5: Multidisciplinary panel (Clauses 16 and 17)

175. The panel must have three members: a legal member, a psychiatrist member, and a social worker member.

176. When the panel receives a case from the Commissioner (Clause 16) they must determine that requirements regarding the first declaration, first assessment and second assessment have been met. They must also determine that the person meets the eligibility criteria.

177. The panel must hear from and may question one or both of the coordinating and independent doctors and (subject to exceptional circumstances) the person.

178. The panel may hear from and may question the person's proxy, and any other person.

179. The panel may ask any person with relevant knowledge or experience to report to it on such matters relating to the person as it considers appropriate.

180. If the panel is satisfied it must grant a certificate of eligibility and notify the person, coordinating doctor, any other person(s) as described in the Bill.

181. It is assumed that Step 5 would take 3 hours of time for each of the psychiatrist member, social worker member, coordinating doctor, and independent doctor.

182. The impact on the legal member, and the cost of setting up and running the Commissioner and panels, is considered separately in the 'VAD Commissioner and Panel' section.

Step 6: Second declaration (Clause 19)

183. If a certificate of eligibility has been granted, and if the person wishes to be provided with assistance to end their own life in accordance with the Bill, the person must make a further declaration to that effect (the "second declaration"). This should be no sooner than 14 days after the certificate of eligibility was granted or, where the coordinating doctor reasonably believes that the person's death is likely to occur before the end of the period of one month beginning with

the day that the certificate was granted, the period of 48 hours beginning with that day.

184. The coordinating doctor must witness the second declaration and may only do so if satisfied that the person is terminally ill, has capacity and a clear, settled and informed wish to end their life and is not being coerced or pressured, and the coordinating doctor must make a statement to that effect.

185. The second declaration is assumed to take 1 hour of the coordinating doctor's time.

Step 7: Dispensing the approved substance

186. It is assumed that a pharmacist would dispense the approved substance to the coordinating doctor, after the second declaration has been recorded.

187. It is assumed that Step 7 would take 1 hour, including time for record keeping.

Step 8: Provision of assistance (Clause 25)

188. The coordinating doctor may provide the person with the approved substance to end their own life when:

188.1. the panel has issued the certificate of eligibility.

188.2. the second period of reflection has ended (14 days beginning on the day on which the certificate of eligibility was granted, or 48 hours where the coordinating doctor reasonably believes the person is likely to die within one month of the certificate being granted).

188.3. the person has made a second declaration.

188.4. the coordinating doctor has made a statement that they are satisfied the person was terminally, ill, has capacity and a clear, settled and informed wish to end their life and was not being coerced or pressured when the second declaration was made.

189. The coordinating doctor:

189.1. must provide the person with the approved substance directly and in person

189.2. must explain that the person can still cancel their declaration and choose not to self-administer the approved substance

189.3. must be satisfied, at the time the approved substance is provided, that the person has capacity to make the decision to end their own life, that they have a clear, settled and informed wish to end their own life, and that

they are requesting provision of that assistance voluntarily and have not been coerced or pressured by any other person

189.4. is then permitted to prepare the approved substance for self-administration by the person, and assist the person to ingest or otherwise self-administer the approved substance

189.5. must remain with the person (but need not be in the same room) until: (a) the person has self-administered the substance and has died, or it is determined by the coordinating doctor that the procedure has failed; or (b) the person has decided to not self-administer the approved substance.

190. An approved substance may be provided to a person by preparing a device which will enable that person to self-administer the substance, and providing that person with the device.

191. The decision to self-administer the approved substance and the final act of doing so must be taken by the person to whom the substance has been provided (Clause 25(9)).

192. It is assumed that Step 8 would take 4 hours; however, the time from self-administration of the approved substance to death is uncertain.

193. In 2024 in Oregon, the reported time from ingestion to death ranged from 7 minutes to 26 hours. The average (median) time reported in both 2024 and 2023 was 53 minutes. The 4 hours assigned therefore reflects the fact that the time required of the coordinating doctor is not limited to the potential time from self-administration to death. Factors that could increase the amount of time include, for example, the approved substance used, the individual's underlying health condition(s), the amount of time the person decides to take before self-administering the substance, and travel to the person (if not co-located).

194. The coordinating doctor may be accompanied by such other health professionals and other persons as they think necessary in carrying out this step. As a sensitivity, the cost of 1 additional member of staff to support the process has been factored into calculations.

Step 9: Final statement (Clause 28)

195. The coordinating doctor must make a final statement when the person has been provided with assistance to end their own life and has died as a result. The statement must be in a form to be determined by Secretary of State, signed and dated by the coordinating doctor.

196. The coordinating doctor must give a copy of the final statement to the Commissioner and record the final statement in the person's medical records (if

they are a practitioner within the person's GP practice) or inform an appropriate practitioner within the person's GP practice to record the final statement.

197. It is assumed Step 9 would take 2 hours of the coordinating doctor's time.

Step 10: Death certification (Clause 38)

198. A death is not to be considered an 'unnatural death' for the purposes of S.1 of the Coroners and Justice Act 2009[103] solely because the death resulted from the self-administration of an approved substance provided in accordance with the Bill. Consequently, these deaths will, by default, be scrutinised and certified, as if they were natural deaths, by an Attending Practitioner or Medical Examiner. The Medical Certificate of Cause of Death for an assisted death must state the cause of death. The death is to be recorded as "assisted death", with a record of the person's terminal illness which enabled the person to receive assistance under the Bill.

199. It is assumed that Step 10 would take 2 hours.

All steps

200. To complete Steps 1 to 10, it is therefore assumed that at least 6 members of health and social care staff are typically required for a total of 32 hours.

201. The IA published for the Assisted Dying for Terminally Ill Adults (Scotland) Bill references an unpublished study; stating that clinician time may range from 6 to 17 hours[104]. There is also research that quotes doctors from other jurisdictions as stating that around 60 hours of working time is required[105]. **The impact of changing the total average amount of time required is explored as a sensitivity analysis in Annex C.**

Use of interpreters

202. The National Institute for Health and Care Research (NIHR) explain that interpreters are different to translators, as they are for the spoken (rather than written) word[106]. Face-to-face interpreters may have a minimum charge of one hour. Interpreting is not a protected profession and quality control within agencies varies. The cost per hour may range from £25 to £40 per hour for an interpreter who holds a DPSI (Diploma in Public Servicing Interpreter) Level 6 qualification.

---

[103] Coroners and Justice Act 2009

[104] Preliminary, unpublished results from qualitative interviews with nurses involved in voluntary assisted dying in Queensland: White, B., Ward, A. & Willmott L (2024) (Australian Centre for Health Law Research. Queensland University of Technology).

[105] Rutherford, J., Willmott, L. and White B. P. (2023), What the Doctor Would Prescribe: Physician Experiences of Providing Voluntary Assisted Dying in Australia - PubMed (viewed in March 2025)

[106] NIHR (2022), Training guides: How to work effectively with interpreters and translators - ARC (viewed in March 2025)

Costs would also vary depending on the rarity of the language. NIHR recommend multiplying the time required for a native English speaker by 2.5 (as everything is said twice, plus allowing for time to brief and debrief the interpreter).

203. This IA assumes that 1.8% of VAD service applicants might require an interpreter. This is taken from the 2021 Census, which reports that of all usual residents (aged 3 and over) in England and Wales, 0.3% could not speak English at all and 1.5% could not speak English well.[107]

Use of independent advocates (Clause 22)

204. The role of independent advocates is to provide support and advocacy to a qualifying person who is seeking to understand options around end-of-life care, including the possibility of requesting assistance to end their own life, to enable them to effectively understand and engage with all the provisions of the Bill. A "qualifying person" is defined in the Bill as including people with a learning disability, a mental disorder under section 1 of the Mental Health Act 1983, autism, and anyone who may experience substantial difficulty in understanding the processes or information relevant to those processes or communicating their views, wishes or feelings.

205. It is assumed that 2.5% of VAD service applicants might require an independent advocate[108] [109] [110] [111]. Estimating the proportion of people with a learning disability, mental disorder, and/or autism is complex; there is likely significant overlap across the three populations, and some underestimation relating to level of official diagnoses. Sensitivity analysis has not been run on the proportion of individuals who require an individual advocate due to the low values.

206. The Bill sets out requirements for who may act as an independent advocate and training needed. It is assumed that the independent advocate is an adult social worker, and the AD process would take 2.5 times longer (allowing for time to brief and debrief the advocate).

11.3 - Estimated staff pay per hour

207. As set out above, this analysis includes the scenario where the coordinating doctor, independent doctor, psychiatrist, social worker, pharmacist, medical examiner, and independent advocate are NHS employees. The interpreter is

[107] Language, England and Wales: Census 2021 (2021), Language, England and Wales: Census 2021 (viewed in March 2025)

[108] Mencap, How Common Is Learning Disability In The UK? How Many People Have A Learning Disability? | Mencap, (viewed April 2025)

[109] NHS England (2016), Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. - NHS England Digital (viewed April 2025)

[110] National Autistic Society, What is autism (viewed April 2025)

[111] Office for National Statistics (2024), Population estimates - Office for National Statistics (viewed in April 2025)

assumed to be a DPSI qualified agency worker. Table 22 sets out the hourly cost for each role used in this IA. This is followed by an explanation of how each cost was calculated. It should be noted that these costs are uncertain, and do not include, for example, additional costs of the assisted death occurring outside of usual working hours and/or at the weekend; costs of travelling to the person; costs of overheads such as IT, buildings, business support.

Table 22 Assumed cost per hour including on costs by role [112] [113] [114]

Role	Assumed hourly pay including on costs (2025/26 prices)
Coordinating doctor	£60.44
Independent doctor	£60.44
Psychiatrist panel member	£60.44
Social worker panel member	£32.75
Pharmacist	£32.75
Medical Examiner	£95.80
Interpreter	£36.66
Independent advocate	£32.75

Medical roles (coordinating doctor, independent doctor, ME)

208. Pay for medical roles varies significantly by grade and experience. As shown in

209. Table 23 below, the annual salary can range from £36.6k for a foundation year 1 doctor through to £140k for the most experienced medical consultant[115].

210. To take a consistent approach across this IA, these figures were inflated to 2025/26 prices using the GDP deflator. From this, an hourly rate was calculated (assuming 40 working hours per week, 52 weeks of the year), and oncosts added (assuming 23.78% pension contribution and 15% National Insurance).

211. The mid-point between the salary of a foundation year 1 doctor and a top level consultant for hospital-based doctors was used to arrive at **an estimated hourly rate plus on costs (2025/2026) of £60.44 for the coordinating doctor, independent doctor,** and **psychiatrist** (excluding any additional fees paid to sit on the Panel).

[112] Hourly rate calculated and inflated from Pay Circular (M&D) (2025), Pay and conditions circulars for medical and dental staff | NHS Employers (viewed in March 2025)

[113] NIHR, Training guides: How to work effectively with interpreters and translators - ARC, (viewed April 2024)

[114] NHS Employers (2024), Pay scales for 2024/25 | NHS Employers (viewed in March 2025)

[115] Pay Circular (M&D) (2025), Pay and conditions circulars for medical and dental staff | NHS Employers (viewed in March 2025)

212. **Medical Examiners** (MEs) are often consultant level doctors[116], so the **hourly salary plus on costs (2025/2026) of £95.80** was used for them. These costs are illustrative only and do not adjust for regional differences in pay.

Table 23 Estimated hourly salary plus on costs (2025/26) for medical staff

Pay band	Annual salary (24/25)[115]	Annual salary (25/26)	Hourly salary (25/26)	Hourly salary plus on costs (25/26)
Foundation Doctor Year 1	£36.6k	£37.6k	£18.07	£25.08
Consultant top of scale	£140k	£144k	£69.03	£95.80

Non-medical roles (pharmacist, social worker, advocate)

213. Pay for non-medical roles (the pharmacist, social worker, and independent advocate) is assumed to be Band 6 (top step point) as reported in the 'NHS terms and conditions annual, hourly and HCAS pay scales for 2024/25'[117]. As above, simple adjustments are made to inflate this to 2025/26 prices using the GDP deflator, and to add 23.78% pension and 15% NI (marginal for both). An **estimated hourly rate plus on costs (2025/2026) of £32.75 was used for the pharmacist, social worker** (excluding any additional fees paid to sit on the panel), **and independent advocate**. See Table 24.

Table 24 Estimated hourly salary plus on costs (2025/26) for non-medical staff

Pay band	Hourly salary (24/25)[118]	Hourly salary (25/26)	Hourly salary plus on costs (25/26)
Band 6 (top step point)	£22.99	£23.60	£32.75

Interpreter

214. As mentioned, the cost per hour for a DPSI Level 6 qualified **interpreter** may range from £25.00 to £40.00 per hour (2022/23 prices). The average of this range was taken to be £32.50 and inflated to 2025/26 prices using the GDP deflator. An estimated **hourly rate of £36.66 per hour** was used for the interpreter.

[116] NHS England (2025), NHS England » National Medical Examiner's guidance for England and Wales (viewed in March 2025)
[117] NHS Employers (2024), NHS terms and conditions annual, hourly and HCAS pay scales (also known as pay bands or pay rates or payscales) for 2024/25 (viewed March 2025)
[118] NHS Employers (2024), Pay scales for 2024/25 | NHS Employers (viewed in March 2025)

11.4 - Estimated cohort by step

215. As set out in our cohort estimates, it is assumed that the number of assisted deaths would represent 60% of the number of people coming forward for the preliminary discussion. The number of people that would leave between each step of the process is unknown, and this could be for a range of reasons (such as being assessed as ineligible or not mentally competent, deciding to withdraw from the process, or dying from their underlying terminal illness).

216. For this IA, it is assumed that:

216.1. 100% of applicants are seen at Step 1: Preliminary discussion

216.2. 95% of applicants are seen at Steps 2 & 3: First declaration and first assessment

216.3. 85% of applicants are seen at Step 4: Second assessment

216.4. 75% of applicants are seen at Step 5: Panel

216.5. 65% of applicants proceed to Step 6 & 7: Second declaration and dispensing of approved substance

216.6. 60% of applicants proceed with Steps 8 to 10 (provision of assistance, final statement, and death certification)

217. The cohort estimates by step of the process are set out in Table 25.

Table 25 Cohort estimates by step (England and Wales)[119]

Step	Description	Year 1 (2029/30, half-year)			Year 10 (2038/39)		
		Low	Central	High	Low	Central	High
1	Preliminary discussion	273	481	1,078	1,737	3,639	7,598
2 & 3	First declaration and first doctor's assessment	260	457	1,024	1,651	3,457	7,218
4	Second doctor's assessment	232	409	916	1,477	3,093	6,458
5	Multidisciplinary panel assessment	205	361	808	1,303	2,729	5,699
6 & 7	Second declaration and dispensing of approved substance	178	313	701	1,129	2,365	4,939
8, 9 & 10	Provision of assistance, final statement, and death certification	164	289	647	1,042	2,183	4,559

[119] DHSC analysis based on Table 5 and Table 9.

Estimated cost of staff time to deliver VAD service

218. As set out in Table 26, the estimated costs of health and social care staff time to deliver VAD services in England and Wales in **Year 1** (which is half a year) is:

218.1. for people who do not require an advocate or interpreter (95.7% of the cohort): between £374k to £1.48m

218.2. for people who require an independent advocate (2.5% of the cohort): between £22.3k to £88.0k

218.3. for people who require an interpreter (1.8% of the cohort): between £16.0k to £63.3k.

Table 26 Estimated cost of staff time to deliver VAD service in Year 1 (which is half a year), England and Wales [120]

Cohort	Costs for people who do not require an advocate or interpreter (95.7% of cohort)	Cost for people who require an independent advocate (2.5% of cohort)	Cost for people who require an interpreter (1.8% of cohort)	Total costs (100% of cohort)
Low	£374k	£22.3k	£16.0k	£412k
Central	£659k	£39.2k	£28.3k	£726k
High	£1.48 m	£88.0k	£63.3k	£1.63m

219. **This gives a total estimated staff time cost of between £412k to £1.63m in Year 1 (half year), excluding panel fees.**

220. To calculate the costs for individuals who require an advocate and/or an interpreter it has been assumed that each step of the process takes 2.5 times as long as without them, apart from dispensing of the approved substance, final statement, and death certification which is expected to take the same amount of time as the remaining cohort.

221. A breakdown of the costs per step of the process is contained in Table 27 Estimated cost of staff time to deliver VAD service in Year 1 (which is half a year), by step, England and Wales (central cohort). The costs associated with people who require an advocate, and those who require an interpreter are captured in the table. There is expected to be a cohort of people who need *both* an interpreter and an advocate, they have been captured in the figures but cannot be separated in this table.

[120] DHSC estimates based on figures found in Tables 21, 22 and Table 25

Table 27 Estimated cost of staff time to deliver VAD service in Year 1 (which is half a year), by step, England and Wales (central cohort)[121]

Step	Description	Year 1 cohort (central)	Costs for people who do not require an advocate or interpreter (95.7% of cohort)	Cost for people who require an independent advocate (2.5% of cohort)	Cost for people who require an interpreter (1.8% of cohort)	Total costs (100% of cohort)
1	Preliminary discussion	481	£55.6k	£3,634	£2,616	£61.9k
2 & 3	First declaration and first doctor's assessment	457	£106k	£6,905	£4,971	£118k
4	Second doctor's assessment	409	£94.6k	£6,178	£4,448	£105k
5	Multidisciplinary panel assessment	361	£222k	£14.5k	£10.4k	£247k
6	Second declaration	313	£18.1k	£1,181	£850	£20.1k
7	Dispensing the approved substance	313	£9,799	£256	£184	£10.2k
8	Provision of assistance (remain with person)	289	£66.8k	£4,361	£3,140	£74.3k
9	Final statement	289	£33.4k	£872	£628	£34.9k
10	Death certification	289	£52.9k	£1,382	£995	£55.3k

222. As set out in

223. Table 28, the estimated costs of health and social care staff time to deliver VAD services in England and Wales in **Year 10** is:

223.1. for people who do not require an advocate or interpreter (95.7% of the cohort): between £2.38m to £10.4m

223.2. for people who require an independent advocate (2.5% of the cohort): between £142k to £620k

223.3. for people who require an interpreter (1.8% of the cohort): between £102k to £446k.

[121] DHSC estimates based on figures found in Table 2 and Table 26

224. **This gives a total estimated staff time cost of between £2.62m to £11.5m in Year 10, excluding panel fees.**

Table 28 Estimated cost of staff time to deliver VAD service in Year 10, England and Wales [122]

Cohort	Costs for people who do not require an advocate or interpreter (95.7% of cohort)	Cost for people who require an independent advocate (2.5% of cohort)	Cost for people who require an interpreter (1.8% of cohort)	Total costs (100% of cohort)
Low	£2.38 m	£142k	£102k	£2.62 m
Central	£4.98 m	£297k	£214k	£5.49 m
High	£10.4 m	£620k	£446k	£11.5 m

225. To calculate the costs for individuals who require an advocate or interpreter it has been assumed that each step of the process takes 2.5 times longer than without them, apart from dispensing of the approved substance, final statement, and death certification which is expected to take the same amount of time as the remaining cohort.

226. Table 29 shows a breakdown of the core and additional costs for each step of the process. The costs associated with people who require an advocate, and those who require an interpreter are captured in the table. There is expected to be a cohort of people who need both an interpreter and an advocate, they have been captured in the figures but cannot be separated in this table.

[122] DHSC estimates based on figures found in Tables 21, 22 and Table 25

Table 29 Estimated cost of staff time to deliver VAD service in Year 10, by step, England and Wales (central cohort)[123]

Step	Description	Y10 cohort (central)	Costs for people who do not require an advocate or interpreter (95.7% of cohort)	Cost for people who require an independent advocate (2.5% of cohort)	Cost for people who require an interpreter (1.8% of cohort)	Total costs (100% of cohort)
1	Preliminary discussion	3,639	£421k	£27.5k	£19.8k	£468k
2 & 3	First declaration and first doctor's assessment	3,457	£800k	£52.2k	£37.6k	£890k
4	Second doctor's assessment	3,093	£716k	£46.7k	£33.7k	£796k
5	Multidisciplinary panel assessment	2,729	£1.68 m	£110k	£78.9k	£1.87 m
6	Second declaration	2,365	£137k	£8,935	£6,433	£152k
7	Dispensing the approved substance	2,365	£74.1k	£1,937	£1,394	£77.5k
8	Provision of assistance (remain with person)	2,183	£505k	£33.0k	£23.8k	£562k
9	Final statement	2,183	£253k	£6,598	£4,751	£264k
10	Death certification	2,183	£400k	£10.5k	£7,530	£418k

227. Annex C contains a series of supplementary tables, with the estimated costs using the low and high cohort scenarios for Years 1 and 10, and to provide a breakdown of results for England and Wales separately.

228. Annex C also contains a range of sensitivity analyses to show the impact on costs of changing staff time and salaries and adding an additional member of staff to Step 8 (provision of assistance).

[123] DHSC estimates based on figures found in Table 2 and Table 28

11.5 - Resourcing implications

229. There may be an opportunity cost of shifting capacity from one area of the health and social care system to another. Furthermore, the potential pool of workforce supporting delivery of the VAD service would be reduced by the proportion of persons who choose to opt-out. See the ‘Information provision and Training’ section for detailed breakdown of potential opt-out rates. This means that capacity of the system to meet demand would vary across settings, alongside the associated opportunity cost.

12 - Voluntary Assisted Dying Commissioner and panel approval

12.1 - Summary

230. The Bill states that there would be a Voluntary Assisted Dying Commissioner, appointed by the Prime Minister. This person must hold or have held office as a judge of the Supreme Court, the Court of Appeal or the High Court. Their principal functions would be: receiving documents made under the legislation; making appointments to a list of persons eligible to sit on Assisted Dying Review panels; making arrangements in relation to such panels and referring cases to them; determining applications for reconsideration of panel decisions; monitoring the operation of the legislation and reporting annually on it. This commissioner would have a deputy and may appoint staff, with the approval of the Secretary of State.

231. There would also be an Assisted Dying Review Panel. This panel would be appointed by the Commissioner and would be made up of legal members, psychiatrist members and social worker members. According to the Bill as drafted after Committee (Commons): when the Commissioner receives a first declaration made by a person, a report about the first assessment of the person and a report about the second assessment of the person, the Commissioner must refer the person's case to the Assisted Dying Review Panel. This Panel would determine the person's eligibility to be provided with assistance. The panel must hear from, and may question, the coordinating doctor and/or independent doctor. They must also hear from and may question the person to whom the referral relates and may hear from them (or their proxy) and any other person appearing to have relevant knowledge or experience to report to it on matters relating to the person seeking assistance as the Panel considers appropriate. If the Panel is satisfied that the criteria for assistance are met, it must grant a "certificate of eligibility", and it must refuse to do so in any other case. The Panel must give reasons, in writing, for its decisions.

232. This IA estimates that the **cost of the Voluntary Assisted Dying Commissioner, and their office**, would be approximately **£10m per year**. The cost of **each panel is estimated to be £2,000 per day**; amounting to an average annual cost of between £900k and £3.6m over the 10-year appraisal period. The **total cost of the Voluntary Assisted Dying Commissioner and panel approval is estimated to cost an average of £10.9m to £13.6m per year**.

12.2 - Implementation costs

233. The provisions for the Voluntary Assisted Dying Commissioner would come in to force 12 months after Royal Assent and a Disability Advisory Board 6 months after this. The bill would be implemented in full within four years of Royal Assent.

234. It has not been possible to estimate the implementation costs at this stage and they have not been included in the IA. Implementation costs would typically include capital and resource expenditure for estates, IT, recruitment, training etc. These costs could start to be incurred within 12 months of Royal Assent.

12.3 - Running costs

The Voluntary Assisted Dying Commissioner and their office

235. Similar non-departmental and arms-length bodies (e.g. the Judicial Appointments Commission, the Health Services Safety Investigations Body, the Human Fertilisation & Embryology Authority, the Investigatory Powers Commission and the Criminal Cases Review Commission) cost between £6.0m to £10.3m per year to run. Given the wide-ranging functions of the Voluntary Assisted Dying Commissioner and their office, this IA has used the top of this range. As such, it is assumed the costs relating to the Voluntary Assisted Dying Commissioner and their office would be approximately £10m per year (inclusive of the cost of the Disability Advisory Board but exclusive of the cost of the Assisted Dying Review Panels).

Assisted Dying Review Panels[124]

236. Each panel would be made up of three members: a legal member, a psychiatrist and a social worker. This IA assumes each panel member has comparable sitting day fees for legal and non-legal members in 2024-25[125], therefore, it would cost approximately £2,000 per day. This does not include any wider administrative costs of convening and running the panels, or the estates costs.

237. The ‘Cohort estimates’ section of this IA sets out the methodology to estimate the number of applications and assisted deaths. Looking at other jurisdictions, most report a larger number of people applying, compared to those who complete

[124] See ‘Version control table’ at the end of this document. In v1.1, the estimated proportion of assisted deaths occurring under the high scenario in Year 1 was corrected from 0.13% to 0.11%; all values derived from this were also updated. In this section of the IA, this included Year 1 high scenario values in Table 30, Table 31Table 86, and associated text. All corrections carried across to v1.2.

[125] Ministry of Justice and Senor Salaries Review Body (2024), Judicial salaries and fees 2024 to 2025 - GOV.UK (viewed in March 2025)

the process and receive assistance to die. A range of reasons are reported to explain this including:

237.1. the person deciding to withdraw from the process

237.2. the person being assessed as ineligible by medical professionals at various assessment points (depending on the scheme)

237.3. the person being assessed as losing their mental capacity later in the process

237.4. the person dying from their underlying terminal illness

238. Based on comparable jurisdictions, this IA has assumed 60% of applications would result in an assisted death.

239. It is assumed that 75% of applicants, who start the process with the consulting doctor, would continue through the assisted dying process to be approved by a panel organised by the Voluntary Assisted Dying Commissioner.

240. It is assumed the remaining 15 percentage point reduction would occur through a combination of individuals leaving the process (withdrawal, death from underlying condition etc.) and those determined ineligible by the panel.

241. Applicants rejected by the panel would have the opportunity to apply to the Voluntary Assisted Dying Commissioner for their case to be reconsidered. If the Commissioner is satisfied that the first Panel's decision contains an error of law, is irrational, or is procedurally unfair, they would be required to refer the case to a second Panel.

242. To illustrate this, it is assumed 0-2% of panel applications that are rejected, then have their appeal heard by a second panel. This is a policy assumption as it has not been possible to estimate how many applications could be rejected and appealed accurately.

243. Table 30 shows the estimated volume of applications the Voluntary Assisted Dying Review Panels would review over the course of the 10-year appraisal period in England and Wales.

Table 30 Estimated number at the panel stage per year, by scenario (low, central, high), England and Wales [126]

Scenario	Year 1 (half-year)	Year 5	Year 10
	2029/30	2033/34	2038/39
Low	205	965	1,303
Central	364	1,704	2,757
High	825	3,471	5,813

[126] MoJ estimates based on cohort numbers estimated from figures found in Annex A

244. It is assumed that a panel would review, on average, 2 applications per day. This assumption is based on average hearing time estimates from the Mental Health Tribunal.

245. Applying these costs to the applications in Table 25, the panels are estimated to incur average costs of £0.9m - £3.6m per year over the 10-year appraisal period (see Table 31).

Table 31 Estimated annual panel costs 2029/30 – 2038/39, England and Wales[127]

Year	Implementation year	Year 5	Year 10	Average Annual Cost
	2029/30	2033/34	2038/39	
Low	£200k	£1.00m	£1.30m	£900k
Central	£400k	£1.70m	£2.80m	£1.70m
High	£800K	£3.50m	£5.80m	£3.60m

12.4 - Resource considerations

246. HMG would work with partners across all three sectors to ensure that the Commissioner has the resource they need to ensure Panels operate as intended.

247. Panels would be made up of one legal member, one psychiatrist and one social worker.

248. To illustrate whether the Bill could have any adverse labour market impacts, the number of full-time equivalent staff the panel would require was estimated and compared with the overall number of legal members, psychiatrists and social workers.

249. In the first year of implementation (which is half a year), there are estimated to be 364 applications to the panel, which would require 182 panels (based on the assumption a panel reviews 2 applications per day).

250. If there are 220 working days in a year[128] and panellists worked full time this is equivalent to roughly two to three full time equivalent (FTE) staff in 2029/30 (approximately one of each panel member). After 10 years it is estimated that this could rise to 19 FTE (roughly six of each panel member).

251. The pool of panel members would need to be larger than this as panellists are not expected to be appointed full time. To illustrate this, assuming each panel member works 15 days per year on the panel, a pool of 36 panellists (12 of each

[127] MoJ estimates based on figures found in Table 30 and in Ministry of Justice and Senor Salaries Review Body (2024), Judicial salaries and fees 2024 to 2025 - GOV.UK (viewed in March 2025)

[128] The number of working days in a year vary by profession and employer. For illustrative purposes, we have assumed that there are 220 working days in a year.

profession) would be required in 2029/30 rising to 273 (91 of each profession) by 2038/39.

252. As of 1 April 2024, there were 2,110 KCs and 255 High Court and Deputy High Court Judges. This includes all KCs, both publicly and privately funded, but does not include any retired judges who may chair panels.

253. There are an estimated 25,000[129] social workers in England and 4,391[130] in Wales. Social Workers working in adult social care have high vacancy rates and turnover. As of September 23/24, the vacancy rate for social workers in local authority departments was 9.4%, or 1,900 vacant posts. The annual turnover rate was 17.2%.

254. The number of full-time equivalent psychiatry consultants working in all NHS trusts and other core organisations in England has increased by 10.7% since 2010 from 4,121 in September 2010 to 4,561 in September 2024. Over the last year, the number of FTE psychiatry consultants has increased by 82 (1.8%) from 4,479 in September 2023 to 4,561 in September 2024.

255. Comparing the FTE that may be required to the overall labour market, it appears that the provision for the Panels as described in the Bill carries a low risk to wider capacity in the justice, health and social care systems. However, there is an opportunity cost to staff time working on this.

[129] Skills for Care (2024), The state of the adult social care sector and workforce in England (viewed in March 2025)

[130] Social Care Wales (2023), Data and information on the social care workforce… | Social Care Wales (viewed in March 2025)

13 - Healthcare costs at end-of-life

13.1 - Summary

256. This section sets out the potential impacts of delivering VAD services on healthcare costs at end-of-life, in terms of reduced expenditure. It is noted that this is not stated as an objective of the policy.

257. The Bill states that the VAD services must be limited to eligible adults who are terminally ill. The Bill (in Clause 2(1)) defines a person as terminally ill if they have an inevitably progressive illness or disease which cannot be reversed by treatment, and their death in consequence of that illness or disease can reasonably be expected within 6 months.

258. There are no official statistics in England and Wales on the number of terminally ill adults, nor the cost of their palliative and end-of-life care.

259. The amount of time it takes to complete the VAD process (from preliminary discussion to assisted death) is uncertain. This IA considers the scenario where the process takes two months. If a person would otherwise have lived for six months, then there would be up to four months of unutilised palliative and end-of-life care. The following analysis therefore estimates the cost of healthcare not required for the final four months of life.

260. The estimated **reduced cost from unutilised healthcare** ranges from between **£919k to £8.46m[131] in Year 1 (which is half a year)**, to between **£5.84m to £59.6m in Year 10**. This captures hospital (both emergency and non-emergency care), primary and community care, hospice, medicines and other care costs, but does not distinguish between different funding avenues. The ranges take into consideration potential variations in projected assisted death numbers (low, central, and high), and the amount of time care is no longer required for (ranging from the final four months to final month of life). As a sensitivity, the impacts of changing the average healthcare costs are considered in Annex E.

13.2 - What palliative and end-of-life care is

261. Palliative care is defined by the World Health Organization as an approach that improves the quality of life of patients and their families who are facing problems associated with life-limiting illness[132]. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and

[131] See 'Version control table' at the end of this document. In v1.1, the estimated proportion of assisted deaths occurring under the high scenario in Year 1 was corrected from 0.13% to 0.11%; all values derived from this were also updated. In this section of the IA, this included Year 1 high scenario values in Table 34 and Table 35, and associated text. All corrections were carried across to v1.2.

[132] World Health Organization (2020), Palliative care (viewed in April 2025)

other problems whether physical, psychosocial or spiritual. In England, the term ‘end-of-life care’ refers to the care given to those reasonably expected to die within the next 12 months.

262. In England and Wales, palliative and end-of-life care is delivered by several sectors, including the NHS, the social care sector, third sector (voluntary and charitable) organisations, the private sector, and unpaid carers such as friends and family[133].

263. The care needed is often divided into two categories:

263.1. ‘specialist care’ delivered by professionals specifically trained in palliative and end-of-life care to support someone with complex symptom management in any setting.

263.2. ‘non-specialist or universal care’, delivered by health and social care professionals in any setting by, for example, district nurses or social carers, in primary care settings by GPs, and in secondary care settings by hospital staff.

Patterns of provision in England and Wales

264. Findings from Marie Curie’s *Better End of Life* report 2024 indicate that patterns of provision are similar in England and Wales.[134]

265. Health and social care in England are the responsibility of the Department of Health and Social Care (DHSC), and social security is the responsibility of the Department for Work and Pensions (DWP). Integrated Care Boards (ICBs) in England have a duty to provide palliative care services to meet the needs of their local populations, but there are known to be variations in service provision.

266. Health and social care in Wales are the responsibility of the Welsh Government. Social security is largely managed by the UK Department for Work and Pensions. Aspirations for palliative and end-of-life care in Wales are set out in the Welsh Government’s Quality Statement for Palliative and End of Life Care. The NHS Wales Executive provides strategic direction to health boards and other relevant bodies via the National Palliative and End of Life Care Programme Board.

267. Delivery is the responsibility of health boards in their respective areas. Local authorities are responsible for the delivery of social care. Regional Partnership

[133] NHS (2022), What end of life care involves - NHS (viewed in March 2025)

[134] Marie Curie (2024), Better End of Life Report | Marie Curie (viewed in March 2025)

Boards bring together health boards, local authorities and the third sector to meet the care and support needs of people in their area.

13.3 - Estimating healthcare costs at end-of-life

268. The National Institute for Health and Care Research (NIHR)-funded Policy Research Unit (PRU) for palliative and end-of-life care has analysed the costs and cost-effectiveness of adult palliative and end-of-life care in the UK.[135]

269. The (as yet unpublished) study shows that healthcare costs generally increase the closer the person is to death. The estimated cost per person in the last 6 months of life is £16.5k (uplifted for 2025/26). This is spread across hospital, primary and community care, hospice, and other care costs. On average, 34% of these costs are incurred in the final month of life. See Table 32 and Table 33 below.

270. The study addresses a range of questions on end-of-life care. For the purpose of this assessment, the PRU's estimate of formal healthcare costs for adults in the last year of life has been used, with data gathered in or adjusted to 2017.

271. This assessment includes hospital costs (A&E visits, ward stays, intensive care unit stays and outpatient visits), costs of primary and community care (GP face-to-face and telephone appointments, district/community nurse visits and GP home visits and GP out-of-hours care), hospice costs and other costs (medications and ambulance) during the last 4 months of life for the estimated cohort. Healthcare costs include inpatient stays for acute hospital costs. Therefore, this is interpreted as accounting for the cost of hospital bed occupancy.

272. The NIHR study does not distinguish between different funding avenues. This means that this IA makes no distinction between someone receiving (or not receiving) end-of-life care as part of, for example, NHS continuing healthcare (also referred to as 'CHC'). Although it is not explicitly estimated, costs in the palliative care section include those that may be funded by CHC.

273. It is acknowledged that some terminally ill adults in the final 6 months of life may have greater palliative care needs than others. The costs may therefore be an underestimate.

[135] Clarke, G., May, P., Cook, A., Mitchell, S., Walshe, C., Bajwah, S., Yorganci, E., Kumar, R., Fraser, L.K., Sleeman, K.E., Murtagh F.E.M. (2025). Costs and cost-effectiveness of adult palliative and end-of-life care. Evidence briefing summary. London: National Institute for Health and Care Research (NIHR) Policy Research Unit (PRU) for Palliative and End-of-Life Care. Summary available at: https://www.kcl.ac.uk/nmpc/assets/research/costs-and-cost-effectiveness-of-adult-palliative-and-end-of-life-care-evidence-briefing-summary.pdf Accessed on 18/03/2025. **Full report is unpublished data – provided via personal communication.**

Table 32 Estimated healthcare cost per person by time to death in 2025/26 prices (unpublished data), England and Wales [136]

Category	Total in last 6 months	Month 6	Month 5	Month 4	Month 3	Month 2	Month 1
Hospital	£13,365	£1,441	£1,448	£1,539	£1,971	£2,495	£4,471
Primary and community care	£1,374	£171	£180	£190	£208	£279	£346
Hospice	£1,055	< £0	< £0	£3	£120	£315	£617
Other	£731	£103	£107	£110	£115	£124	£172
Total healthcare costs	**£16,525**	**£1,715**	**£1,735**	**£1,842**	**£2,414**	**£3,213**	**£5,606**

Table 33 Estimated healthcare costs each month, as proportion of total costs in last 6 months (unpublished data), England and Wales [136]

Category	Month 6 as proportion of total in last 6	Month 5	Month 4	Month 3	Month 2	Month 1
Hospital	11%	11%	12%	15%	19%	33%
Primary and community care	12%	13%	14%	15%	20%	25%
Hospice	0%	0%	<1%	11%	30%	59%
Other	14%	15%	15%	16%	17%	24%
Total healthcare costs	10%	10%	11%	15%	19%	34%

[136] DHSC estimates based on table 2 and figures from Clarke, G., May, P., Cook, A., Mitchell, S., Walshe, C., Bajwah, S., Yorganci, E., Kumar, R., Fraser, L.K., Sleeman, K.E., Murtagh F.E.M. (2025). Costs and cost-effectiveness of adult palliative and end-of-life care. Evidence briefing summary. London: National Institute for Health and Care Research (NIHR) Policy Research Unit (PRU) for Palliative and End-of-Life Care. Summary available at: https://www.kcl.ac.uk/nmpc/assets/research/costs-and-cost-effectiveness-of-adult-palliative-and-end-of-life-care-evidence-briefing-summary.pdf Accessed on 18/03/2025. **Full report is unpublished data – provided via personal communication.**

13.4 – Estimating unutilised healthcare costs

274. The palliative and end-of-life care costs for 1 month and 4 months of unutilised care have been estimated in Table 34 and Table 35.

275. **Assuming all assisted deaths occur after 2 months**, reducing the length of life by 4 months, then it is estimated that 79% of the associated healthcare costs (for months 4 to 1) are no longer required. As set out in Table 34 this amounts to a **potential reduction in spend of between £2.14m to £8.46m in Year 1 (which is half a year)** and **£13.6m and £59.6m in Year 10** (in 2025/26 prices).

276. **Assuming all assisted deaths occur after 5 months**, reducing the length of life by 1 month, then it is estimated that 34% of the associated healthcare costs (for month 1) are no longer required. As set out in Table 35 this amounts to a **potential reduction in spend of between £919k and £3.63m in Year 1 (which is half a year)** and **£5.84m and £25.6m in Year 10** (in 2025/26 prices).

277. Palliative and end-of-life care costs may vary depending on a range of factors. For example, the last 6 months of a terminally ill person's life may be more costly than the average person's last 6 months of life[137]. This is considered in a sensitivity analysis in Annex E. The sensitivity analysis considers scenarios where the total costs of care at end of life are 20% lower and 20% higher. In other jurisdictions, the majority of people who have an assisted death are cancer patients, who may have higher hospital care costs[138]. Therefore, it may be considered that the 'high' scenario is more likely than the 'low' scenario, although this is uncertain.

Table 34 Estimated palliative and end-of-life care expenditure not required, for 4 months of unutilised care, Year 1 (2029/30, half-year) and Year 10 (2038/39), in 2025/26 prices, England and Wales [139]

Implementation Year	Scenario	Number of deaths	Hospital care not utilised	Primary and community care not utilised	Hospice care not utilised	Other care not utilised	Total healthcare not utilised
Year 1 (half-year)	Low	164	£1.72m	£168k	£173k	£85.4k	**£2.14m**
	Central	289	£3.02m	£295k	£305k	£150k	**£3.77m**
	High	647	£6.78m	£662k	£682k	£337k	**£8.46m**
Year 10	Low	1,042	£10.9m	£1.07m	£1.10m	£543k	**£13.6m**
	Central	2,183	£22.9m	£2.23m	£2.30m	£1.14m	**£28.6m**
	High	4,559	£47.8m	£4.67m	£4.81m	£2.38m	**£59.6m**

Note: Table assumes that each person would have lived for 6 months, and that they have an assisted death after 2 months, meaning the final 4 months of care are not required.

[137] Marie Curie, The cost of dying: the financial impact of terminal illness (viewed in April 2025)

[138] Nuffield Trust (2014), Exploring the cost of care at the end of life | Nuffield Trust, (viewed in April 2025)

[139] DHSC estimates based on table 2 and figures from Clarke, G., May, P., Cook, A., Mitchell, S., Walshe, C., Bajwah, S., Yorganci, E., Kumar, R., Fraser, L.K., Sleeman, K.E., Murtagh F.E.M. (2025). Costs and cost-effectiveness of adult palliative and end-of-life care. Evidence briefing summary. London: National Institute for Health and Care Research (NIHR) Policy Research Unit (PRU) for Palliative and End-of-Life Care. Summary available at: https://www.kcl.ac.uk/nmpc/assets/research/costs-and-cost-effectiveness-of-adult-palliative-and-end-of-life-care-evidence-briefing-summary.pdf Accessed on 18/03/2025. **Full report is unpublished data – provided via personal communication.**

Table 35 Estimated palliative and end-of-life care expenditure not required, for 1 month of unutilised care, Year 1 (2029/30, half-year) and Year 10 (2038/39), in 2025/26 prices, England and Wales [140]

Implementation Year	Scenario	Number of deaths	Hospital care not utilised	Primary and community care not utilised	Hospice care not utilised	Other care not utilised	Total healthcare not utilised
Year 1 (half-year)	Low	164	£733k	£56.8k	£101k	£28.2k	**£919k**
	Central	289	£1.29m	£100k	£178k	£49.6k	**£1.62m**
	High	647	£2.89m	£224k	£399k	£111k	**£3.63m**
Year 10	Low	1,042	£4.66m	£361k	£644k	£179k	**£5.84m**
	Central	2,183	£9.76m	£756k	£1.35m	£375k	**£12.2m**
	High	4,559	£20.4m	£1.58m	£2.82m	£784k	**£25.6m**

Note: Table assumes that each person would have lived for 6 months, and that they have an assisted death after 5 months, meaning the final 1 month of care is not required.

13.5 - Resourcing implications

278. Assisted dying may reduce pressures on some parts of the palliative and end-of-life care workforce, for care no longer needed. However, palliative care and end-of-life care services face high demand, and so this reduction may result in replacement activity, rather than reduced expenditure. According to the Association of Palliative Medicine and Marie Curie, approximately 50% of people requiring specialist or generalist palliative care in 2021 were estimated to have received it [141].

279. Assisted dying may also increase pressures on some parts of the palliative and end-of-life care workforce. The potential high rate of opt-out among palliative care professionals is noted, as set out in the 'Information Provision and Training' section. For those involved in delivery of the service, there would be an associated cost of this workforce receiving training on assisted dying.

280. There may also be new or increased uptake of care as a result of the preliminary discussion with the registered medical practitioner, if the person was not receiving any or all of the care they were entitled to, and they decided to take that up. The scale of this is not known and factors such as type of terminal illness, stage of illness, provision and location of end-of-life care, and location of the assisted dying service, would affect this.

[140] DHSC estimates based on table 2 and figures from Clarke, G., May, P., Cook, A., Mitchell, S., Walshe, C., Bajwah, S., Yorganci, E., Kumar, R., Fraser, L.K., Sleeman, K.E., Murtagh F.E.M. (2025). Costs and cost-effectiveness of adult palliative and end-of-life care. Evidence briefing summary. London: National Institute for Health and Care Research (NIHR) Policy Research Unit (PRU) for Palliative and End-of-Life Care. Summary available at: https://www.kcl.ac.uk/nmpc/assets/research/costs-and-cost-effectiveness-of-adult-palliative-and-end-of-life-care-evidence-briefing-summary.pdf Accessed on 18/03/2025. **Full report is unpublished data – provided via personal communication.**

[141] Association of Palliative Medicine and Marie Curie (2021), Association of Palliative Medicine and Marie Curie survey of palliative care practitioners 2021 (viewed in March 2025)

281. Pressures may also vary by area in England and Wales; for example, some areas of Wales have limited access to specialist services, particularly in sparsely populated areas.

282. There are also likely to be impacts on organisations delivering palliative and end-of-life care, as explored in the NIHR study[142]. This includes impacts on hospices which may be funded through NHS or local authority funding or charitable donations. Hospice staff, like those in other organisations delivering palliative care, would need to familiarise their workforce with the VAD service and its processes, including safeguarding, which may entail opportunity costs on staff time.

[142] Clarke, G., May, P., Cook, A., Mitchell, S., Walshe, C., Bajwah, S., Yorganci, E., Kumar, R., Fraser, L.K., Sleeman, K.E., Murtagh F.E.M. (2025). Costs and cost-effectiveness of adult palliative and end-of-life care. Evidence briefing summary. London: National Institute for Health and Care Research (NIHR) Policy Research Unit (PRU) for Palliative and End-of-Life Care. Summary available at: https://www.kcl.ac.uk/nmpc/assets/research/costs-and-cost-effectiveness-of-adult-palliative-and-end-of-life-care-evidence-briefing-summary.pdf Accessed on 18/03/2025. **Full report is unpublished data – provided via personal communication.**

14 - Social care sector [143]

14.1 - Summary

283. This section sets out the potential impacts of delivering VAD services on the social care sector; specifically, care homes and domiciliary care.

284. The Bill does not state the type of location or setting from which assistance to end a life would be provided. The condition(s) people live with as they approach the end of their life can affect where they are cared for and where they ultimately die. In England and Wales, death registration data does not capture whether the person died of a "terminal illness" (and therefore where terminally ill people have died).

285. In other jurisdictions, people with end-stage cancer are reported to make up the majority of assisted deaths[144]. There is some available data on place of death for adults who died of cancer in England in 2023: 36% died in their own home, 33% in hospital, 16% in a hospice, 13% in a care home, and 2% in other places[145]. These proportions are applied to the estimated number of assisted deaths in England and in Wales.

286. The amount of time it takes to complete the VAD process (from preliminary discussion to assisted death) is uncertain. This IA considers the scenario where the process takes two months. If a person would otherwise have lived for six months, then there would be up to four months of care home or domiciliary care provision no longer required.

287. It is **estimated that between 22 to 85 care home residents would have an assisted death** in England and Wales in **Year 1** (which is half a year), rising to **between 138 and 602** care home residents in **Year 10**. This represents a very small proportion of the total care home population. Based on various assumptions (covering, for example, funding routes, fees paid, and whether the bed remains vacant for 1 to 4 months) the estimated **reduction in care home profits** ranges from **£22.5k to £653k in Year 1 (which is half a year),** to between **£143k and £4.61m in Year 10.**

288. It is estimated that in **Year 1 (which is half a year)** in England and Wales, **between 29 and 116 people in receipt of domiciliary care would have an assisted death at home**, rising to **between 187 and 818 people in Year 10**. Based on various assumptions (covering, for example, funding routes, fees paid, and the scenario where all domiciliary care is provided by an external agency rather than unpaid carers), the estimated **profit loss for the domiciliary care sector** ranges from between **£8.25k to £130k in Year 1 (which is half a year)**, to between **£52.5k and £918k in Year 10**.

[143] See 'Version control table' at the end of this document. In v1.1, the estimated proportion of assisted deaths occurring under the high scenario in Year 1 was corrected from 0.13% to 0.11%; all values derived from this were also updated. In this section of the IA, this included Year 1 high scenario values in Table 36, Table 38, Table 39, Table 40, Table 41, Table 42, Table 44, Table 45, Table 46, Table 47, and associated text. All corrections carried across to v1.2.

[144] For data source, see Annex A

[145] Department of Health & Social Care (2025), Palliative and end of life care factsheet: Patterns of care, England 2023 (viewed in March 2025)

289. There is a high degree of uncertainty in these estimates and so they should be considered as illustrative only. The potential impacts on health and social care staff are discussed in the 'Impacts on individuals and specific groups of individuals' section.

14.2 - Place of death

290. There is no official data on the number of people in England and Wales who have died from a "terminal illness". It therefore follows that there is no official data on the usual place of death for terminally ill adults. To estimate the potential distribution of assisted deaths across community and social care settings, this IA uses death registration data by broad underlying cause of death.

291. Of all deaths occurring in England in 2023, 28% took place in people's own home, 21% in a care home, and 5% in a hospice[146]. For people who died of cancer specifically, 36% died in their own home, 13% in a care home, and 16% in a hospice[146]. It is arguably more appropriate to apply the usual place of death for cancer patients to the estimated number of assisted deaths for two reasons. First, because international data suggests that cancer patients make up the majority of assisted deaths[146]; and second, because 36% of all deaths in care homes in England in 2023 were from dementia[146]. It is highly unlikely that a person with dementia would be eligible for an assisted death due to limited mental capacity, and so using the overall proportion of deaths in care homes would likely overestimate the population living in care homes who would be eligible for or have an assisted death. It is also assumed that patterns in assisted deaths by location would be the same across England and Wales.

14.3 - Impact on care homes

Estimated number of privately and local authority funded residents

292. It is estimated that between 22 and 85 people who have an assisted death in Year 1 (which is half a year) will be care home residents, rising to between 138 to 602 people in Year 10 (see Table 36). As noted previously, the amount of time it takes to complete the VAD process (from preliminary discussion to assisted death) is uncertain. If it is assumed that the process would take 2 months, and a person would otherwise have lived for 6 months in a care home, then there would be up to 4 months of care home provision no longer required.

293. The cost of care home provision no longer required, in terms of fees that would otherwise have been paid, will vary due to a range of reasons. This includes, for example, the age of the person (over/under 65), whether nursing care is needed or not, the type of care the home provides, inspection ratings, and how new the home is. Fees also vary depending on whether the resident is funded by the local authority or privately.

[146] Department of Health & Social Care (2025), Palliative and end of life care factsheet: Patterns of care, England 2023 (viewed in March 2025)

294. There is regional variation in the proportion of local authority and self-funded clients. The ONS[147] states that in 2022-23 the South East had the highest proportion of self-funders in care homes (47.5%), whilst the North East had the lowest proportion of self-funders (26.4%). To estimate the potential impact of assisted dying on care homes it is assumed that in line with the national average, 37% are self-funded and 63% local authority funded[147].

295. As shown in Table 36, if this split is applied to the total estimated number of assisted deaths in care homes across England and Wales, there would be:

295.1. between 8 and 32 assisted deaths among self-funded care home residents in Year 1 (which is half a year), rising to between 51 and 223 in Year 10.

295.2. between 14 and 54 assisted deaths among local authority funded care home residents in Year 1, rising to between 87 and 379 in Year 10.

Table 36 Estimated number of assisted deaths among self-funded and local authority funded care home residents in Year 1 (which is half a year) and Year 10, England and Wales[148]

Implementation year	Scenario	Total number of assisted deaths (all care home residents)	Number of assisted deaths: self-funded care home residents	Number of assisted deaths: local authority funded care home residents
Year 1 (half-year)	Low	22	8	14
	Central	38	14	24
	High	85	32	54
Year 10	Low	138	51	87
	Central	288	107	182
	High	602	223	379

Note: some figures may not add to the total due to rounding.

Estimated care home fees

296. Privately funded care home residents ("self-funders") are likely to pay higher fees than local authorities.

297. Carterwood's 2024 self-funded fee report[149] suggests that in Great Britain, the average self-funded fee (per person, per week) was £1,200 without nursing care, and £1,567 with nursing care. There is variation across Great Britain, with the average nursing care self-funded fee in Wales reported to be £1,367, London reported at £1,801 and North East England at £1,302. Personal care self-funded fees (without nursing care) are lower, with the average in Wales at £1,067, London at £1,456 and North East

[147] Office for National Statistics (2023), Care homes and estimating the self-funding population, England - Office for National Statistics (viewed in March 2023)
[148] DHSC estimates based on figures found in table 2 and Place of death information in Department of Health and Social Care (2025), Palliative and end of life care factsheet: Patterns of care, England 2023 (viewed in March 2025)
[149] Carterwood (2024), 2024 Self-funded fee and trading performance review - Carterwood, improve decision making (viewed in March 2025)

England at £1,034. This illustrates the range of weekly fee rates paid in England and Wales.

298. DHSC's 2024/25 provider fee report[150] estimates that the average fee paid (per person per week) by local authorities to external providers of care homes ranged from £888 (care homes for residents aged 65+ without nursing) to £1,692 (care homes for residents aged 18 to 64 without nursing). Average fees with nursing range from £1,027 for clients above the age of 65, and £1,396 for clients aged 18-64. Neither average local authority reported fee includes the NHS Funded Nursing Care payment of £235.88 per week from April 2024. If a person who has an assisted death is receiving state (local authority) funded nursing care, then the NHS Funded Nursing Care payment would no longer be paid which would constitute a cost reduction for the NHS. However, it is unclear how many people who have an assisted death would receive nursing care or care without nursing.

299. These fees were uplifted to 2025/26 prices and used to estimate the potential reduced payments to care homes for people having an assisted death and therefore no longer requiring the care home bed (see Table 37).

Table 37 Average self-funded and local authority funded care home fees 2025/26

	Self-funded care home fee		Local authority funded care home fee	
Scenario	**2024/25 prices** [151]	**2025/26 prices**	**2024/25 prices** [150]	**2025/26 prices**
Lower bound	£1,034	£1,061	£888	£911
Upper bound	£1,801	£1,849	£1,692	£1,737

Estimated reduction in care home payments

300. The impact of care home provision no longer being required for between 1 to 4 months (assuming the VAD process takes 2 months from preliminary discussion to assisted death), will vary according to whether the individual using the VAD service is self-funded or local authority funded. For example, a local authority funded individual no longer requiring care would entail a reduction in revenue for the care home but an equal reduction in expenditure for the local authority.

301. To estimate the impact on care homes, the estimated number of assisted deaths in care homes in England and Wales is split by the proportion that are assumed to be self-funded or local authority funded. To estimate a total impact on revenue, the number of LA or self-funded individuals using the VAD service is then multiplied by the estimated weekly average fee. To estimate the impact on profits, the total revenue loss is multiplied by an assumed percentage profit rate.

[150] Department of Health and Social Care (2024), Market Sustainability and Improvement Fund (MSIF): provider fee reporting 2024 to 2025 - GOV.UK (viewed in March 2025)
[151] Carterwood (2024), 2024 Self-funded fee and trading performance review - Carterwood, improve decision making (viewed in April 2025)

Self-funders

302. As shown in Table 38, the reduction in care home payments from self-funders is estimated to be:

302.1. in Year 1 (which is half a year), between £34.0k and £934k

302.2. in Year 10, between £216k and £6.59m.

Table 38 Estimated reduction in fees paid to care homes by self-funders, England and Wales [152]

Implementation year	Scenario	Number of assisted deaths, self-funded care home residents	Lower bound fee		Upper bound fee	
			1 month not required	4 months not required	1 month not required	4 months not required
Year 1 (half-year)	Low	8	£34.0k	£136k	£59.2k	£237k
	Central	14	£59.8k	£239k	£104k	£417k
	High	32	£134k	£536k	£234k	£934k
Year 10	Low	51	£216k	£865k	£376k	£1.51m
	Central	107	£453k	£1.81m	£789k	£3.15m
	High	223	£945k	£3.78m	£1.65m	£6.59m

Local authorities

303. As shown in Table 39, the reduction in care home payments from local authorities is estimated to be:

303.1. in Year 1 (which is half a year), between £49.7k and £1.49m

303.2. in Year 10, between £316k and £10.5m.

Table 39 Estimated reduction in fees paid to care homes by local authorities, England and Wales [152]

Implementation year	Scenario	Number of assisted deaths, local authority funded care home residents	Lower bound fee		Upper bound fee	
			1 month not required	4 months not required	1 month not required	4 months not required
Year 1 (half-year)	Low	14	£49.7k	£199k	£94.7k	£379k
	Central	24	£87.5k	£350k	£167k	£667k
	High	54	£196k	£784k	£374k	£1.49m
Year 10	Low	87	£316k	£1.26m	£602k	£2.41m
	Central	182	£662k	£2.65m	£1.26m	£5.05m
	High	379	£1.38m	£5.53m	£2.63m	£10.5m

[152] DHSC estimates based on figures found in Table 34 and Table 36

304. A reduction in fees paid to care homes by local authorities would constitute a reduction in expenditure for local authorities. However, the Association of Directors of Adult Social Services (ADASS) report that "there were 418,029 people waiting for an assessment, care or direct payments to begin or a review of their care plan as of 31 March 2024"[153]. This suggests that there is a high level of demand for local authority funded care, so it reasonable to assume that if a local authority is no longer funding the care of someone who has an assisted death, that they would instead pay for someone else. Therefore, any potential reductions in expenditure from no longer paying for someone's care are unlikely to materialise.

Care homes

305. Table 40 presents the total estimated reduction in care home revenue from both self-funded and local authority funded individuals. The impact is expected to be:

305.1. in Year 1 (which is half a year), between £83.7k and £2.43m

305.2. in Year 10, between £532k and £17.1m

Table 40 Total estimated reduction in care homes revenue from both self-funded and local authority funded individuals, England and Wales [154]

Implementation year	Scenario	Total assisted deaths, care home residents	Lower bound fee		Upper bound fee	
			1 month not required	4 months not required	1 month not required	4 months not required
Year 1 (half-year)	Low	22	£83.7k	£335k	£154k	£616k
	Central	38	£147k	£589k	£271k	£1.08m
	High	85	£330k	£1.32m	£607k	£2.43m
Year 10	Low	138	£532k	£2.13m	£979k	£3.91m
	Central	288	£1.11m	£4.46m	£2.05m	£8.20m
	High	602	£2.33m	£9.31m	£4.28m	£17.1m

Estimated reduction in care home profits

306. Relative to the size of the care home population overall, the number of people pursuing an assisted death is estimated to be small. For example, in England, there were an estimated 354,753 care home residents (as of February 2025), with an occupancy rate of 85.7%[155] (the estimated number of residents is a slight under-estimate as it excludes care homes that did not report during the reporting window of 8th to 14th February 2025). In Wales, there were an estimated 23,000 care beds for the elderly (in 2017)[156]. To illustrate this using a very broad estimate, **based on a high scenario estimate of 85 care home residents using the VAD service in year 1**

[153] Directors of Adult Social Services (ADASS) (2024), People needing more intense care and support, pushing councils to overspend, says ADASS survey - ADASS (viewed in March 2025)

[154] DHSC estimates based on figures found in Table 38 and Table 39

[155] Department of Health and Social Care (2025), Adult social care in England, monthly statistics: March 2025 - GOV.UK (viewed in March 2025). Note that the estimated number of residents is a slight under- estimate as it excludes care homes that did not report during the reporting window of 8th to 14 February 2025.

[156] Competition and Markets Authority (2017), Short summary for Wales - Care homes market study final report (viewed in March 2025)

(which is a half year), less than 0.05% of care home residents are estimated use the VAD service.

307. The extent of this impact on care homes will be influenced, in part, by how quickly the vacant bed is filled. If a care home organisation does not fill the vacant bed immediately, they would experience the loss of revenue and therefore a loss of profit. For care homes, it is assumed that 26.9% of revenue is profit, to give an indication of the scale of impact.[157]

308. For care homes the profit assumption is 26.9% based on the CQC Market Oversight Scheme estimate of the Earnings Before Interest Tax Depreciation and Amortisation Rent and Management (EBITDARM) margin in March 2024. Significant costs need to be paid out of the care home EBITDARM margin including the cost of renting the property or paying off the mortgage on the property, and these costs plus any remaining profit will not be covered if a bed is empty.

309. For the purpose of this indicative analysis, it is assumed the care organisation does not fill the vacant bed immediately, and thus experiences a loss of revenue and profit (although the bed may be quickly refilled in some cases). The analysis shows this impact over 1 month and 4 months. Analysing profit in this way assumes (non-ITDARM) costs are infinitely flexible in the short term, whilst in reality a care home (or homecare organisation which is discussed later in the impact assessment), may not be able to adjust its costs in the short run, as many costs are staffing. However, this very broad calculation does offer an indication of the scale of profit impacts.

310. As shown in

311. Table 41 the **estimated reduction in care home profits** ranges from:

311.1. in **Year 1 (which is half a year)**, between **£22.5k** and **£653k**

311.2. in **Year 10**, between **£143k** and **£4.61m**

Table 41 Total estimated reduction in care homes profits, England and Wales [158]

Implementation year	Scenario	Total assisted deaths, care home residents	**Lower bound fee**		**Upper bound fee**	
			1 month not required	**4 months not required**	**1 month not required**	**4 months not required**
Year 1 (half-year)	Low	22	£22.5k	£90.0k	£41.4k	£166k
	Central	38	£39.6k	£159k	£72.9k	£292k
	High	85	£88.8k	£355k	£163k	£653k
Year 10	Low	138	£143k	£573k	£263k	£1.05m
	Central	288	£300k	£1.20m	£551k	£2.21m
	High	602	£626k	£2.50m	£1.15m	£4.61m

[157] Earnings Before Interest Tax Depreciation and Amortisation Rent and Management (EBITDARM) margin in March 2024, taken from the Care Quality Commission (2024), The state of health care and adult social care in England 2023/24 - Care Quality Commission (viewed in March 2025)

[158] DHSC estimates based on figures found in Table 40 and profit assumptions from Care Quality Commission (2024), The state of health care and adult social care in England 2023/24 - Care Quality Commission (viewed in April 2025)

14.4 - Impact on domiciliary care providers

Estimated number of people receiving domiciliary care

312. It is estimated that the number of people having an assisted death in their own home would range from between 59 and 232 in Year 1 (which is half a year), to between 374 and 1,637 in Year 10. It is probable that some, but not all, individuals who die at home would be receiving domiciliary care. As an illustrative example, this IA assumes that 50% of people who have an assisted death at home would be receiving domiciliary care at the time of their death.

313. Domiciliary care may be provided by independent for-profit or voluntary organisations, and/or by friends and family through unpaid care. It is delivered in the person's own home. Local authorities and councils are responsible for assessing a person's care needs and would arrange and fully or part fund care for those who meet specific criteria. Adult social care currently makes up the largest area of discretionary expenditure for local authorities. If those criteria are not met, then the individual would pay for all (or some) of their own care.

314. There is no official data on the number of people receiving domiciliary care at the time of their death, but there are some estimates available on the number of local authority and self-funded community care users in England. For example, NHS Digital reported that in in 2023-24, there were 462,745 local authority supported community care users[159], and the Policy Research Unit in Adult Social Care reported that in 2022, there were 119,000 older people self-funding community care[160]. This suggests there are approximately 580,000 community care users in England. Furthermore, the ONS estimated that in England in 2023, 23% of people using community care services were self-funded [161]. This IA therefore considers the scenario where, of those having an assisted death in their own home and receiving domiciliary care, 23% were self-funded and 77% were local authority funded. See Table 42.

[159] NHS England Digital (2024), Adult Social Care Activity and Finance Report - NHS England Digital (viewed in March 2025)
[160] Hu, B., Hancock, R., Wittenberg, R. and others (2025), Projections of Adult Social Care Demand and Expenditure in England, 2022 to 2042 | ASCRU, P12, Figure 3, number of older service users in community care that are privately funded (viewed in March 2025)
[161] Office for National Statistics (2023), Estimating the size of the self-funding population in the community, England - Office for National Statistics (viewed in March 2025)

Table 42 Estimated number of people having an assisted death at home and receiving domiciliary care, England and Wales [162]

Implementation year	Scenario	Total number of assisted deaths (in own home)	Estimated number receiving domiciliary care (50% assumption)	Number of assisted deaths: self-funded domiciliary care	Number of assisted deaths: local authority funded domiciliary care
Year 1 (half-year)	Low	59	29	7	23
	Central	104	52	12	40
	High	232	116	27	89
Year 10	Low	374	187	43	144
	Central	784	392	90	302
	High	1,637	818	188	630

Estimated domiciliary care fees

315. Domiciliary care fees differ significantly across England and Wales, and the fee paid would vary based on a range of factors including, for example, the type and level of support a person needs (which could range from an hour a week to specialist live-in nursing care). The average local authority domiciliary care fee in England was £24 per hour in 2024/25[163]. People who self-fund are likely to pay more but there is limited data available on this. As an example, the Homecare Association suggest in 2025/26 the "minimum price for homecare" in England is £32.14 per hour[164].

316. As previously noted, it is uncertain how long the VAD process will take from preliminary discussion to assisted death. If it is assumed that this process takes 2 months, then a person having an assisted death in their own home, may have up to 4 months of unutilised domiciliary care. The amount of domiciliary care received over this 4-month period is uncertain and would vary according to a range of factors, including the person's terminal illness and prognosis. This IA assumes that individuals who have an assisted death are likely to have high care needs, and so 35 hours of care per week is assumed (although this figure is highly uncertain). Estimated self-funded and local authority funded domiciliary care fees for England and Wales, in 2025/26 prices, assuming an average of 35 hours per week are shown in Table 43.

[162] DHSC estimates based on table 2 and figures in Place of Death in Department of Health and Social Care (2025), Palliative and end of life care factsheet: Patterns of care, England 2023 (viewed in March 2025) and proportion of state/self-funders from Office for National Statistics (2023), Estimating the size of the self-funding population in the community, England - Office for National Statistics (viewed in March 2025)
[163] Department of Health and Social Care (2024), Market Sustainability and Improvement Fund (MSIF): provider fee reporting 2024 to 2025 - GOV.UK (viewed in March 2025)
[164] Homecare Association (2024), Minimum Price for Homecare - England 2025-2026 (viewed in March 2025)

Table 43 Average self-funded and local authority funded domiciliary care fee

	Local authority funded domiciliary care fee [165]		Self-funded domiciliary care fee [166]
Scenario	2024/25 prices	2025/26 prices	2025/26 prices
Average fee per hour	£24	£24.63	£32.14
Average weekly fees paid assuming 35 hours per week	£840	£862.05	£1,124.90

Estimated reduction in domiciliary care payments

317. The impact of domiciliary care no longer being required for between 1 to 4 months (assuming the VAD process takes 2 months from preliminary discussion to assisted death), would vary according to whether the impacted party is the individual self-funder, the local authority funder, or the domiciliary care provider.

318. To estimate the impact on domiciliary care providers, it is estimated 50% of people choosing to have an assisted death at home would have been receiving domiciliary care. It is also assumed that 23% of those receiving domiciliary care would be self-funded, and 77% local authority funded[167]. The estimated number of people having an assisted death, who would have been receiving self-funded or local authority funded domiciliary care, is multiplied by the estimated weekly average fee (assuming 35 hours of care per week).

Self-funded care

319. Based on these assumptions, expenditure by self-funders may reduce by

    319.1. between £30.4k and £481k in Year 1 (which is half year)

    319.2. between £194k and £3.39m in Year 10.

320. This would constitute a loss of revenue for domiciliary care organisations.

[165] Department of Health and Social Care (2024), Market Sustainability and Improvement Fund (MSIF): provider fee reporting 2024 to 2025 - GOV.UK (viewed in March 2025)

[166] Homecare Association (2024), Minimum Price for Homecare - England 2025-2026 (viewed in March 2025)

[167] Office for National Statistics (2023), Estimating the size of the self-funding population in the community, England - Office for National Statistics (viewed in March 2025)

Table 44 Estimated reduction in fees paid to domiciliary care organisations by self-funders, England and Wales [168]

Implementation year	Scenario	Number of people having an assisted death estimated to be self-funded domiciliary care users	Domiciliary care lost revenue from self-funders: Lower bound 1 month (4 weeks) of care no longer needed	Domiciliary care lost revenue from self-funders: Upper bound, 4 months (16 weeks) of care no longer needed
Year 1 (half-year)	Low	7	£30.4k	£122k
	Central	12	£53.6k	£214k
	High	27	£120k	£481k
Year 10	Low	43	£194k	£775k
	Central	90	£406k	£1.62m
	High	188	£847k	£3.39m

Local authority funded care

321. Based on these assumptions, local authority expenditure may reduce by

321.1. between £78.1k and £1.23m in Year 1 (which is half a year)

321.2. between £497k and £8.69m in Year 10.

322. This would constitute a loss of revenue for domiciliary care organisations from local authority funded individuals.

Table 45 Estimated reduced spend by local authorities on domiciliary care, England and Wales [169]

Implementation year	Scenario	Number of people having an assisted death estimated to be local authority funded domiciliary care users	Local authority reduced expenditure: Lower bound 1 month (4 weeks) of care no longer needed	Local authority reduced expenditure: Upper bound, 4 months (16 weeks) of care no longer needed
Year 1 (half-year)	Low	23	£78.1k	£313k
	Central	40	£138k	£550k
	High	89	£308k	£1.23m
Year 10	Low	144	£497k	£1.99m
	Central	302	£1.04m	£4.16m
	High	630	£2.17m	£8.69m

[168] DHSC estimates based on figures found in table 42 and Homecare Association (2024), Minimum Price for Homecare - England 2025-2026 (viewed in March 2025)

[169] DHSC estimates based on figures found in table 42 and Department of Health and Social Care (2024), Market Sustainability and Improvement Fund (MSIF): provider fee reporting 2024 to 2025 - GOV.UK (viewed in March 2025)

323. As discussed in the care home impacts section, there is a high level of demand for social care services. The Association of Directors of Adult Social Services (ADASS) report that "there were 418,029 people waiting for an assessment, care or direct payments to begin or a review of their care plan as of 31 March 2024"[170]. This suggests that there is a high level of demand for local authority funded care, so it reasonable to assume that if a local authority is no longer funding the care of someone who has an assisted death, that they would instead pay for someone else. Therefore, any potential reductions in expenditure from no longer paying for someone's care are unlikely to materialise.

Domiciliary care provider revenue

324. Assuming all self-funded and local authority domiciliary care would be provided by external domiciliary care organisations, this would amount to reduced revenue of:

324.1. in Year 1 (which is half year), between £109k and £1.71m

324.2. in Year 10, between £691k and £12.1m

Table 46 Total estimated reduced revenue for domiciliary care organisations, England and Wales [171]

Implementation year	Scenario	Number of people having an assisted death estimated to be domiciliary care users	Total lost revenue: Lower bound 1 month (4 weeks) of care no longer needed	Total lost revenue: Upper bound, 4 months (16 weeks) of care no longer needed
Year 1 (half-year)	Low	29	£109k	£434k
	Central	52	£191k	£765k
	High	116	£428k	£1.71m
Year 10	Low	187	£691k	£2.76m
	Central	392	£1.45m	£5.79m
	High	818	£3.02m	£12.1m

[170] Directors of Adult Social Services (ADASS) (2024), People needing more intense care and support, pushing councils to overspend, says ADASS survey - ADASS (viewed in March 2025)

[171] DHSC estimates based on figures found in Table 44 and Table 45

Domiciliary care provider profits

325. To give an impact on domiciliary care organisation profit, the total revenue reduction is multiplied by a profit assumption. For domiciliary care estimates the assumed profit rate is 7.6% based on LaingBuisson estimates of the Earnings Before Interest Tax Depreciation and Amortisation (EBITDA)[172] margin. Analysing profit in this way assumes costs are flexible in the short term, although a domiciliary care organisation may not be able to adjust its costs in the short run, as many of these costs are staffing. Estimated impacts also do not adjust for any change in demand to adult social care services which may increase with an ageing population[173]. However, this very broad calculation does offer an indication of the scale of profit impacts.

326. Assuming all self-funded and local authority domiciliary care would be provided by external domiciliary care organisations, this would amount to **reduced profit** of:

326.1. in **Year 1 (which is half year)**, between **£8.25k and £130k**

326.2. in **Year 10**, between **£52.5k and £918k**

327. There is a high degree of uncertainty in these estimates.

Table 47 Total estimated reduced profit for domiciliary care organisations, England and Wales [174]

Implementation year	Scenario	Number of people having an assisted death estimated to be domiciliary care users	Total lost profit: Lower bound 1 month (4 weeks) of care no longer needed	Total lost profit: Upper bound, 4 months (16 weeks) of care no longer needed
Year 1 (half-year)	Low	29	£8.25k	£33.0k
	Central	52	£14.5k	£58.1k
	High	116	£32.6k	£130k
Year 10	Low	187	£52.5k	£210k
	Central	392	£110k	£440k
	High	818	£230k	£918k

[172] LaingBuisson (2024), LaingBuisson adult social care market report (viewed in March 2024)

[173] Hu, B., Hancock, R., Wittenberg, R. and others (2025), Projections of Adult Social Care Demand and Expenditure in England, 2022 to 2042 | ASCRU (viewed in March 2025)

[174] DHSC estimates based on figures found in Table 46 and profit assumptions from LaingBuisson (2024), LaingBuisson adult social care market report (viewed in March 2024)

15 - Wider impacts on state pensions and state benefits[175]

15.1 - Summary

328. This section describes the potential wider impacts of VAD services on social security payments, specifically state pensions and state benefits. **Social security payments are considered "economic transfers"[176] in HM Treasury's Green Book, meaning they do not constitute a saving or cost for society.** It is also noted that reducing social security payments is not stated as an objective of the policy.

329. In England and Wales, the Department for Work and Pensions (DWP) has overall responsibility for much of the social security system, delivering the State Pension and a range of working-age, disability and ill-health benefits to "claimants". [177] This section looks at the following social security payments which individuals who have an assisted death could be in receipt of:

    329.1. State Pension (including the basic state pension and the new state pension)

    329.2. State Benefits available under the Special Rules for people at end of life

    329.3. Carer's Allowance

330. The total economic transfer associated with the impact on these social security payments has not been quantified, however, the economic transfer for state pensions and state benefits (Special Rules End of Life) individually has been quantified and is shown in tables 50 and 53 respectively. Carers Allowance is also a classed as a state benefit; however, this impact has not been quantified and is described qualitatively.

331. The number of people choosing to have an assisted death, who would otherwise have been in receipt of a state pension or state benefit(s) is unknown. To give some indication of the scale of potential economic transfers, it is assumed (based on international evidence) that just over 3 in 4 people who have an assisted death would be in receipt of state pension and Attendance Allowance. It is then assumed that the remaining 1 in 4 people who have an assisted death would be under pension age and in receipt of Personal Independence Payment (PIP).

332. The amount of time it takes to complete the VAD process (from preliminary discussion to assisted death) is uncertain. For this illustrative analysis, the scenario where this process takes two months is considered. If a person would otherwise have lived for six months, then there would be up to four months of social security payment(s) no longer required.

---

[175] See 'Version control table' at the end of this document. In v1.1, the estimated proportion of assisted deaths occurring under the high scenario in Year 1 was corrected from 0.13% to 0.11%; all values derived from this were also updated. In this section of the IA, this included Year 1 high scenario values in Table 48, Table 50, Table 51, Table 52, Table 53, and associated text. All corrections were carried across to v1.2.

[176] HM Treasury and Government Finance Function (2024), The Green Book (2022) - GOV.UK (viewed in March 2025)

[177] House of Commons Library (2022), An introduction to social security in the UK - House of Commons Library (viewed in April 2025)

333. The estimated **economic transfer** is:

333.1. for **state pensions**, between **£113k** and **£1.79m** in **Year 1 (which is half a year)**, to between **£1.05m** and **£18.3m** in **Year 10**;

333.2. for **Attendance Allowance**, between **£55.7k** and **£880k in Year 1 (which is half a year)**, to between **£354k** and **£6.20m** in **Year 10**; and

333.3. for **PIP**, between **£28.5k** and **£449k** in **Year 1 (which is half a year)**, to between **£181k** and **£3.17m** in **Year 10**.

334. These estimates contain a high degree of uncertainty so should be interpreted as illustrative only.

15.2 - State pension

Estimated number of state pension recipients

335. As of August 2024,[178] there were 10.8 million people receiving State Pension in England and Wales. Of these, 7.1 million received the basic State Pension and 3.7 million people received the new State Pension.

336. A person must meet several eligibility criteria to access State Pension. One of these is their age. At present, a person is eligible for basic State Pension if they were born before 6 April 1951 (for men) or born before 6 April 1953 (for women). Anyone born on or after these dates are eligible to claim the new State Pension instead. The current State Pension age is 66 but is set to rise to 67 between 2026 and 2028.

337. It is not known how many of those eligible and interested in using a VAD service would be of state pension age. Not all jurisdictions collect data on assisted deaths by age, and where they do, there is variation in the approach to grouping ages together for reporting purposes. Based on available international data, it is assumed that 77%[179] of people having an assisted death would be of pension age, and it is assumed that State Pension age remains static across the 10-year appraisal period.

338. Based on these assumptions, the estimated number of assisted deaths among people who are of pension age ranges from 126 to 498 in Year 1 (which is half a year), to between 803 to 3,510 in Year 10. This would represent less than 0.05% of the total number of state pension claimants in 2024, referenced above.

[178] Stat-Xplore (2018), Stat-Xplore (viewed in March 2025). Dataset: State Pension (from May 2018), Table: SP 1 – Category of Pension (available at: State Pension latest data.xlsx)

[179] This is the mid-point of the average proportion of assisted deaths reported among those aged 65+, 70+, or 79+, across comparable jurisdictions. See 'cohort demographics' for further detail.

Table 48 Estimated number of assisted deaths of people who are of state pension age, England and Wales [180]

Estimate	Year 1: Oct '29 – Apr '30 (half-year)	Year 10: Apr '38 - Mar '39
Low	126	803
Central	222	1,681
High	498	3,510

Estimated state pension payments

339. The full rate of the basic State Pension as of 2025/26 is £176.45[181] per week but this may be topped up if someone is eligible for an Additional State Pension. The full rate of the new State Pension was £230.25[182] per week, and claimants may be eligible for a "protected payment" paid on top of the full rate.

340. Generally, both the basic and new state pensions increase every year by whichever is the highest of the following: (a) earnings - the average percentage growth in wages (in Great Britain); or (b) prices - the percentage growth in prices in the UK as measured by the Consumer Prices Index (CPI); or (c) 2.5%. If claimants have a protected payment or an additional state pension, it increases each year in line with the CPI.

341. To provide an indication of scale, the potential reduction in state pension payments to people of pension age who have an assisted death is estimated. Expenditure (in real terms) and caseload forecasts from the DWP[183] have been used to determine the average entitlement per individual until 2029/30 (which is Year 1). The average annual entitlement per person was estimated by dividing the expenditure by the caseload. This was then divided by 52 to estimate the average weekly entitlement per individual. See Table 49.

Table 49 Estimated average entitlement per individual, from DWP forecast data[183]

Metric	2029/30
State pension forecast expenditure (real terms, 2025/26 prices)	£157bn
State pension forecast caseload	£13.4m
Average entitlement per individual (annually)	£11.7k
Average entitlement per individual (weekly)	£224.29

[180] DHSC estimates based on figures found in Table 2 and Table 7

[181] UK Government (2025),The basic State Pension: How much you get - GOV.UK (viewed in March 2025)

[182] UK Government (2025), The new State Pension: What you'll get - GOV.UK (viewed in March 2025)

[183] UK Government (2025), Benefit expenditure and caseload tables 2025 - GOV.UK (viewed March 2025)

342. The average weekly state pension is uprated each year in line with the 'triple lock'[184], which assumes it will rise by the highest of CPI inflation, average earnings growth, or 2.5 per cent[185]. The average weekly entitlement per individual is therefore estimated at £224.29 (2025/26 prices) in Year 1 (which is half a year), and £326.39 (2025/26 prices) in Year 10.

Estimated state pension economic transfer

343. As previously stated, the amount of time the VAD process would take from preliminary discussion to assisted death is uncertain. If it is assumed that the process takes 2 months, and that the person would otherwise have lived for up to 6 months, then this would represent up to 4 months of state pension no longer required. For illustrative purposes, the estimated number of people in receipt of state pension who have an assisted death, is multiplied by the number of weeks payment is no longer required. A month is defined as 4 weeks.

344. As shown in Table 50, it is estimated that unutilised state pension would represent an economic transfer of:

344.1. in Year 1 (which is half a year) between £113k and £447k (for 1 month of unutilised state pension), to between £453k and £1.79m (for 4 months of unutilised state pension)

344.2. in Year 10 between £1.05m and £4.58m (for 1 month of unutilised state pension), to between £4.19m and £18.3m (for 4 months of unutilised state pension).

345. However, the Green Book states that social security payments are "economic transfers", so they do not make society better or worse off as they transfer purchasing power from one set of individuals to another.[186]

Table 50 Estimated state pension economic transfer, England and Wales [187]

	1 month (4 weeks) not required		4 months (16 weeks) not required	
	Y1 - 2029/30	**Y10 - 2038/39**	**Y1 – 2029/30**	**Y10 – 2038/39**
Low	£113k	£1.05m	£453k	£4.19m
Central	£199k	£2.19m	£797k	£8.78m
High	£447k	£4.58m	£1.79m	£18.3m

[184] Office for Budget Responsibility (2024), Economic and fiscal outlook – March 2024 - Office for Budget Responsibility (viewed in March 2025)

[185] Office for Budget Responsibility (2024), Welfare spending: pensioner benefits - Office for Budget Responsibility (viewed in March 2025)

[186] HM Treasury and Government Finance Function (2024), The Green Book (2022) - GOV.UK (viewed in March 2025)

[187] DHSC estimates based on figures found in Table 48 and Table 49

15.3 - State benefits available through Special Rules End of Life

Estimated number of state benefit recipients

346. There are Special Rules for end of life (SREL) in the benefit system which support people nearing end of life to get faster and easier access to certain benefits, get higher payments for certain benefits, and avoid medical assessment[188]. At present, Special Rules define an individual as nearing the end of life when they are likely to have less than 12 months to live. It is uncertain how many people choosing to have an assisted death would have been in receipt of one or multiple state benefits, and the eligibility criteria for each benefit varies (see Annex G).

347. For illustrative purposes, it is assumed that all people of pension age, who choose to have an assisted death, would have been in receipt of Attendance Allowance[189]. It is then assumed that all people under state pension age, who choose to have an assisted death, would have been in receipt of Personal Independence Payment[190]. Both are available under SREL to people with a life-limiting illness, disability, or condition. The assumption that 77% of assisted deaths are among people of state pension age is carried across from the previous section, and so 23% are assumed to be under pension age.

Estimated state benefit payments to people of pension age

348. It is estimated that between 126 and 498 people of state pension age having an assisted death in Year 1 (which is half a year), increasing to between 803 and 3,510 in Year 10.

349. People claiming Attendance Allowance under the special rules for end of life get the higher rate at £110.40 per week (as of 2025/26)[191]. For illustrative purposes, it is assumed that a person receiving Attendance Allowance (SREL) would receive the same payment in Year 1 (which is half a year) as in Year 10.

350. For illustrative purposes, the estimated number of people in receipt of Attendance Allowance (SREL) who have an assisted death, is multiplied by the number of weeks payment is no longer required for (up to a maximum of 4 months, assuming the VAD process takes 2 months from preliminary discussion to assisted death).

351. As shown in Table 51, it is estimated that unutilised Attendance Allowance (SREL) would represent an economic transfer of:

[188] Department for Work & Pensions (2024), The 'Special Rules': how the benefit system supports people nearing the end of life - GOV.UK (viewed in March 2025)

[189] UK Government (2025) Attendance Allowance (viewed March 2025)

[190] UK Government (2025) Personal Independence Payment (PIP), (viewed March 2025)

[191] UK Government, Attendance Allowance: Claiming Attendance Allowance if you're nearing the end of life - GOV.UK (viewed in March 2025)

351.1. between £55.7k and £220k (1 month not required), to between £223k and £880k (4 months not required) in Year 1 (which is half a year)

351.2. between £354k and £1.55m (1 month not required), to between £1.42m and £6.20m (4 months not required) in Year 10.

Table 51 Estimated economic transfer, individuals over pension age, Attendance Allowance (SREL), England and Wales[192]

	1 month (4 weeks) not required		4 months (16 weeks) not required	
	Y1 - 2029/30	**Y10 - 2038/39**	**Y1 – 2029/30**	**Y10 – 2038/39**
Low	£55.7k	£354k	£223k	£1.42m
Central	£98.1k	£742k	£393k	£2.97m
High	£220k	£1.55m	£880k	£6.20m

Estimated state benefit payments to people under pension age

352. It is estimated that between 38 and 149 people under pension age would have an assisted death in Year 1 (which is half a year), and between 240 and 1,049 in Year 10.

353. The average weekly Personal Independence Payment (SREL) for people at the end of life (as defined by the DWP) and under state pension age was £183.95 in January 2025. It is unclear whether or by how much benefit entitlements would change in the future. To be consistent in approach across this IA, this figure is uplifted in line with inflation to £188.82 (2025/26 prices). For illustrative purposes, it is assumed that the value of the payment in Year 1 (which is half a year) would be the same as Year 10.

354. As shown in Table 52, it is estimated that unutilised Personal Independence Payment (SREL) would represent an economic transfer of:

354.1. in Year 1 (which is half a year), from between £28.5k and £112k (1 month not required), to between £114k and £449k (4 months not required), based on between 38 and 149 individuals under state pension age using VAD

354.2. in Year 10, from between £181k and £792k (1 month not required), to between £724km and £3.17m (4 months not required), based on between 240 and 1,049 individuals under state pension age using VAD.

Table 52 Estimated economic transfer, individuals under state pension age, Personal Independence Payment (SREL), England and Wales [193]

	1 month (4 weeks) not required		4 months (16 weeks) not required	
	Y1 - 2029/30	**Y10 - 2038/39**	**Y1 – 2029/30**	**Y10 – 2038/39**
Low	£28.5k	£181k	£114k	£724k
Central	£50.1k	£379k	£201k	£1.52m
High	£112k	£792k	£449k	£3.17m

[192] DHSC estimates based on figures found in Table 48 and UK Government, Attendance Allowance: Claiming Attendance Allowance if you're nearing the end of life - GOV.UK (viewed in March 2025)

[193] DHSC estimates based on figures found in Table 48 and Stat Xplore (2025), Stat-Xplore - Home (viewed in March 2025). Dataset: PIP cases with entitlement (from 2019). Table: Caseload by End of Life Rules indicator. Filters: England and Wales, State Pension age and below state pension age and (by the number of cases and the mean financial award).

Estimated state benefits economic transfer

355. The estimated economic transfer for state benefits payments has been calculated by summing the estimated state benefit payments for individuals under pension age (table 51) and the estimated state benefit payments for individuals of pension age (table 52).

356. As shown in Table 53**, it is estimated that unutilised state benefits would represent an economic transfer of:**

356.1. In year 1 (which is half a year), from between £84.2k and £332k (1 month not required) to between £337k and £1.33m (4 months not required).

356.2. In year 10, from between £536k and £2.34m (1 month not required) to between £2.14m and £9.37m (4 months not required).

Table 53 Estimated state benefit economic transfer, total, England and Wales [194]

	Lower bound 1 month (4 weeks)		Upper bound 4 months (16 weeks)	
	Y1 – 2029/30	**Y10 – 2038/39**	**Y1 – 2029/30**	**Y10 – 2038/39**
Low	£84.2k	£536k	£337k	£2.14m
Central	£148k	£1.12m	£593k	£4.49m
High	£332k	£2.34m	£1.33m	£9.37m

15.4 - Carer's Allowance

357. Some people who choose to have an assisted death may receive unpaid care from, for example, friends and family. In England and Wales, eligible carers may currently claim up to £81.90 a week if they care for someone for at least 35 hours a week[195]. The number of people choosing to have an assisted death who would also receive care from an individual receiving Carer's Allowance is unknown. The potential economic transfer relating to a person no longer requiring Carer's Allowance due to caring for an individual who chooses to have an assisted death, is therefore not quantified. A qualitative summary of the potential impacts of the Bill on relatives and unpaid carers, based on international evidence, is discussed in the 'Impacts on Individuals and specific groups of individuals' section.

[194] DHSC estimates based on figures found in Table 51 and Table 52

[195] UK Government (2025), Carer's Allowance: How it works - GOV.UK (viewed in March 2025)

16 – Wider impacts on the justice system, and death certification and registration

358. This section considers the wider impacts of the Bill on the justice system, as well as on death certification and registration processes.

16.1 - His Majesty's Prison and Probation Service (HMPPS)

359. Clause 1 may have an impact on His Majesty's Prison and Probation Service (HMPPS). HMPPS are required to facilitate access to health services for offenders who are in scope of the legislation and who may wish to apply for VAD.

360. Prisoners at the end of their life can be placed in specialist accommodation (under escort or Release on Temporary Licence) or be released on compassionate grounds with approval from the relevant Secretary of State. In the 12 months to December 2024, there were 192 deaths in custody due to natural causes, 110 of which occurred in hospitals, hospices or nursing homes[196] [197]. Between 2010 - 2023, there were an average of 10 early releases on compassionate grounds per year[198].

361. Whilst this IA is unable to accurately estimate the number of prisoners who would seek to access VAD, it is notable that the number of older prisoners has more than doubled since 2009 (believed to be caused by a combination of longer sentences, the prosecution of historical sex offences, and ageing in the wider population). This is forecast to increase over the next 5 years[199].

362. Costs to implement the Bill for HMPPS could involve escorting individuals between prisons and the health service, training costs for staff and putting procedures in place to implement the legislation. It has not been possible to monetise the costs of this for this IA.

16.2 - Changes to the Criminal Law

363. The Bill would provide that where a person provides assistance to a person to end their own life in accordance with the Bill; performs any other function under and in accordance with the Bill; or assists a person seeking to end their own life in accordance with the Bill and in connection with the doing of anything under the Bill, they do not commit a criminal offence, including the offence of encouraging or assisting suicide. The Bill would also create a defence to the offence of encouraging or assisting suicide in cases where a person reasonably believes they were acting in accordance with the Bill and took all reasonable precautions and exercised all due diligence to avoid committing

[196] Ministry of Justice and HM Prison & Probation Service (2025), Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to December 2024 Assaults and Self-harm to September 2024 - GOV.UK (viewed in March 2025)

[197] Ministry of Justice and HM Prison & Probation Service (2025), Safety in custody statistics - GOV.UK (viewed in March 2025)

[198] Ministry of Justice (2024), Written questions and answers - Written questions, answers and statements - UK Parliament (viewed in March 2025)

[199] House of Commons Justice Committee (2020), Ageing prison population - Committees - UK Parliament (viewed in March 2025)

the offence. However, it is not possible to determine how many historic recorded cases would have been captured under this Bill.

Impacts on the Police

364. Since April 2013, there have been an average of 37 police recorded crimes per year for the offence of encouraging or assisting suicide under the Suicide Act 1961.

Table 54 Police recorded crime for encouraging or assisting suicide from year ending March 2013 to year ending June 2024[200]

Financial Year	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Aiding suicide	11	19	32	29	26	37	48	73	49	51	52	20

365. Given the low levels of police recorded crime for encouraging or assisting suicide it is assumed there would be a minor reduction in police time spent on these investigations by decriminalising the offence for individuals who are compliant with this Bill.

Impacts on the Crown Prosecution Service (CPS)

366. According to the CPS[201]: "From 1 April 2009 up to 31 March 2024, our manual records indicate there have been 187 cases referred to the CPS by the police that have been recorded as assisted suicide. Of these 187 cases 127 were not proceeded with by the CPS and 36 cases have been withdrawn by the police. There are currently six ongoing cases. Four cases of encouraging or assisting suicide have been successfully prosecuted. One case of assisted suicide was charged and acquitted after trial in May 2015 and eight cases were referred onwards for prosecution for homicide or other serious crime."

367. As set out in Table 55 there are five cases with an unknown outcome; excluding these and the six ongoing cases, there have been 176 cases over the past 15 years with a known outcome.

[200] Home Office (2025), Police recorded crime and outcomes open data tables - GOV.UK (viewed in January 2025)

[201] Crown Prosecution Service (2024), Assisted Suicide | The Crown Prosecution Service (viewed in March 2025)

Table 55 CPS Assisted Suicide Cases from 1st April 2009 – 31st March 2024 [201]

Type	Number
Cases referred to Crown Prosecution Service	187
Cases not proceeded	127
Cases withdrawn by police	36
Cases ongoing	6
Cases successfully prosecuted	4
Cases acquitted after trial	1
Cases referred onwards for homicide or more serious crime	8
Unknown Outcome	5

368. Over the past 15 years, 92% of cases have not been proceeded by the CPS or been withdrawn by the police (see Table 56). The remaining 8% have been brought to trial or referred on for a more serious crime.

369. Averaging this data over the 15 years suggests that the CPS has approximately 12 cases referred to it each year by the police. Of these, 11 are not proceeded and the remaining case would either be referred onward for a more serious offence or be brought to trial.

Table 56 CPS Encouraging or Assisting Suicide Cases with a known outcome from 1st April 2009 – 31st March 2024[202]

Cases	No. of Cases	% of Cases
Cases referred to CPS	176	100%
Cases not proceeded	127	72%
Cases withdrawn by police	36	20%
Cases successfully prosecuted	4	2%
Cases acquitted after trial	1	1%
Cases referred onwards for homicide or more serious crime	8	5%

370. These figures demonstrate that encouraging or assisting suicide is rarely prosecuted by the CPS and changing the criminal law for individuals who are compliant with the Bill would have negligible time reductions for the CPS.

[202] Crown Prosecution Service (2024), Assisted Suicide | The Crown Prosecution Service (viewed in March 2025)

Impact on Ministry of Justice (including HMCTS, the Legal Aid Agency and HMPPS)

371. Between 2010-2023, eight individuals were proceeded against for encouraging or assisting suicide (as the principal offence). Five[203] of these individuals were convicted and sentenced[204], and of those sentenced: 1 received a conditional discharge in 2010; 1 received a suspended sentence in 2017; 3 have been sentenced to custody in 2013, 2018 and 2021 respectively. Their custodial sentence lengths were not available.

372. It is not possible to estimate how many of these cases would have been captured by this Bill. However, given the low volumes for this offence, it is reasonable to assume any cost reductions from changing the criminal law would be negligible for the Ministry of Justice or its agencies.

New criminal offences for dishonesty, coercion or pressure and falsification or destruction of documentation

373. The Bill creates several criminal offences which could impact on the justice system.

374. Prosecutions for encouraging or assisting suicide must pass the CPS's evidential stage and public interest stage to be brought forward. 'The DPP [Director of Public Prosecutions] will only consent to a prosecution for an offence of encouraging or assisting suicide in a case where the full code is met'[205].

375. Where there is sufficient evidence to justify a prosecution, prosecutors must then determine whether a prosecution is required in the public interest.

376. According to the CPS[205] a prosecution under the Suicide Act 1961 is more likely if (among other factors):

376.1. 'the victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide';

376.2. 'the victim had not reached a voluntary, clear, settled and informed decision to commit suicide';

376.3. 'the suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim';

376.4. 'the suspect pressured the victim to commit suicide';

376.5. 'the suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide';

[203] There is discrepancy between the CPS statistics quoted in table 56 and the Criminal Justice Quarterly Statistics (4 successful prosecutions to 5 convictions). It is assumed the missing conviction is labelled as a case with an 'unknown outcome' in the CPS data. However, the impact is immaterial for the analysis.

[204] Ministry of Justice (2024), Criminal Justice System statistics quarterly: June 2024 - GOV.UK (viewed in March 2025)

[205] Crown Prosecution Service (2014), Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide | The Crown Prosecution Service (viewed in March 2025)

377. Based on this information, the CPS appears more likely to prosecute an individual for encouraging or assisting suicide where there has been some form of dishonesty, coercion, or pressure. Therefore, it is assumed that any individuals who would be prosecuted and convicted for the new offences in Clauses 34, 35 and 36 would have been prosecuted under the existing offence of encouraging or assisting suicide in the Suicide Act (1961) which carries a maximum penalty of up to 14 years imprisonment.

378. There is a risk that reporting of coercion or dishonesty may rise under a new regime. However, given the low levels of prosecutions and convictions in the past 15 years, the risk of this occurring is assumed to be low.

379. In combination with prosecution guidance for the existing offence of assisted suicide, it is assumed these new offences would impose negligible costs on the police, CPS, Ministry of Justice and its agencies.

16.3 - Civil Liability

380. The legislation expressly provides that if the due process in the legislation is followed there would be immunity from civil suit (Clause 33).

16.4 - Impacts on death certification and registration

381. According to the Bill as amended in the House of Commons, the scrutiny and certification of assisted deaths would align with the existing process for natural deaths. As the deceased person would have been expected to die from the natural progression of the terminal disease within six months in any event, there would be no significant additional resource impact for Attending Practitioners and Medical Examiners arising from the Bill's death certification provisions. However, there would be resource implications in terms of the preparation and delivery of training and guidance.

382. It would be open to anyone, including medical practitioners, to report an assisted death to the coroner if they have concerns that it was not carried out in accordance with the provisions of the Bill (or for any other reason). As the projected number of any assisted deaths is expected to be small (particularly in the early years of the scheme) and it would be expected that only a small proportion would be referred to the coroner for investigation, the additional resource burden for coroners would be unlikely to be significant, notwithstanding that training and guidance would need to be prepared and delivered.

383. Changes might be needed, in the context of assisted deaths, to the processes and mechanisms by which the information required for death certification and registration is collected should this Bill pass.

17 - Impact on businesses, including small and micro businesses

384. The estimated impacts of the VAD service on social care organisations are detailed in the 'Social care' section.[206] Many of these care organisations are small or micro businesses. It is estimated that the total impact on care home sector profit would be between £22.5k and £653k in Year 1 (which is half a year) and between £143k and £4.61m in Year 10. It is estimated that the total impact on domiciliary care sector profit would be between £8.25k and £130k in Year 1 (which is half a year) and between £52.5k and £918k in Year 10. All estimates are in 2025/26 prices. The economic impacts of VAD on social care are estimated to be small compared to the sector's turnover and profits: while the number of assisted deaths relative to the number of social care providers will mean that impacts are not felt evenly from business to business, the scale of impact on smaller and micro businesses is still likely to be limited.

385. Life insurance businesses would need to develop clear guidelines, practice standards and new policy terms to avoid disputes, challenges and regulatory clashes. It is expected there would be minimal impacts for these businesses.

386. According to the Bill as amended in the House of Commons, the deceased person would be expected to die from the natural progression of the terminal disease within six months in any event. If death registrations were to take the same amount of time for assisted deaths as for a natural death, the impact on funeral directors is expected to be minimal. However, were there to be delays to a death registration for an assisted death this may impact upon mortuary capacity, although these impacts are likely to be small as assisted deaths typically account for less than 1% of deaths in comparable jurisdictions.

387. The Bill does not state that VAD service provision must be through the NHS, and therefore it is possible that registered health and care providers in the private sector (non-NHS) could be involved in delivering VAD services. The extent of this impact is not known. These providers, as well as the NHS, would be prohibited from advertising VAD services, with some possible exceptions, such as the provision of certain information to users or providers of services.[207] It is unclear whether this would limit the number of people who seek an assisted death through private providers.

18 - Potential trade implications of measure

388. No potential trade implications are anticipated from the assisted dying policy.

19 - Equality Impact Assessment (EQIA)

389. In parallel to this Impact Assessment, Government has published an Equality Impact Assessment (EQIA) which assesses potential impacts of the policy on people who share

[206] See 'Version control table' at the end of this document. Estimated proportion of assisted deaths occurring under the high scenario in Year 1 corrected from 0.13% to 0.11%; all values derived from this have also been updated.

[207] See 'Version control table' at the end of this document. In v1.2, new text added to paragraph 387 to reflect new clause on advertising.

the 9 protected characteristics set out in Section 4 of the Equality Act 2010, plus 3 additional dimensions (socio-economic background, geography, and mental health).

20 - Implementation considerations

20.1 - Summary

390. HM Treasury Green Book guidance recommends that risks relating to the design, creation, implementation and operation of policies are considered as part of both the appraisal and evaluation process. The Government is neutral on the policy of assisted dying and the passage of this Bill. While a final decision on the passage of this Bill rests with Parliament, the Government is considering potential implementation requirements to ensure that, should the Bill pass, an appropriate delivery, monitoring and evaluation plan can be formulated.

391. The question of how much time is required to bring all provisions into force from passage of the Bill is complex. However, the Bill sets a 'back-stop' for England of four years; meaning that any provisions not fully brought into force within four years of Royal Assent would come into force.

392. In this section, we set out some key considerations for implementation. Where possible, reference has been made to implementation reviews and evidence from other jurisdictions. However, differences in public health systems and VAD service procedures and processes, limit comparability.

20.2 - Key considerations

Workforce and training

393. The size and distribution of the workforce responsible for delivering VAD services is uncertain. The Bill does not specify where in England and Wales VAD services must be delivered, and the training, qualification, and experiences required of those responsible for delivering VAD services are to be specified through future regulations. Time would be needed to develop the content of these regulations with relevant stakeholders (including regulators responsible for setting professional standards independently of government), lay affirmative regulations, design the training, and deliver the training.

394. The Bill provides for clinicians to opt out of participating in providing VAD services. There is a high degree of uncertainty around the level of opt out in England and Wales. Surveys conducted by Royal Colleges and professional bodies suggest that this could range from 35% to 76% for specific groups of staff.[208] Consideration would need to be given to the impact of a high level of opt out on the workability of a national service model (including equity of access), as well as the impact of shifting resources from one area of the health and care system to another.

[208] British Medical Association (2020), Surveys of Palliative Medicine Clinicians' views about Assisted Dying (2015) (viewed in March 2025)

Oversight, regulation, and data

395. To enable monitoring and reporting as set out in Clauses 47 to 50 of the Bill, a national data strategy for England and Wales would need to be developed. This would need to include, for example: what data and insights are to be collected (including in relation to protected and other key characteristics), who is responsible for collecting it, how it is to be reported and collated, whether this would be through existing or new IT systems (or a combination of both), the interoperability of these systems, compliance with data protection legislation and data sharing agreements, compliance with the protections and safeguards set out in the Bill, and associated resourcing and cost implications.

396. The level of oversight and regulation varies across jurisdictions, which may impact time from legalisation of VAD service provision to implementation. For example, the law in Oregon does not include any oversight or regulation that is distinct from what is done for other medical care[209]. The Oregon Health Authority (OHA) is responsible for keeping track of data on participation and issuing an annual report. OHA does not investigate whether patients met the eligibility criteria, nor how their diagnosis, prognosis, and treatment options were determined. In addition, once a prescription has been dispensed, the person may hold on to the approved substances even if they choose not to self-administer, and a physician does not need to be present. This means that it is not possible to determine the number of people coming forward to access the VAD service, and for some people it is not known whether their death was due to self-administering the approved substance or other causes. If any instances of non-compliance are found in the information received by OHA, it is reported to the Oregon Medical Board for further investigation.

Approved substances

397. The Bill (Clause 27) requires the Secretary of State to make regulations specifying the approved substance(s) for the purposes of assisted dying. Potential substances and combinations thereof would need to be identified, discussed and compatibility ensured. The Secretary of State is also required to make regulations which make provision about (a) the supply or offer for supply, or administration, of approved substances; (b) the transportation, storage, handling and disposal of approved substances; and (c) record-keeping in relation to approved substances (see Clause 37). As detailed in the 'Approved Substance' section, there is evidence from international jurisdictions, such as Oregon and Canada, that certain medications can lead to prolonged deaths and unpleasant side effects which should be considered[210]. Moreover, certain suppliers may not want their medication to be used for assisted dying purposes. This is a risk that has not been formally assessed.

[209] Oregon Health Authority (2022), Oregon Health Authority : Frequently Asked Questions : Death with Dignity Act : State of Oregon (viewed in March 2025)
[210] Worthington, A., Finlay, I. and Regnard, C. (2022), Efficacy and safety of drugs used for 'assisted dying' - PMC

Timelines

398. As set out in Annex A, VAD services vary considerably across jurisdictions, both in terms of who can access them and how they are delivered. While a small number of VAD services have been operational for decades (for example, in Switzerland and Oregon), some have only been operational for a couple of years (for example, in New South Wales and New Zealand). This, together with differences in oversight and reporting requirements, means that evidence on learning from pre to post implementation is inconsistent.

399. The amount of time taken in other jurisdictions to design, set-up and fully implement VAD services also differs. The amount of time required will be dependent on a range of factors, including where the 'starting' point is observed. For example:

399.1. in Oregon (USA): 3 years from enactment (in November 1994) to implementation (in October 1997). There was a legal challenge and corresponding injunction that may have prolonged implementation.

399.2. in Victoria (Australia): 3 years from an Inquiry into End-of-Life Choices (in June 2016) or 18 months from enactment (in November 2017) to implementation (in June 2019)

400. Across the 10 jurisdictions that are comparable to the Bill in terms of eligibility criteria, none include a three-stage approvals process with a multidisciplinary panel. The Bill goes further than some other jurisdictions in terms of oversight, regulation, protections and safeguards, and as such the time taken to fully operationalise VAD services is not directly comparable.

21 - Monitoring and Evaluation

21.1 - Summary

401. There are several provisions for monitoring and evaluation in the Bill. **Any costs associated with monitoring and evaluation, including new data collections, have not been quantified at this stage**.

402. Clause 47 of the Bill states that after the end of each reporting period, the Secretary of State must prepare, publish and lay before Parliament a report about:

402.1. Progress made in that period in connection with the implementation of the Bill, and

402.2. The Secretary of State's plans for implementing the Bill in subsequent reporting periods (including in the expected timetable for implementation)

403. Reporting periods are the period of one year beginning with when the Bill, should it be passed, is implemented and each subsequent period of six months (the last reporting period).

404. For the first reporting period, the report must set out an assessment of the state of health services to persons with palliative and end of life care needs and the implications of the Bill on these services.

405. This report must include an assessment of the availability, quality and distribution of appropriate health services to persons with palliative and end of life care needs[211], including:

405.1. pain and symptom management;

405.2. psychological support for those persons and their families; and

405.3. information about palliative care and how to access it.

406. Clause 49 of the Bill sets out that the Voluntary Assisted Dying Commissioner is required to:

406.1. monitor the operation of the Bill;

406.2. investigate and report to the Secretary of State or, in the case of Wales, the Welsh Ministers, on matters relating to the Bill which are referred for investigation; and

406.3. submit an annual report to the Secretary of State or, in Wales, the Welsh Ministers on the operation of the Bill.

[211] See 'Version control table' at the end of this document. In v1.2, new text added at paragraph 405 to reflect new clause on assessment of palliative and end of life care services.

407. Clause 50 requires that the Secretary of State must review the operation of the Bill and prepare a report on that review, and this review must take place at least 5, but not more than 6, years after the passing of the Bill. The report must be laid before Parliament, and must, in particular, set out:

407.1. the extent to which the Bill has successfully met its aim of allowing adults who are terminally ill, subject to safeguards and protections, to request and be provided with assistance to end their own lives;

407.2. an assessment of the availability, quality and distribution of appropriate health services to persons with palliative care needs, including – Pain and symptom management; Psychological support for those persons and their families; Information about palliative care and how to access it;

407.3. an assessment of the impact of this Bill on persons with learning disabilities, including any concerns about the operation of this Bill in relation to such persons.

407.4. any concerns with the operation of this Bill which have been raised; and

407.5. the Secretary of State's response to any such concerns, including any recommendations for changes to codes of practice, guidance or any enactment (including this Bill).

408. Clause 48 states that the Commissioner must, within six months of being appointed, appoint a Disability Advisory Board to advise on the implementation and impact of this Bill in its operation on disabled people. Within six months, the Advisory Board must report to the Secretary of State and the Commissioner to advise on the implementation of the Bill and then annually thereafter report on the impact of the Bill's operation on disabled people.

21.2. Future considerations

409. Government would develop more detailed monitoring and evaluation plans if the Bill passes. These plans would build on the provisions made in the Bill and seek to address known evidence gaps.

410. As part of this planning, existing data collections would need to be reviewed to assess to what extent monitoring and evaluation could be accommodated by current data collections and what additional data would need to be collected. Should the Bill be passed, Government would ensure adequate baseline data is captured to facilitate evaluations as part of the 5-year review, such as current palliative and end-of-life care experiences. The following can act as an example for future evaluation and monitoring plans.

411. Throughout the assisted dying process, data would be collected at various points and should be available for reporting and evaluation subject to sufficient data quality. These data sources are the first and second declaration (and if these are cancelled at any point), medical practitioner's statements (from consultations), certificates of eligibility, letters of refusal and final statements.

412. It is possible that, along with this data, more may need to be collected**. Monitoring questions could include but would not be limited to**:

412.1. How many people are accessing assisted dying at each stage of the process?

412.2. What are the characteristics of those requesting assisted dying?

412.3. What are the outcomes for people who do not proceed with assisted dying (due to withdrawal or unassisted death)?

412.4. What are the key procedural and clinical details of assisted deaths?

412.5. How is the assisted dying process being implemented by healthcare professionals?

413. Should the Bill pass, the Department of Health and Social Care would work with stakeholders to ensure relevant data is collected and available for monitoring and evaluation, building on the duties outlined in the Bill as amended in the House of Commons.

414. This data collection would help assess the legislation's impact during implementation and for the five-year review.

415. Should the Bill pass, it would be important to undertake a **process evaluation**. This would be needed to understand how terminally ill people, registered medical practitioners, and other stakeholders have interacted with the Bill and whether there have been any unforeseen barriers. This would aim to answer questions such as:

415.1. Have assisted dying services been implemented as intended?

415.2. Are there any barriers to assisted dying services?

415.3. What areas of assisted dying services are working more or less well, and why?

416. An **impact evaluation** can be part of or build on the five-year review. This would assess whether the original objectives of the Bill have been met and would analyse the impacts of the Bill on family and friends of the deceased, terminally ill adults, health and care professionals, the judiciary system and the healthcare system as a whole. This impact evaluation could aim to address questions such as:

416.1. Have assisted dying services achieved the expected outcomes and to what extent?

416.2. Have assisted dying services resulted in any unintended outcomes?

416.3. To what extent have different populations been impacted by the Bill and in what way?

417. The guidance provided here is based on the Bill as amended in the House of Commons, and procedures followed in other international jurisdictions with similar assisted dying provisions.

Annex A International context: Jurisdictions with an operational assisted dying service

418. This annex contains three tables. The first provides an overview of the eligibility criteria used in other jurisdictions with an operational assisted dying service and a summary of any key changes to the service over time. The other two tables set out the underlying data on the number of assisted deaths and total number of deaths in each jurisdiction that is comparable to the Bill in terms of eligibility criteria.

Table 57 Information on other jurisdictions with an operational assisted dying service[212] [213] [214]

Jurisdiction ("*" if comparable to the Bill in terms of eligibility criteria)	First year available	Legal basis: terminal diagnosis	Time to live (from terminal diagnosis)	Legal basis: intolerable suffering	Law extends to psychiatric conditions	Law extends to minors	Limited to citizens/ residents	Self-administer substance	Physician can administer substance	Description of key changes to legislation over time
Austria	2022	Not established	Not established	Yes	No	No	Yes	Yes	No	None
Belgium	2002	Yes	Not established	Yes	Yes	Yes	No	Yes	Yes	2014: amendment to include children
***California (USA)**	2016	Yes	6 months	No	No	No	Yes	Yes	No	2018: amendment to "prohibit a person whose actions are compliant with the ELO Act from being prosecuted for deliberately aiding, advising, or encouraging suicide." 2021: amendment to eliminate barriers to access
Canada	2016	Yes	Not established	Yes	No	No	Yes	Yes	Yes	2020: introduced Bill c-7 to remove the "reasonably foreseeable death" requirement expanding access to people with serious disabilities or chronic illness, even if not terminally ill
***Colorado (USA)**	2016	Yes	6 months	No	No	No	Yes	Yes	No	2024: amendments aimed at improving the accessibility and efficiency of the physician-assisted dying process (including advanced nurse practitioners as evaluators and prescribers, reducing the waiting period and allowing providers to waive the waiting period)
***Hawaii (USA)**	2019	Yes	6 months	No	No	No	Yes	Yes	No	2023: amendments to reduce barriers to medical aid (including reducing the mandatory waiting period,

[212] Health and Social Care Committee (2024), Assisted Dying/Assisted Suicide - Health and Social Care Committee (viewed in March 2025)

[213] Death with Dignity (2025), Death with Dignity U.S. Legislative Status State Map (viewed in March 2025)

[214] Life Issues Institute (2024), Euthanasia and Assisted Suicide Global Timeline - Life Issues Institute (viewed in March 2025)

Jurisdiction ("*" if comparable to the Bill in terms of eligibility criteria)	First year available	Legal basis: terminal diagnosis	Time to live (from terminal diagnosis)	Legal basis: intolerable suffering	Law extends to psychiatric conditions	Law extends to minors	Limited to citizens/ residents	Self-administer substance	Physician can administer substance	Description of key changes to legislation over time
										allowing the attending provider to waive the waiting period and allowing advanced nurse practitioners to practice as both the attending and consulting providers)
Luxembourg	2009	Yes	Not established	Yes	No	No	No	Yes	Yes	None
***Maine (USA)**	2019	Yes	6 months	No	No	No	Yes	Yes	No	None
New Jersey (USA)	2019	Yes	6 months (or 12 months for neurodegenerative diseases)	No	No	No	Yes	Yes	No	None
***New Mexico (USA)**	2021	Yes	6 months	No	No	No	Yes	Yes	No	None
New South Wales (Aus)	2023	Yes	6 months (or 12 months for neurodegenerative diseases)	No	No	No	Yes	Yes	Yes	None
***New Zealand**	2021	Yes	6 months	No	No	No	Yes	Yes	Yes	No changes (but discussions continue about broadening the scope to make more people eligible and include mental health justifications)
***Oregon (USA)**	1998	Yes	6 months	No	No	No	No	Yes	No	2019: amendment to make patients exempt from any waiting period that exceeds their life expectancy 2023: residency requirement lifted meaning non-residents can receive assistance
Portugal	2023	Yes	Not established	Yes	No	No	Yes	Yes	Yes	None

Jurisdiction ("*" if comparable to the Bill in terms of eligibility criteria)	First year available	Legal basis: terminal diagnosis	Time to live (from terminal diagnosis)	Legal basis: intolerable suffering	Law extends to psychiatric conditions	Law extends to minors	Limited to citizens/ residents	Self-administer substance	Physician can administer substance	Description of key changes to legislation over time
Queensland (Aus)	2023	Yes	12 months	No	No	No	Yes	Yes	Yes	None
South Australia (Aus)	2023	Yes	6 months (or 12 months for neurodegenerative diseases)	No	No	No	Yes	Yes	Yes	None
Spain	2021	Not established	Not established	Yes	Yes	No	Not established	Yes	Yes	None
Switzerland	1942	Yes	Not established	Yes	Yes	Yes	No	Yes	No	2006: Swiss Federal Supreme Court ruled that people with severe mental illness could be eligible 2014: it was decided that elderly people who wished to die could receive assistance without any severe illness
Tasmania (Aus)	2022	Yes	6 months (or 12 months for neurodegenerative diseases)	No	No	No	Yes	Yes	Yes	None
***The District of Columbia (USA)**	2017	Yes	6 months	No	No	No	Yes	Yes	No	None
The Netherlands	2002	Yes	Not established	Yes	Yes	Yes	No	Yes	Yes	2004: protocol introduced to allow euthanasia for infants 2020: Dutch Supreme Court ruled that assistance was permissible for patients with advanced dementia if they had an advanced request 2023: euthanasia was made legal for children aged 1-12.

Jurisdiction ("*" if comparable to the Bill in terms of eligibility criteria)	First year available	Legal basis: terminal diagnosis	Time to live (from terminal diagnosis)	Legal basis: intolerable suffering	Law extends to psychiatric conditions	Law extends to minors	Limited to citizens/ residents	Self-administer substance	Physician can administer substance	Description of key changes to legislation over time
***Vermont (USA)**	2013	Yes	6 months	No	No	No	No	Yes	No	2022: amendment to permit patients to speak with prescribing physicians via telemedicine and eliminate the final 48-hour waiting period. 2023: expanded access to non-residents, allowing terminally ill adults who live outside of Vermont to consult with Vermont-licensed physicians about receiving a prescription to end life.
Victoria (Aus)	2019	Yes	6 months (or 12 months for neurodegenerative diseases)	No	No	No	Yes	Yes	Yes	None
***Washington (USA)**	2008	Yes	6 months	No	No	No	Yes	Yes	No	2023: amendment to increase access (including changes to qualified medical providers, reducing the waiting period and healthcare systems and hospices having to post their aid-in-dying policies)
Western Australia (Aus)	2021	Yes	6 months (or 12 months for neurodegenerative diseases)	No	No	No	Yes	Yes	Yes	None

Table 58 Total number of deaths in comparable jurisdictions, by year assisted dying service was implemented

Jurisdiction	Washington (USA)[215]	California (USA)[216]	New Zealand[217]	Oregon (USA)[218]	Hawaii (USA)[219]	District of Columbia (USA)[220]	Maine (USA)[221]	Vermont (USA)[222]
Implementation year	2009	2016	2021	1997	2019	2017	2019	2013
First full year of data[223]	2010	2017	2022	1998	2019	2018	2020	2014
Year 1	48,146	269,409	38,574	29,346	11,736	5,008	15,737	5,627
Year 2	49,385	270,129	37,884	29,356	12,027	4,927	17,270	5,919
Year 3	50,056	270,952	37,941	29,541	12,877	6,198	17,361	5,908
Year 4	51,038	320,893	NA	30,128	13,307	5,833	16,741	6,010
Year 5	52,034	334,817	NA	31,082	12,751	5,385	NA	6,027
Year 6	54,513	315,676	NA	30,813	12,687	4,916	NA	5,956
Year 7	54,748	297,724	NA	30,201	NA	NA	NA	6,461
Year 8	57,012	NA	NA	30,854	NA	NA	NA	6,880
Year 9	56,913	NA	NA	31,304	NA	NA	NA	6,972
Year 10	58,297	NA	NA	31,433	NA	NA	NA	6,771
Year 11	63,177	NA	NA	32,020	NA	NA	NA	NA
Year 12	68,749	NA	NA	31,547	NA	NA	NA	NA
Year 13	69,116	NA	NA	31,899	NA	NA	NA	NA
Year 14	NA	NA	NA	32,731	NA	NA	NA	NA
Year 15	NA	NA	NA	32,475	NA	NA	NA	NA

[215] Washington State Department of Health, Death with Dignity Data | Washington State Department of Health (viewed in March 2025)

[216] California Department for Public Health, RAB End of Life Option Act (viewed in March 2025)

[217] Health New Zealand, Assisted Dying Service data and reporting – Health New Zealand | Te Whatu Ora (viewed in March 2025)

[218] Oregon Health Authority, Oregon Health Authority : Death with Dignity Act Annual Reports : Death with Dignity Act : State of Oregon (viewed in March 2025). As stated in this report (p.7), 2023 is the most recent year for which final death data are available, and as such Year 27 for Oregon has been added but reported as "Not published" in this table.

[219] Hawaii Department of Health (2024), 2023-OCOCA-Annual-Report-1.pdf (viewed in March 2025)

[220] DC Health, Death with Dignity Annual Reports | doh (viewed in March 2025)

[221] Maine Death with Dignity, State Reports - Maine Death with Dignity (viewed in March 2025)

[222] Vermont Department of Health, Patient Choice & Control at End of Life | Vermont Department of Health (viewed in March 2025)

[223] A full year of data may be a calendar year or financial year, depending on the jurisdiction's protocols.

Jurisdiction	Washington (USA)[215]	California (USA)[216]	New Zealand[217]	Oregon (USA)[218]	Hawaii (USA)[219]	District of Columbia (USA)[220]	Maine (USA)[221]	Vermont (USA)[222]
Year 16	NA	NA	NA	33,931	NA	NA	NA	NA
Year 17	NA	NA	NA	34,160	NA	NA	NA	NA
Year 18	NA	NA	NA	35,709	NA	NA	NA	NA
Year 19	NA	NA	NA	35,799	NA	NA	NA	NA
Year 20	NA	NA	NA	36,640	NA	NA	NA	NA
Year 21	NA	NA	NA	36,191	NA	NA	NA	NA
Year 22	NA	NA	NA	37,397	NA	NA	NA	NA
Year 23	NA	NA	NA	40,226	NA	NA	NA	NA
Year 24	NA	NA	NA	45,028	NA	NA	NA	NA
Year 25	NA	NA	NA	44,593	NA	NA	NA	NA
Year 26	NA	NA	NA	42,592	NA	NA	NA	NA
Year 27	NA	NA	NA	Not published	NA	NA	NA	NA

Table 59 Total number of assisted deaths in comparable jurisdictions, by year assisted dying service was implemented

Jurisdiction	Washington (USA)[224]	California (USA)[225]	New Zealand[226]	Oregon (USA)[227]	Hawaii (USA)[228]	District of Columbia (USA)[229]	Maine (USA)[230]	Vermont (USA)[231]
Implementation year	2009	2016	2021	1997	2019	2017	2019	2013
First full year of data [232]	2010	2017	2022	1998	2019	2018	2020	2014
Year 1	51	409	328	16	15	2	30	29
Year 2	70	429	344	27	25	5	46	
Year 3	83	504	NA	27	29	2	40	
Year 4	119	497	NA	21	37	6	53	
Year 5	126	523	NA	38	51	8	NA	28
Year 6	166	890	NA	42	38	NA	NA	
Year 7	192	884	NA	37	NA	NA	NA	17
Year 8	164	NA	NA	38	NA	NA	NA	
Year 9	203	NA	NA	46	NA	NA	NA	72
Year 10	225	NA	NA	49	NA	NA	NA	
Year 11	252	NA	NA	60	NA	NA	NA	NA
Year 12	291	NA	NA	59	NA	NA	NA	NA
Year 13	363	NA	NA	65	NA	NA	NA	NA
Year 14	427	NA	NA	71	NA	NA	NA	NA
Year 15	NA	NA	NA	85	NA	NA	NA	NA

[224] Washington State Department of Health, Death with Dignity Data | Washington State Department of Health (viewed in March 2025)

[225] California Department for Public Health, RAB End of Life Option Act (viewed in March 2025)

[226] Health New Zealand, Assisted Dying Service data and reporting – Health New Zealand | Te Whatu Ora (viewed in March 2025)

[227] Oregon Health Authority, Oregon Health Authority : Death with Dignity Act Annual Reports : Death with Dignity Act : State of Oregon (viewed in March 2025)

[228] Hawaii Department of Health (2024), 2023-OCOCA-Annual-Report-1.pdf (viewed in March 2025)

[229] DC Health, Death with Dignity Annual Reports | doh (viewed in March 2025)

[230] Maine Death with Dignity, State Reports - Maine Death with Dignity (viewed in March 2025)

[231] Vermont Department of Health, Patient Choice & Control at End of Life | Vermont Department of Health (viewed in March 2025). Vermont did not publish reports on a regular, annual basis.

[232] A full year of data may be a calendar year or financial year, depending on the jurisdiction's protocols.

Jurisdiction	Washington (USA)[224]	California (USA)[225]	New Zealand[226]	Oregon (USA)[227]	Hawaii (USA)[228]	District of Columbia (USA)[229]	Maine (USA)[230]	Vermont (USA)[231]
Year 16	NA	NA	NA	73	NA	NA	NA	NA
Year 17	NA	NA	NA	105	NA	NA	NA	NA
Year 18	NA	NA	NA	135	NA	NA	NA	NA
Year 19	NA	NA	NA	139	NA	NA	NA	NA
Year 20	NA	NA	NA	158	NA	NA	NA	NA
Year 21	NA	NA	NA	178	NA	NA	NA	NA
Year 22	NA	NA	NA	193	NA	NA	NA	NA
Year 23	NA	NA	NA	259	NA	NA	NA	NA
Year 24	NA	NA	NA	255	NA	NA	NA	NA
Year 25	NA	NA	NA	304	NA	NA	NA	NA
Year 26	NA	NA	NA	367	NA	NA	NA	NA
Year 27	NA	NA	NA	376	NA	NA	NA	NA

Annex B Training cost sensitivities[233]

419. The sensitivity analysis set out in this Annex pertain to the main IA section 'Information provision and training'. Please refer to this section for detailed assumptions.

B1 - Variation to assume nurses receive Tier 2 training

420. It is assumed in this IA that nurses would initially receive Tier 1 training only. The two tables below show the impact of including nurses in Tier 2 training on the total cost.

Table 60 Estimated cost of training in Year 1, England and Wales, (values are based on previously rounded figures) [234]

	Year 1 (half year)			
Scenario	No opt-out	33% opt out	50% opt out	90% opt out
Low	£32.6 m	£21.9 m	£16.4 m	£3.40 m
Central	£32.7 m	£22.0 m	£16.5 m	£3.52 m
High	£33.1 m	£22.4 m	£16.8 m	£3.86 m

Table 61 Estimated cost training in Year 10, England and Wales, (values are based on previously rounded figures) [234]

	Year 10			
Scenario	No opt-out	33% opt out	50% opt out	90% opt out
Low	£17.2 m	£11.9 m	£9.11 m	£2.61 m
Central	£18.3 m	£12.9 m	£10.2 m	£3.70 m
High	£20.6 m	£15.2 m	£12.4 m	£5.95 m

B2 - Variation to assume GPs receive Tier 2 training

421. It is assumed in this IA that GPs would initially receive Tier 1 training only. The two tables below show the impact of including GPs in Tier 2 training on the total cost.

Table 62 Estimated cost of training in Year 1, England and Wales, (values are based on previously rounded figures) [234]

	Year 1 (half year)			
Scenario	No opt-out	33% opt out	50% opt out	90% opt out
Low	£13.4 m	£9.0 m	£6.8 m	£1.5 m
Central	£13.5 m	£9.1 m	£6.9 m	£1.6 m
High	£13.8 m	£9.5 m	£7.2 m	£1.9 m

[233] See 'Version control table' at the end of this document. In v1.1, the estimated proportion of assisted deaths occurring under the high scenario in Year 1 was corrected from 0.13% to 0.11%; all values derived from this were also updated. In this annex, this included Year 1 high scenario values in Table 60, Table 62, Table 64, Table 65, and associated text. All corrections were carried across to v1.2.

[234] DHSC estimates based on figures found in Table 14, 15 and Table 17

Table 63 Estimated cost training in Year 10, England and Wales, (values are based on previously rounded figures) [235]

	Year 10			
Scenario	No opt-out	33% opt out	50% opt out	90% opt out
Low	£7.6 m	£5.4 m	£4.3 m	£1.6 m
Central	£8.7 m	£6.5 m	£5.4 m	£2.7 m
High	£10.9 m	£8.8 m	£7.6 m	£5.0 m

B3 - Variation to change cohort numbers (impacting Tier 3)

422. It is assumed in this IA that assisted deaths represent 60% of applicants. In the two tables below, we show the impact of assuming assisted deaths represent 33% or 80% of applicants (thus increasing or reducing the number of staff needing to complete Tier 3 training).

Table 64 Estimated cost of training, England and Wales – sensitivity analysis for 33% of applicants proceeding to have an assisted death, (values are based on previously rounded figures) [236]

	Year 1 (half year)				Year 10			
Scenario	No opt-out	33% opt out	50% opt out	90% opt out	No opt-out	33% opt out	50% opt out	90% opt out
Low	£11.0 m	£7.49 m	£5.66 m	£1.36 m	£7.18 m	£5.40 m	£4.49 m	£2.34 m
Central	£11.3 m	£7.71 m	£5.88 m	£1.57 m	£9.15 m	£7.37 m	£6.46 m	£4.31 m
High	£11.9 m	£8.32 m	£6.50 m	£2.19 m	£13.25 m	£11.47 m	£10.56 m	£8.41 m

Table 65 Estimated cost of training, England and Wales – sensitivity analysis for 80% of applicants proceeding to have an assisted death, (values are based on previously rounded figures)[237]

	Year 1 (half year)				Year 10			
Scenario	No opt-out	Assume 33% opt out	Assume 50% opt out	Assume 90% opt out	No opt-out	Assume 33% opt out	Assume 50% opt out	Assume 90% opt out
Low	£10.9 m	£7.32 m	£5.50 m	£1.19 m	£6.12 m	£4.35 m	£3.43 m	£1.28 m
Central	£11.0 m	£7.41 m	£5.58 m	£1.28 m	£6.93 m	£5.16 m	£4.24 m	£2.09 m
High	£11.2 m	£7.67 m	£5.84 m	£1.54 m	£8.63 m	£6.85 m	£5.94 m	£3.78 m

[235] DHSC estimates based on figures found in Tables 14, 15 and 17

[236] DHSC estimates based on figures found in Tables 11, 14, 15 and 17

[237] DHSC estimates based on figures found in Tables 10, 14, 15 and 17

Annex C Health and social care staff time supplementary tables and sensitivity analysis[238]

423. The supplementary tables and sensitivity analysis in this Annex pertain to the main IA section 'Health and social care staff time'. Please refer to this section for description of main assumptions.

C1 - Supplementary tables (England and Wales)

Low cohort scenario

424. The following two tables provide a breakdown of the estimated cost of health and social care staff time for England and Wales, in Year 1 and Year 10, using the **low cohort** scenario.

Table 66 Estimated cost of health and social care staff time, England and Wales, Year 1 (which is half a year), low cohort scenario [239]

Step	Description	Y1 cohort (low)	Costs for people who do not require an advocate or interpreter (95.7% of cohort)	Cost for people who require an independent advocate (2.5% of cohort)	Cost for people who require an interpreter (1.8% of cohort)	Total costs (100% of cohort)
1	Preliminary discussion	273	£31.6k	£2,064	£1,486	£35.2k
2 & 3	First declaration and first doctor's assessment	260	£60.0k	£3,921	£2,823	£66.8k
4	Second doctor's assessment	232	£53.7k	£3,509	£2,526	£59.8k
5	Multidisciplinary panel assessment	205	£126k	£8,224	£5,921	£140k
6	Second declaration	178	£10.3k	£671	£483	£11.4k
7	Dispensing the approved substance	178	£5,565	£145	£105	£5,815
8	Provision of approved substance (remain with person)	164	£37.9k	£2,477	£1,783	£42.2k

[238] See 'Version control table' at the end of this document. In v1.1, the estimated proportion of assisted deaths occurring under the high scenario in Year 1 was corrected from 0.13% to 0.11%; all values derived from this were also updated. In this annex, this included Year 1 high scenario values in Table 68, Table 70, Table 71, Table 72, Table 73, Table 74, Table 76, and associated text. All corrections were carried across to v1.2.

[239] DHSC estimates based on figures found in Table 25 and Table 26

9	Final statement	164	£19.0k	£495	£357	£19.8k
10	Death certification	164	£30.1k	£785	£565	£31.4k

Table 67 Estimated cost of health and social care staff time, England and Wales, Year 10, low cohort scenario [240]

Step	**Description**	**Y10 cohort (low)**	Costs for people who do not require an advocate or interpreter (95.7% of cohort)	Cost for people who require an independent advocate (2.5% of cohort)	Cost for people who require an interpreter (1.8% of cohort)	**Total costs (100% of cohort)**
1	Preliminary discussion	1,737	£201k	£13.1k	£9,451	£224k
2 & 3	First declaration and first doctor's assessment	1,651	£382k	£24.9k	£18.0k	£425k
4	Second doctor's assessment	1,477	£342k	£22.3k	£16.1k	£380k
5	Multidisciplinary panel assessment	1,303	£801k	£52.3k	£37.7k	£891k
6	Second declaration	1,129	£65.3k	£4,266	£3,071	£72.7k
7	Dispensing the approved substance	1,129	£35.4k	£925	£666	£37.0k
8	Provision of approved substance (remain with person)	1,042	£241k	£15.8k	£11.3k	£268k
9	Final statement	1,042	£121k	£3,150	£2,268	£126k
10	Death certification	1,042	£191k	£4,993	£3,595	£200k

[240] DHSC estimates based on figures found in Table 25 and Table 26

High cohort scenario

425. The following two tables provide a breakdown of the estimated cost of health and social care staff time for England and Wales, in Year 1 and Year 10, using the **high cohort** scenario.

Table 68 Estimated cost of health and social care staff time, England and Wales, Year 1 (which is half a year), high cohort scenario [241]

Step	Description	Y1 cohort (high)	Costs for people who do not require an advocate or interpreter (95.7% of cohort)	Cost for people who require an independent advocate (2.5% of cohort)	Cost for people who require an interpreter (1.8% of cohort)	Total costs (100% of cohort)
1	Preliminary discussion	1,078	£125k	£8,144	£5,864	£139k
2 & 3	First declaration and first doctor's assessment	1,024	£237k	£15.5k	£11.1k	£264k
4	Second doctor's assessment	916	£212k	£13.8k	£10.0k	£236k
5	Multidisciplinary panel assessment	808	£497k	£32.4k	£23.4k	£553k
6	Second declaration	701	£40.5k	£2,647	£1,906	£45.1k
7	Dispensing the approved substance	701	£22.0k	£547	£413	£22.9k
8	Provision of approved substance (remain with person)	647	£150k	£9,773	£7,036	£166k
9	Final statement	647	£74.8k	£1,955	£1,407	£78.2k
10	Death certification	647	£119k	£3,098	£2,231	£124k

[241] DHSC estimates based on figures found in Table 25 and Table 26

Table 69 Estimated cost of health and social care staff time, England and Wales, Year 10, high cohort scenario [242]

Step	Description	Y10 cohort (high)	Costs for people who do not require an advocate or interpreter (95.7% of cohort)	Cost for people who require an independent advocate (2.5% of cohort)	Cost for people who require an interpreter (1.8% of cohort)	Total costs (100% of cohort)
1	Preliminary discussion	7,598	£879k	£57.4k	£41.3k	£978k
2 & 3	First declaration and first doctor's assessment	7,218	£1.67 m	£109k	£78.5k	£1.86 m
4	Second doctor's assessment	6,458	£1.49 m	£97.6k	£70.3k	£1.66 m
5	Multidisciplinary panel assessment	5,699	£3.50 m	£229k	£165k	£3.90 m
6	Second declaration	4,939	£286k	£18.7k	£13.4k	£318k
7	Dispensing the approved substance	4,939	£155k	£4,044	£2,911	£162k
8	Provision of approved substance (remain with person)	4,559	£1.05 m	£68.9k	£49.6k	£1.17 m
9	Final statement	4,559	£527k	£13.8k	£9,919	£551k
10	Death certification	4,559	£836k	£21.8k	£15.7k	£873k

[242] DHSC estimates based on figures found in Table 25 and Table 26

C2 - Supplementary tables (England only)

426. The following table provides a breakdown of the estimated size of the cohort by step, for England only.

Table 70 Cohort estimates by step, England only, Y1 (half a year) and Y10 [243]

Step	Description	Year 1 (2029/30, half-year)			Year 10 (2029/30)		
		Low	Central	High	Low	Central	High
1	Preliminary discussion	256	452	1,012	1,632	3,418	7,136
2 & 3	First declaration and first doctor's assessment	244	429	961	1,550	3,247	6,780
4	Second doctor's assessment	218	384	860	1,387	2,905	6,066
5	Multidisciplinary panel assessment	192	339	759	1,224	2,563	5,352
6 & 7	Second declaration, dispensing of approved substance	167	294	658	1,061	2,222	4,639
8, 9 & 10	Provision of approved substance, final statement, and death certification	154	271	607	979	2,051	4,282

427. The following table provides the total estimated cost of health and social care staff time to deliver the VAD service, for England only.

Table 71 Estimated cost of staff time to deliver VAD service, England only, Year 1 (half-year) [244]

Cohort (England only)	Costs for people who do not require an advocate or interpreter (95.7% of cohort)	Cost for people who require an independent advocate (2.5% of cohort)	Cost for people who require an interpreter (1.8% of cohort)	Total costs (100% of cohort)
Low	£351k	£20.9k	£15.1k	£387k
Central	£618k	£36.8k	£26.5k	£682k
High	£1.39 m	£82.6k	£59.5k	£1.53 m

[243] DHSC estimates based on figures found in Annex A and ONS (2025), National population projections (viewed in March 2025)

[244] DHSC estimates based on figures found in Table 21, Table 22 and Table 78

C3 - Supplementary tables (Wales only)

428. The following table provides a breakdown of the estimated size of the cohort by step, for Wales only.

Table 72 Cohort estimates by step, Wales only, Y1 (half a year) and Y10 [245]

Step	Description	Year 1 (2029/30, half-year)			Year 10 (2029/30)		
		Low	Central	High	Low	Central	High
1	Preliminary discussion	17	29	66	106	221	462
2 & 3	First declaration and first doctor's assessment	16	28	63	100	210	439
4	Second doctor's assessment	14	25	56	90	188	392
5	Multidisciplinary panel assessment	13	22	49	79	166	346
6 & 7	Second declaration, dispensing of approved substance	11	19	43	69	144	300
8, 9 & 10	Provision of approved substance, final statement, and death certification	10	18	40	63	133	277

429. The following table provides the total estimated cost of health and social care staff time to deliver the VAD service, for Wales only.

Table 73 Estimated cost of staff time to deliver VAD service, Wales only, Year 1 (half-year) [246]

Cohort (Wales only)	Costs for people who do not require an advocate or interpreter (95.7% of cohort)	Cost for people who require an independent advocate (2.5% of cohort)	Cost for people who require an interpreter (1.8% of cohort)	Total costs (100% of cohort)
Low	£22.9k	£1,363	£982	£25.2k
Central	£40.3k	£2,400	£1,728	£44.4k
High	£90.3k	£5,379	£3,873	£100k

[245] DHSC estimates based on figures found in Annex A and ONS (2025), National population projections (viewed in March 2025)

[246] DHSC estimates based on figures in Table 21, Table 22 and Table 80

C4 - Sensitivity analysis – variation to add additional staff member

430. The two tables below show the costs of an additional nurse attending step 8 to deliver the VAD service.

Table 74 Estimated cost of an additional nurse attending step 8 to deliver VAD service, Year 1 (half-year) England and Wales [247]

Cohort	Total costs (100% of cohort)	Cost of an extra nurse attending Step 8	Total cost (100% of cohort) including the cost of an extra nurse attending Step 8
Low	£412k	£21.5k	£434k
Central	£726k	£37.8k	£764k
High	£1.63 m	£84.8k	£1.71 m

Table 75 Estimated cost of an additional nurse attending step 8 to deliver VAD service, Year 10 England and Wales [247]

Cohort	Total costs (100% of cohort)	Cost of an extra nurse attending Step 8	Total cost (100% of cohort) including the cost of an extra nurse attending Step 8
Low	£2.62 m	£137k	£2.76 m
Central	£5.49 m	£286k	£5.78 m
High	£11.5 m	£598k	£12.1 m

[247] DHSC estimates based on figures found in Table 26

C5 - Sensitivity analysis – variation to increase staff salary or time

431. The two tables below show the total estimated cost of health and social care staff time to deliver the VAD service by:

431.1. salary: the impact of increasing hourly wages to that of a consultant or reducing hourly wages to that of a junior doctor, for the coordinating doctor, independent doctor and psychiatrist (all other costs associated with VAD service remain constant including the proportion of the cohort who need an advocate and interpreter)

431.2. time required: the impact of increasing or reducing the amount of staff time required by 50% (using the same hourly wages as in the main IA)

Table 76 Sensitivity analysis of cost of providing base VAD in Year 1 (half year), England and Wales [248]

		Sensitivity – staff wages		Sensitivity – staff time	
Cohort	**Total costs (100% of cohort)**	**Consultant wages**	**Junior doctor wages**	**50% more time**	**50% less time**
Low	£412k	£619k	£205k	£619k	£206k
Central	£726k	£1.09m	£362k	£1.09m	£363k
High	£1.63 m	£2.44 m	£811k	£2.44 m	£814k

Table 77 Sensitivity analysis of cost of providing base VAD in Year 10, England and Wales [248]

		Sensitivity – staff wages		Sensitivity – staff time	
Cohort	**Total costs (100% of cohort)**	**Consultant wages**	**Junior doctor wages**	**50% more time**	**50% less time**
Low	£2.62 m	£3.94m	£1.31m	£3.93 m	£1.31 m
Central	£5.49 m	£8.25m	£2.74m	£8.24 m	£2.75 m
High	£11.5 m	£17.2m	£5.71m	£17.2 m	£5.74 m

[248] DHSC estimates based on figures found in Table 23 and Table 25

C6 – Sensitivity analysis – varying number of applicants

432. In the main IA, we assume the number of assisted deaths represent 60% of applicants. The following two tables look at the impact of changing this to **33%**.

Table 78 Estimated cost of health and social care staff time, England and Wales, Year 1 (half year), central cohort scenario [249]

Step	Description	Y1 (half year) central cohort	Costs for people who do not require an advocate or interpreter (95.7% of cohort)	Cost for people who require an independent advocate (2.5% of cohort)	Cost for people who require an interpreter (1.8% of cohort)	Total costs (100% of cohort)
1	Preliminary discussion	875	£101k	£6,607	£4,757	£113k
2 & 3	First declaration and first doctor's assessment	743	£172k	£11.2k	£8,087	£191k
4	Second doctor's assessment	612	£142k	£9,250	£6,660	£158k
5	Multidisciplinary panel assessment	525	£322k	£21.1k	£15.2k	£359k
6	Second declaration	394	£22.8k	£1,487	£1,070	£25.3k
7	Dispensing the approved substance	394	£12.3k	£322	£232	£12.9k
8	Provision of approved substance (remain with person)	289	£66.8k	£4,361	£3,140	£74.3k
9	Final statement	289	£33.4k	£872	£628	£34.9k
10	Death certification	289	£52.9k	£1,382	£995	£55.3k

[249] DHSC estimates based on figures found in Table 11 and Table 26

Table 79 Estimated cost of health and social care staff time, England and Wales, Year 10, central cohort scenario [249]

Step	Description	Y10 cohort (central)	Costs for people who do not require an advocate or interpreter (95.7% of cohort)	Cost for people who require an independent advocate (2.5% of cohort)	Cost for people who require an interpreter (1.8% of cohort)	Total costs (100% of cohort)
1	Preliminary discussion	6,617	£765k	£50.0k	£36.0k	£851k
2 & 3	First declaration and first doctor's assessment	5,624	£1.30 m	£85.0k	£61.2k	£1.45 m
4	Second doctor's assessment	4,632	£1.07 m	£70.0k	£50.4k	£1.19 m
5	Multidisciplinary panel assessment	3,970	£2.44 m	£159k	£115k	£2.71 m
6	Second declaration	2,977	£172k	£11.2k	£8,098	£192k
7	Dispensing the approved substance	2,977	£93.3k	£2,438	£1,755	£97.5k
8	Provision of approved substance (remain with person)	2,183	£505k	£33.0k	£23.8k	£562k
9	Final statement	2,183	£253k	£6,598	£4,751	£264k
10	Death certification	2,183	£400k	£10.5k	£7,530	£418k

433. In the main IA, we assume the number of assisted deaths represent 60% of applicants. The following two tables look at the impact of changing this to **80%.**

Table 80 Estimated cost of health and social care staff time, England and Wales, Year 1, central cohort scenario [250]

Step	Description	Y1 cohort (central)	Costs for people who do not require an advocate or interpreter (95.7% of cohort)	Cost for people who require an independent advocate (2.5% of cohort)	Cost for people who require an interpreter (1.8% of cohort)	Total costs (100% of cohort)
1	Preliminary discussion	361	£41.7k	£2,725	£1,962	£46.4k
2 & 3	First declaration and first doctor's assessment	354	£81.8k	£5,342	£3,846	£91.0k
4	Second doctor's assessment	325	£75.1k	£4,906	£3,532	£83.6k
5	Multidisciplinary panel assessment	317	£195k	£12.7k	£9,175	£217k
6	Second declaration	303	£17.5k	£1,145	£824	£19.5k
7	Dispensing the approved substance	303	£9,498	£248	£179	£9,925
8	Provision of approved substance (remain with person)	289	£66.8k	£4,361	£3,140	£74.3k
9	Final statement	289	£33.4k	£872	£628	£34.9k
10	Death certification	289	£52.9k	£1,382	£995	£55.3k

[250] DHSC estimates based on figures found in Table 10 and Table 26

Table 81 Estimated cost of health and social care staff time, England and Wales, Year 10, central cohort scenario [250]

Step	Description	Y10 cohort (central)	Costs for people who do not require an advocate or interpreter (95.7% of cohort)	Cost for people who require an independent advocate (2.5% of cohort)	Cost for people who require an interpreter (1.8% of cohort)	Total costs (100% of cohort)
1	Preliminary discussion	2,729	£316k	£20.6k	£14.8k	£351k
2 & 3	First declaration and first doctor's assessment	2,675	£619k	£40.4k	£29.1k	£688k
4	Second doctor's assessment	2,456	£568k	£37.1k	£26.7k	£632k
5	Multidisciplinary panel assessment	2,402	£1.48 m	£96.4k	£69.4k	£1.64 m
6	Second declaration	2,293	£133k	£8,660	£6,235	£147k
7	Dispensing the approved substance	2,293	£71.9k	£1,877	£1,352	£75.1k
8	Provision of approved substance (remain with person)	2,183	£505k	£33.0k	£23.8k	£562k
9	Final statement	2,183	£253k	£6,598	£4,751	£264k
10	Death certification	2,183	£400k	£10.5k	£7,530	£418k

Annex D Assisted Dying Review Panels Sensitivity

434. The sensitivity analysis in this Annex pertain to the main IA section 'Voluntary Assisted Dying Commissioner and Panels'. Please refer to this section for description of main assumptions.

Table 82 Changing the average time per hearing, England and Wales [251]

	1 hearing per day	2 hearings per day
Scenario	**Average Annual Cost**	
Low	£1.80m	£900k
Central	£3.40m	£1.70m
High	£7.10m	£3.60m

Table 83 Changing the proportion of applications the panel hears, whilst holding the projected number of deaths constant, England and Wales [251]

	60% of applications heard by panel	75% of applications heard by panel	88% of applications heard by panel
Scenario	**Average Annual Cost**		
Low	£1.30m	£900k	£800k
Central	£2.40m	£1.70m	£1.50m
High	£5.20m	£3.60m	£3.10m

For the number of applicants in the sensitivity analysis, refer to the main IA section 'Cohort sensitivity analysis' for an explanation of how the cohort numbers are calculated.

[251] MoJ estimates based on figures found in Table 30 and in Ministry of Justice and Senor Salaries Review Body (2024), Judicial salaries and fees 2024 to 2025 - GOV.UK (viewed in March 2025)

Annex E Healthcare costs at end-of-life [252]

435. This annex contains supplementary tables showing sensitivity analysis for the 'Healthcare costs at end-of-life' section in the IA. Table 85 show the total healthcare spend along with a high scenario and a low scenario to reflect cost fluctuations.

436. Palliative and end-of-life care costs may vary depending on a range of factors. This sensitivity analysis considers scenarios where the total costs of care at end of life are 20% lower and 20% higher. In other jurisdictions, a majority of people who have an assisted death are cancer patients, who may have higher hospital care costs[253]. Therefore, it may be assumed that the 'high' scenario is more likely than the 'low' scenario, although this is uncertain.

Table 84 Estimated palliative and end-of-life care expenditure not required, sensitivity analysis of higher and lower care costs, for 1 month of unutilised care, England and Wales [254]

Implementation Year	Cohort Scenario	Number of deaths	Total healthcare not required (core scenario)	Total healthcare not required (20% lower)	Total healthcare spend not (20% higher)
Year 1 (half-year)	Low	164	£919k	£735k	£1.10m
	Central	289	£1.62m	£1.29m	£1.94m
	High	647	£3.63m	£2.90m	£4.35m
Year 10	Low	1042	£5.84m	£4.68m	£7.01m
	Central	2183	£12.2m	£9.79m	£14.7m
	High	4559	£25.6m	£20.4m	£30.7m

Note: Table assumes that each person would have lived for 6 months, and that they have an assisted death after 5 months, meaning the final 1 month of care is not required.

Table 85 Estimated palliative and end-of-life care expenditure not required, sensitivity analysis of higher and lower care costs, for 4 months of unutilised care, England and Wales [255]

Implementation Year	Cohort Scenario	Number of deaths	Total healthcare not required (core scenario)	Total healthcare not required (20% lower)	Total healthcare not required (20% higher)
Year 1 (half-year)	Low	164	£2.14m	£1.71m	£2.57m
	Central	289	£3.77m	£3.02m	£4.53m
	High	647	£8.46m	£6.77m	£10.1m
Year 10	Low	1042	£13.6m	£10.9m	£16.4m
	Central	2183	£28.6m	£22.8m	£34.3m
	High	4559	£59.6m	£47.7m	£71.5m

Note: Table assumes that each person would have lived for 6 months, and that they have an assisted death after 2 months, meaning the final 4 months of care are not required.

[252] See 'Version control table' at the end of this document. In v1.1, the estimated proportion of assisted deaths occurring under the high scenario in Year 1 was corrected from 0.13% to 0.11%; all values derived from this were also updated. In this annex, this included Year 1 high scenario values in Table 84 and Table 85. All corrections were carried across to v1.2.

[253] Nuffield Trust (2014), Exploring the cost of care at the end of life | Nuffield Trust (viewed in April 2025)

[254] DHSC estimates based on figures from Table 35 and Clarke, G., May, P., Cook, A., Mitchell, S., Walshe, C., Bajwah, S., Yorganci, E., Kumar, R., Fraser, L.K., Sleeman, K.E., Murtagh F.E.M. (2025). Costs and cost-effectiveness of adult palliative and end-of-life care. Evidence briefing summary. London: National Institute for Health and Care Research (NIHR) Policy Research Unit (PRU) for Palliative and End-of-Life Care. Summary available at: https://www.kcl.ac.uk/nmpc/assets/research/costs-and-cost-effectiveness-of-adult-palliative-and-end-of-life-care-evidence-briefing-summary.pdf Accessed on 18/03/2025. **Full report is unpublished data – provided via personal communication.**

[255] As above.

Annex F Social care sector supplementary table[256]

437. This annex contains a supplementary table showing, based on evidence on the location of deaths in England in 2023[257], estimates of the number of assisted deaths that may take place in different locations.

Table 86 Estimated number of assisted deaths in each location in England and Wales [258]

	Scenario	Care homes	Home	Hospice	Hospital	Other places	Total
Year 1: 2029/30, half-year	Low	22	59	26	54	3	164
	Central	38	104	46	96	5	289
	High	85	232	103	215	12	647
Year 10: 2038/39	Low	138	374	167	346	19	1042
	Central	288	784	349	725	39	2183
	High	602	1,637	729	1,514	82	4559

[256] See 'Version control table' at the end of this document. In v1.1, the estimated proportion of assisted deaths occurring under the high scenario in Year 1 was corrected from 0.13% to 0.11%; all values derived from this were also updated. In this annex, this included Year 1 high scenario values in Table 86. All corrections were carried across to v1.2.

[257] Department of Health & Social Care (2025), Palliative and end of life care factsheet: Patterns of care, England 2023 (viewed in March 2025)

[258] DHSC estimates based on figures found in table 2 and Place of death in Department of Health and Social Care (2025), Palliative and end of life care factsheet: Patterns of care, England 2023 (viewed in March 2025)

Annex G Wider impacts on state pensions and state benefits supplementary table

438. This annex shows the eligibility of the state benefits that are part of the Special Rules for end of life (SREL)[259].

Table 87 State benefit eligibility, England and Wales

State benefit	Claimants under special rules	Average claim
Attendance Allowance **Attendance Allowance benefits help support individuals with a physical disability, a mental disability, or a health condition who require additional support to look after themselves.[260]**	As of August 2024, there were 96,294[261] people of state pension age, living in England and Wales, with either a malignant disease or a terminal illness who were receiving AA payments.	The average weekly AA payment for these recipients in August 2024 was £102.48[262]. There is no published data on the SREL, however, those eligible under the special rules will automatically get the higher rate of £110.40 per week (as of 2025/26)[263].
Personal Independence Payment **Personal Independence Payment (PIP) is available for people with long-term physical or mental health conditions or disability who may struggle with everyday tasks because of their condition.[264]**	As of January 2025, there were 32,573[265] people across England and Wales receiving special rules end of life (SREL) PIP payments. Of these 32,573 people, 26,317 were under state pension age.	The average SREL PIP payment for all recipients was £181.47 per week in January 2025. The average SREL PIP payment for those under state pension age was £183.95.

[259] UK Government (2025), The 'Special Rules': how the benefit system supports people nearing the end of life - GOV.UK (viewed in April 2025)

[260] UK Government (2025), Attendance Allowance: Overview - GOV.UK (viewed in March 2025)

[261] Stat-Xplore (2025), Stat-Xplore (viewed in March 2025). Dataset: AA Cases in Payment (Data from May 2018). Filtered by: England and Wales, main disabling condition as malignant disease or terminal illness (by the number of AA in payment and the mean weekly award amount)

[262] Stat-Xplore (2025), Stat-Xplore (viewed in March 2025). Dataset: AA Cases in Payment (Data from May 2018). Filtered by: England and Wales, main disabling condition as malignant disease or terminal illness (by the number of AA in payment and the mean weekly award amount)

[263] DHSC estimates based on figures found in Table 48 and UK Government, Attendance Allowance: Claiming Attendance Allowance if you're nearing the end of life - GOV.UK (viewed in March 2025)

[264] UK Government (2025), Personal Independence Payment (PIP): What PIP is for - GOV.UK (viewed in March 2025)

[265] Stat-Xplore (2025), Stat-Xplore (viewed in March 2025). Dataset: PIP cases with entitlement (from 2019)
Table: Caseload by End-of-Life Rules indicator. Filters: England & Wales, State Pension age & below state pension age and (by the number of cases and the mean of financial award)

Employment and Support Allowance **The Employment and Support Allowance (ESA) provides funding to help people who are unable to work or need support to get back to work with living costs.[266]**	From 2026 there will only be a New Style ESA, as those on an income-based ESA will start receiving UC. There is no published data on the SREL, however as of August 2024 there were 1,314,461[267] individuals over the age of 18, and living in England and Wales, were receiving ESA payments.	The average weekly payment for these recipients was £162.77 in August 2024.
Universal Credit **Universal Credit is a payment to help support individuals with their cost of living.[268]**	As of December 2024, there were 10,514[269] individuals over the age of 18 with a terminal illness, living in England and Wales, claiming Universal Credit (UC).	UC has complex eligibility criteria and a range of standard allowances, so an average claim figure is not provided.
Disability Living Allowance **Disability Living Allowance for adults is being replaced by other benefits, although some adults may continue to get DLA as long as they are eligible.[270]**	Disability Living Allowance (DLA) is being replaced by PIP for most adults who were born after 8 April 1948, however, this change will take time. As of August 2024, there were 10,355[271] individuals aged 18 and over, living in England or Wales, with either a malignant disease or a terminal illness receiving DLA payments.	This group of people had an average DLA payment of £133.55 per week, as of August 2024.

[266] UK Government (2025), Employment and Support Allowance (ESA): Overview - GOV.UK (viewed in March 2025)

[267] Stat-Xplore (2025), Stat-Xplore (viewed in April 2025). Dataset: ESA – Data from May 2018. Table: ESA Caseload 2 – Age. Filtered by: England and Wales, and age bands 18 and over, (by Support Allowance Caseload and mean of weekly award amount)

[268] UK Government (2025), Universal Credit: What Universal Credit is - GOV.UK (viewed in March 2025)

[269] Stat-Xplore (2025), Stat-Xplore (viewed in April 2025). Dataset: Universal Credit Work Capability Assessments: UC Health Caseload. Table: UC WCA Caseload 3 – Age. Filtered by: England and Wales, age bands aged 18 and over, by the terminally ill (by caseload only)

[270] UK Government (2025), Disability Living Allowance (DLA) for adults: Overview - GOV.UK (viewed in March 2025). Please note DLA is changing, some adults are still receiving DLA.

[271] Stat-Xplore (2025), Stat-Xplore (viewed in March 2025). Dataset: DLA: Cases in Payment – Data from May 2018. Table: DLA in Payment 2 – Age. Filtered by: England and Wales, age bands 18 and over, main disabling condition as malignant disease or terminal illness (by the number of DLA in payment and the mean of weekly award amount)

Annex H Sensitivity - implementation starting in 2028[272]

439. The main IA text shows the scenario where the VAD service would be implemented in 2029/30. The Bill does not preclude implementation taking place earlier, and so this annex shows the main quantified impacts if the VAD service were implemented in 2028/29.

H1 - Cohort estimates

Table 88 Estimated number of applicants and assisted deaths, by implementation year, for England and Wales combined [273]

Cohort	Estimate	Year 1:	Year 10:
		Oct 2028 – Apr 2029 (half-year)	Apr 2037 - Mar 2038
Number of applicants	Low	270	1,719
	Central	476	3,601
	High	1,066	7,518
Number of assisted deaths	Low	162	1,031
	Central	285	2,160
	High	640	4,511

H2 - Training

Table 89 Estimated training costs Year 1, (values are based on previously rounded figures) [274]

	Year 1 (half year)			
Scenario	No opt-out	Assume 33% opt out	Assume 50% opt out	Assume 90% opt out
Low	£10.9 m	£7.36 m	£5.53 m	£1.23 m
Central	£11.0 m	£7.48 m	£5.65 m	£1.35 m
High	£11.4 m	£7.82 m	£5.99 m	£1.68 m

Table 90 Estimated training costs Year 10, (values are based on previously rounded figures) [274]

	Year 10			
Scenario	No opt-out	Assume 33% opt out	Assume 50% opt out	Assume 90% opt out
Low	£5.87 m	£4.09 m	£3.18 m	£1.03 m
Central	£6.40 m	£4.63 m	£3.72 m	£1.56 m
High	£7.52 m	£5.75 m	£4.83 m	£2.68 m

[272] See 'Version control table' at the end of this document. In v1.1, the estimated proportion of assisted deaths occurring under the high scenario in Year 1 was corrected from 0.13% to 0.11%; all values derived from this were also updated. In this annex, this included Year 1 high scenario values in Table 88, Table 89, Table 91, Table 93, Table 94, Table 95, Table 96, Table 97, Table 98, Table 99, Table 100, Table 101, Table 102, Table 103, Table 104, Table 105, Table 106, Table 107. All corrections were carried across to v1.2.

[273] DHSC estimates based on figures found in Annex A and ONS (2025), National population projections (viewed in March 2025)

[274] DHSC estimates based on figures found in Table 14 and Table 17

H3 - Health and social care staff time

Table 91 Estimated cost of staff time to deliver VAD service in Year 1 (which is half a year), England and Wales [275]

Cohort	Costs for people who do not require an advocate or interpreter (95.7% of cohort)	Cost for people who require an independent advocate (for 2.5% of cohort)	Cost for people who require an interpreter (for 1.8% of cohort)	Total Costs (100% of cohort
Low	£370k	£22.0k	£15.9k	£408k
Central	£651k	£38.8k	£28.0k	£718k
High	£1.46 m	£87.0k	£62.6k	£1.61 m

Table 92 Estimated cost of staff time to deliver VAD service in Year 10, England and Wales [276]

Cohort	Costs for people who do not require an advocate or interpreter (95.7% of cohort)	Cost for people who require an independent advocate (for 2.5% of cohort)	Cost for people who require an interpreter (for 1.8% of cohort)	Total Costs (100% of cohort)
Low	£2.35 m	£140k	£101k	£2.60 m
Central	£4.93 m	£294k	£212k	£5.44 m
High	£10.3 m	£613k	£442k	£11.3 m

H4 - Voluntary Assisted Dying Panels

Table 93 Estimated annual panel costs 2028/29 – 2037/38, England and Wales[277]

	Implementation year	Year 5	Year 10	Average Annual Cost
	2028/29 (half year)	2032/33	2037/38	
Low	£200k	£1.00k	£1.30m	£900k
Central	£400k	£1.70m	£2.70m	£1.70m
High	£800k	£3.50m	£5.80m	£3.60m

[275] DHSC estimates based on figures found in Table 21, Table 22 and Table 88

[276] DHSC estimates based on figures found in Table 21, Table 22 and Table 88

[277] MoJ estimates based on figures estimating the number of applications at the panel stage based on Annex A and Ministry of Justice and Senor Salaries Review Body (2024), Judicial salaries and fees 2024 to 2025 - GOV.UK (viewed in March 2025)

H5 - Healthcare costs at end-of-life

Table 94 Estimated palliative and end-of-life care costs for 1 month of unutilised care, by implementation Year 1 (2028/29, half-year) and Year 10 (2037/38) in 2025/26 prices, England and Wales[278]

Implementation Year	Scenario	Number of deaths	Hospital care not required	Primary and community care not required	Hospice care not required	Other care not required	Total healthcare spend not required
Year 1 (half-year)	Low	162	£725 k	£56.2 k	£100 k	£27.9 k	£909 k
	Central	285	£1.28 m	£98.9 k	£176 k	£49.1 k	£1.60 m
	High	640	£2.86 m	£222 k	£395 k	£110 k	£3.59 m
Year 10	Low	1,031	£4.61 m	£357 k	£637 k	£177 k	£5.78 m
	Central	2,160	£9.66 m	£748 k	£1.33 m	£371 k	£12.1 m
	High	4,511	£20.2 m	£1.56 m	£2.79 m	£775 k	£25.3 m

Note: Table assumes that each person would have lived for 6 months, and that they have an assisted death after 5 months, meaning the final 1 month of care is not required.

Table 95 Estimated palliative and end-of-life care costs for 4 months of unutilised care, by implementation Year 1 (2028/29, half-year) and Year 10 (2037/38) in 2025/26 prices, England and Wales[279]

Implementation Year	Scenario	Number of deaths	Hospital spend not required	Primary and community care not required	Hospice care not required	Other care not required	Total healthcare spend not required
Year 1 (half-year)	Low	162	£1.70m	£166k	£171k	£84.5k	£2.12m
	Central	285	£2.99m	£292k	£301k	£149k	£3.73m
	High	640	£6.70m	£655k	£675k	£333k	£8.36m
Year 10	Low	1,031	£10.8m	£1.06m	£1.09m	£537k	£13.5m
	Central	2,160	£22.6m	£2.21m	£2.28m	£1.13m	£28.2m
	High	4,511	£47.3m	£4.62m	£4.76m	£2.35m	£59.0m

Note: Table assumes that each person would have lived for 6 months, and that they have an assisted death after 2 months, meaning the final 4 months of care are not required.

[278] DHSC estimates based on table 88 and figures from Clarke, G., May, P., Cook, A., Mitchell, S., Walshe, C., Bajwah, S., Yorganci, E., Kumar, R., Fraser, L.K., Sleeman, K.E., Murtagh F.E.M. (2025). Costs and cost-effectiveness of adult palliative and end-of-life care. Evidence briefing summary. London: National Institute for Health and Care Research (NIHR) Policy Research Unit (PRU) for Palliative and End-of-Life Care. Summary available at: https://www.kcl.ac.uk/nmpc/assets/research/costs-and-cost-effectiveness-of-adult-palliative-and-end-of-life-care-evidence-briefing-summary.pdf Accessed on 18/03/2025. **Full report is unpublished data – provided via personal communication.**

[279] DHSC estimates based on table 88 and figures from Clarke, G., May, P., Cook, A., Mitchell, S., Walshe, C., Bajwah, S., Yorganci, E., Kumar, R., Fraser, L.K., Sleeman, K.E., Murtagh F.E.M. (2025). Costs and cost-effectiveness of adult palliative and end-of-life care. Evidence briefing summary. London: National Institute for Health and Care Research (NIHR) Policy Research Unit (PRU) for Palliative and End-of-Life Care. Summary available at: https://www.kcl.ac.uk/nmpc/assets/research/costs-and-cost-effectiveness-of-adult-palliative-and-end-of-life-care-evidence-briefing-summary.pdf Accessed on 18/03/2025. **Full report is unpublished data – provided via personal communication.**

H6 - Social care sector

Care homes

Reduced fees paid by self-funders

Table 96 Estimated reduction in fees paid to care homes by self-funders, England and Wales– 2028/29 implementation[280]

Implementation year	Scenario	Number of assisted deaths, self-funded care home residents	Lower bound fee		Upper bound fee	
			1 month not required	4 months not required	1 month not required	4 months not required
Year 1 (half-year)	Low	8	£33.6k	£134k	£58.5k	£234k
	Central	14	£59.2k	£237k	£103k	£412k
	High	31	£133k	£531k	£231k	£924k
Year 10	Low	50	£214k	£855k	£373k	£1.49 m
	Central	106	£448k	£1.79 m	£780k	£3.12 m
	High	220	£935k	£3.74 m	£1.63 m	£6.52 m

Reduced fees paid by local authorities

Table 97 Estimated reduction in fees paid to care homes by local authorities, England and Wales – 2028/29 implementation[281]

Implementation year	Scenario	Number of assisted deaths, local authority funded care home residents	Lower bound fee		Upper bound fee	
			1 month not required	4 months not required	1 month not required	4 months not required
Year 1 (half-year)	Low	13	£49.1k	£197k	£93.7k	£375k
	Central	24	£86.6k	£346k	£165k	£660k
	High	53	£194k	£776k	£370k	£1.48 m
Year 10	Low	86	£313k	£1.25 m	£596k	£2.38 m
	Central	180	£655k	£2.62 m	£1.25 m	£4.99 m
	High	375	£1.37 m	£5.47 m	£2.61 m	£10.4 m

[280] DHSC estimates based on figures found in Table 88 and Place of death information in Department of Health and Social Care (2025), Palliative and end of life care factsheet: Patterns of care, England 2023 (viewed in March 2025) and Carterwood (2024), 2024 Self-funded fee and trading performance review - Carterwood, improve decision making (viewed in April 2025)

[281] DHSC estimates based on figures found in Table 88 and Place of death information in Department of Health and Social Care (2025), Palliative and end of life care factsheet: Patterns of care, England 2023 (viewed in March 2025) and Department of Health and Social Care (2024), Market Sustainability and Improvement Fund (MSIF): provider fee reporting 2024 to 2025 - GOV.UK (viewed in March 2025)

Reduced care home revenue

Table 98 Total estimated reduction in care homes revenue from both self-funded and local authority funded individuals, England and Wales – 2028/29 implementation[282]

Implementation year	Scenario	Total assisted deaths, care home residents	Lower bound fee		Upper bound fee	
			1 month not required	4 months not required	1 month not required	4 months not required
Year 1(half-year)	Low	21	£82.8k	£331k	£152k	£609k
	Central	38	£146k	£583k	£268k	£1.07 m
	High	84	£327k	£1.31 m	£601k	£2.40 m
Year 10	Low	136	£527k	£2.11 m	£968k	£3.87 m
	Central	285	£1.10 m	£4.41 m	£2.03 m	£8.11 m
	High	595	£2.30 m	£9.21 m	£4.24 m	£16.94 m

Reduced care home profit

Table 99 Total estimated reduction in care home profit, England and Wales – 2028/29 implementation[283]

Implementation year	Scenario	Total assisted deaths, care home residents	Lower bound fee		Upper bound fee	
			1 month not required	4 months not required	1 month not required	4 months not required
Year 1 (half-year)	Low	21	£22.3k	£89.1k	£40.9k	£164k
	Central	38	£39.2k	£157k	£72.1k	£288k
	High	84	£87.9k	£351k	£162k	£646k
Year 10	Low	136	£142k	£567k	£261k	£1.04 m
	Central	285	£297k	£1.19 m	£546k	£2.18 m
	High	595	£620k	£2.48 m	£1.14 m	£4.56 m

[282] DHSC estimates based on figures found in Table 96 and 97

[283] DHSC estimates based on figures found in Table 98 and profit assumptions from Care Quality Commission (2024), The state of health care and adult social care in England 2023/24 - Care Quality Commission (viewed in April 2025)

Domiciliary care

Reduced fees paid by self-funders

Table 100 Estimated reduction in fees paid to domiciliary care organisations by self-funders, England and Wales – 2028/29 implementation[284]

Implementation year	Scenario	Number of people having an assisted death estimated to be self-funded domiciliary care users	Domiciliary care lost revenue from self-funders: Lower bound 1 month (4 weeks) of care no longer needed	Domiciliary care lost revenue from self-funders: Upper bound, 4 months (16 weeks) of care no longer needed
Year 1 (half-year)	Low	7	£30.1k	£120k
	Central	12	£53.0k	£212k
	High	26	£119k	£475k
Year 10	Low	43	£192k	£766k
	Central	89	£401k	£1.61 m
	High	186	£838k	£3.35 m

Reduced fees paid by local authorities

Table 101 Estimated reduced spending by local authorities on domiciliary care, England and Wales – 2028/29 implementation[285]

Implementation year	Scenario	Number of people having an assisted death estimated to be local authority domiciliary care users	Local authority reduced expenditure: Lower bound 1 month (4 weeks) of care no longer needed	Local authority reduced expenditure: Upper bound, 4 months (16 weeks) of care no longer needed
Year 1 (half-year)	Low	22	£77.3k	£309k
	Central	39	£136k	£544k
	High	88	£305k	£1.22 m
Year 10	Low	143	£492k	£1.97 m
	Central	299	£1.03 m	£4.12 m
	High	623	£2.15 m	£8.60 m

[284] DHSC estimates based on figures found in table 88 and figures in Place of Death in Department of Health and Social Care (2025), Palliative and end of life care factsheet: Patterns of care, England 2023 (viewed in March 2025) and proportion of state/self-funders from Office for National Statistics (2023), Estimating the size of the self-funding population in the community, England - Office for National Statistics (viewed in March 2025) and Homecare Association (2024), Minimum Price for Homecare - England 2025-2026 (viewed in March 2025)

[285] DHSC estimates based on figures found in Table 88 and Place of Death in Department of Health and Social Care (2025), Palliative and end of life care factsheet: Patterns of care, England 2023 (viewed in March 2025) and proportion of state/self-funders from Office for National Statistics (2023), Estimating the size of the self-funding population in the community, England - Office for National Statistics (viewed in March 2025) Department of Health and Social Care (2024), and Market Sustainability and Improvement Fund (MSIF): provider fee reporting 2024 to 2025 - GOV.UK (viewed in March 2025)

Reduced domiciliary care revenue

Table 102 Total estimated reduced revenue for domiciliary care organisations, England and Wales – 2028/29 implementation[286]

Implementation year	Scenario	Number of people having an assisted death estimated to be domiciliary care users	Total lost revenue: Lower bound 1 month (4 weeks) of care no longer needed	Total lost revenue: Upper bound, 4 months (16 weeks) of care no longer needed
Year 1 (half-year)	Low	29	£107k	£430k
	Central	51	£189k	£756k
	High	115	£424k	£1.70 m
Year 10	Low	185	£683k	£2.73 m
	Central	388	£1.43 m	£5.72 m
	High	810	£2.99 m	£11.95 m

Reduced domiciliary care profit

Table 103 Total estimated reduced profit for domiciliary care organisations, England and Wales – 2028/29 implementation[287]

Implementation year	Scenario	Number of people having an assisted death estimated to be domiciliary care users	Total lost profit: Lower bound 1 month (4 weeks) of care no longer needed	Total lost profit: Upper bound, 4 months (16 weeks) of care no longer needed
Year 1 (half-year)	Low	29	£8,162	£32.6k
	Central	51	£14.4k	£57.5k
	High	115	£32.2k	£129k
Year 10	Low	185	£51.9k	£208k
	Central	388	£109k	£435k
	High	810	£227k	£908k

[286] DHSC estimates based on figures found in Table 100 and Table 101

[287] DHSC estimate based on Table 102 and profit assumptions from LaingBuisson (2024), LaingBuisson adult social care market report (viewed in March 2024)

H7 - Wider impacts on state pensions and state benefits

State pension

Table 104 Estimated state pension economic transfer, England and Wales - 2028/29 implementation [288]

	Lower bound 1 month (4 weeks)		Upper bound 4 months (16 weeks)	
	Y1 - 2028/29	Y10 - 2037/38	Y1 – 2028/29	Y10 – 2037/38
Low	£111k	£994k	£444k	£3.97m
Central	£195k	£2.08m	£782k	£8.32m
High	£438k	£4.34m	£1.75m	£17.4m

State benefits

Table 105 Estimated state benefits economic transfer, state pension age individuals, Attendance Allowance (SREL), England and Wales - 2028/29 implementation [289]

	Lower bound 1 month (4 weeks) not required		Upper bound 4 months (16 weeks) not required	
	Y1 - 2028/29	Y10 - 2037/38	Y1 – 2028/29	Y10 – 2037/38
Low	£55.1k	£351k	£221k	£1.40m
Central	£97.1k	£735k	£388k	£2.94m
High	£218k	£1.53m	£870k	£6.14m

Table 106 Estimated state benefits economic transfer, individuals under state pension age, Personal Independence Payment (SREL), England and Wales- 2028/29 implementation [290]

	Lower bound 1 month (4 weeks) not required		Upper bound 4 months (16 weeks) not required	
	Y1 - 2028/29	Y10 - 2037/38	Y1 – 2028/29	Y10 – 2037/38
Low	£28.2k	£179k	£113k	£717k
Central	£49.6k	£375k	£198k	£1.50m
High	£111k	£784k	£445k	£3.13m

Table 107 Estimated state benefit economic transfer, total, England and Wales - 2028/29 implementation [291]

	Lower bound 1 month (4 weeks)		Upper bound 4 months (16 weeks)	
	Y1 - 2028/29	Y10 - 2037/38	Y1 – 2028/29	Y10 – 2037/38
Low	£83.3k	£530k	£333k	£2.12m
Central	£147k	£1.11m	£587k	£4.44m
High	£329k	£2.32m	£1.31m	£9.27m

[288] DHSC estimates based on Table 88, adjusted for state pension recipients, and Department for Work and Pensions (2025), Benefit expenditure and caseload tables 2025 - GOV.UK (viewed in April 2025)

[289] DHSC estimates based on figures found in Table 88, adjusted for state pension recipients, and UK Government, Attendance Allowance: Claiming Attendance Allowance if you're nearing the end of life - GOV.UK (viewed in March 2025)

[290] DHSC estimates based on figures found in Table 88, adjusted for those not claiming state pension, and Stat Xplore (2025), Stat-Xplore - Home (viewed in March 2025). Dataset: PIP cases with entitlement (from 2019). Table: Caseload by End-of-Life Rules indicator. Filters: England and Wales, State Pension age and below state pension age and (by the number of cases and the mean financial award).

[291] DHSC estimates based on figures found in Table 105 and Table 106

Version control table

Version	Date	Description of changes
1.0	02/05/2025	n/a – first publication, reflecting the Bill as amended through Committee Stage in the House of Commons.
1.1	14/05/2025	After publication of v1.0, two errors were identified. These were corrected and the IA was republished as v1.1. **The first was an error with the explanatory text used to describe how the high cohort scenario for England and Wales was derived.** In v1.0, the high estimate referred to "the most recent 10 complete years of assisted death data from Oregon (2014 to 2023)"; the reference years were corrected in v1.1 to "(2013 to 2022)". Associated Figure 4 was also updated to include the previously missing data series for 2013, and to visually show the break in time series for Oregon in 2023 (when the eligibility criteria changed). **The second was an error with the calculation of the estimated proportion of assisted deaths under the high scenario, in Year 1.** In v1.0, the estimated proportion of assisted deaths under the high scenario in Year 1 incorrectly drew on data from Oregon in 2012 (Year 15 in Tables 58 and 59) instead of 2013 (Year 16 in Tables 58 and 59). In v1.1 this was corrected, leading to an adjustment of 0.02 percentage points, from 0.13% to 0.11% in the estimated proportion of assisted deaths occurring under the high scenario in Year 1. This meant that the estimated number of assisted deaths under the high scenario in Year 1 was also updated from 787 to 647, and the estimated number of applicants from 1,311 to 1,078. The calculation of impacts under the Year 1 high scenario were therefore adjusted across the assessment.
1.2	26/06/2025	In v1.2, minor updates have been made to clause numbers and language to reflect the Bill as amended through the House of Commons. This includes references to new clauses pertaining to, for example, a person voluntarily stopping eating or drinking, future regulations around advertising of voluntary assisted dying services, and a requirement to assess availability of palliative and end of life care services. Two updates and two corrections have been made to Table 12 (and associated text). These are: • correction to the position statement for the Association of Palliative Care Social Workers from "opposition" to "neutral" • correction to the percentage of respondents from the British Medical Association who were cited as being opposed to or for assisted dying (from 40% opposed and 33% for, to 33% opposed and 40% for) • update to reflect new statement issued by the Royal College of Psychiatrists, since v1.1 • update to include new statement issued by the Royal College of Pathologists, since v1.1 All analysis of impacts (including cohort estimates) remains the same as v1.1. While some new data publications have been released (as referenced in paragraph 4), updating the analysis for this new data would not have a material impact on the results. Therefore, for consistency and speed to align with the Parliamentary process, the data used remains the same as v1.1 (and v1.0).