

Title: Terminally Ill Adults (End of Life) Bill (as introduced to Parliament on 17 June 2026 by Lauren Edwards MP) 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: 28 August 2026	
				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 2026/27 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 published in the House of Commons on 16 July 2026 by Lauren Edwards MP. This Private Members' Bill is a reintroduced version of the Terminally Ill Adults (End of Life) Bill 2024-26. It is identical to the previous Bill, as it left the House of Commons at third reading in the 2024-2026 session, bar three amendments agreed in the House of Lords committee stage before the Bill fell. 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.					
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. As this is a Private Members' bill, the Government has not developed its own policy options. 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 <u>Green Book</u> 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: 2032/33, if enacted in 2027					
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 CO₂ equivalent change in greenhouse gas emissions? (Million tonnes CO₂ 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:

A small rectangular box containing a handwritten signature in black ink. The signature appears to be "C. Mun".

Date:

28/08/2026

Summary: Analysis & Evidence**Policy Option 1****Description: Introducing a Voluntary Assisted Dying service in England and Wales**

Description: Introducing a Voluntary Assisted Dying Service in England and Wales					
Price Base Year 26/27	Implementation Year 1 31/32	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 the emotional or psychological impacts on relatives and friends. 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 Burdens¹ 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 as much (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.

¹ MHCLG (2022), [New burdens doctrine: guidance for government departments](#), (viewed in July 2026)

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, rather than an additional cost or benefit.

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 the 2031 to 2032 financial year; (ii) the number of applicants would range from between 496 and 4,610 in Year 1, to between 2,278 and 10,428 in Year 10; (iii) that 60% of applicants would complete the process, resulting in between 298 and 2,766 assisted deaths in Year 1, to between 1,367 and 6,257 assisted deaths in Year 10; (iv) that information provision, training and service delivery would initially focus on the NHS.

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	

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1 - Introduction

1. This Impact Assessment (IA) appraises the Terminally Ill Adults (End of Life) Bill as introduced to Parliament on 17 June 2026 by Lauren Edwards MP. This Bill is a reintroduced version of the Terminally Ill Adults (End of Life) Bill, identical to the version as it left the House of Commons at third reading in the 2024-2026 session, bar three amendments agreed in the House of Lords committee stage before the Bill fell, having failed to pass all necessary stages in the House of Lords before the end of the last session. As with the previous Terminally Ill Adults (End of Life) Bill, 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 the publication of the last impact assessment for the previous Terminally Ill Adults (End of Life) Bill, the methodology for estimating the number of assisted deaths in England and Wales has been reviewed and minor adjustments made, plus additional international evidence which has become available has been incorporated. These changes and the inclusion of the latest data for all jurisdictions have led to a widened range and an increase in the estimated number of assisted deaths in England and Wales under the three scenarios presented in section 7. The scenarios remain indicative given the substantial uncertainty surrounding the uptake of such a scheme in England and Wales.

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 introduced to 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^[OBJ]. At the point of publishing 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:
 - **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
 - **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
 - **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
 - **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
 - **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
 - **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), 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 2024 for example, assisted deaths accounted for 0.4% of all deaths in California (USA)², compared to 5.1% in Canada³. This range is narrower across the 10 jurisdictions with eligibility criteria comparable to the Bill.
11. Factors influencing uptake over time may include, but are not limited to:
 - the amount of time the service has been operational
 - how broad or narrow the potential cohort of service users is
 - how people access the service (from initial application to administration of the approved substance)
 - changes to the eligibility criteria and/or service design
 - 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). 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 department⁴ ⁵. These are Italy, Germany, Columbia, Montana (USA) and Ecuador. There are also other jurisdictions actively addressing legalisation, for example, France⁶. The British Crown Dependency of Jersey has voted to legalise assisted dying and received Royal Assent on 9 July 2026. 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 was awaiting

² California Department of Public Health (2025), [California End of Life Option Act Report 2024 Data Report](#), page 7 (Viewed in July 2026)

³ Health Canada (2025), [Sixth Annual Report on Medical Assistance in Dying in Canada - Canada.ca](#) (Viewed in July 2026)

⁴ Health and Social Care Committee (2024), [Assisted Dying/Assisted Suicide - Health and Social Care Committee](#) (viewed in July 2026)

⁵ The Life Issues Institute (2024), [Euthanasia and Assisted Suicide Global Timeline - Life Issues Institute](#) (viewed in July 2026)

⁶ France's National Assembly passed a bill to create a right to assisted dying in July 2026

Royal Assent as of July 2026 after further amendments were made following scrutiny by the UK Ministry of Justice.

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 1961⁷ 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 vote on the law was in 2025 when the Commons voted in favour of the Terminally Ill Adults (End of Life) Bill⁸. This was a Private Member's Bill, introduced by Kim Leadbeater MP.

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

17. The Terminally Ill Adults (End of Life) Bill was introduced to Parliament on 17 June 2026 by Lauren Edwards having been drawn second highest in the Private Members' Bill ballot for the 2026 session.
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.

⁷ UK Government (1961), [Suicide Act 1961](#) (Viewed in July 2026)

⁸ UK Parliament (2026), [Terminally Ill Adults \(End of Life\) Bill - Parliamentary Bills - UK Parliament](#) (Viewed in July 2026)

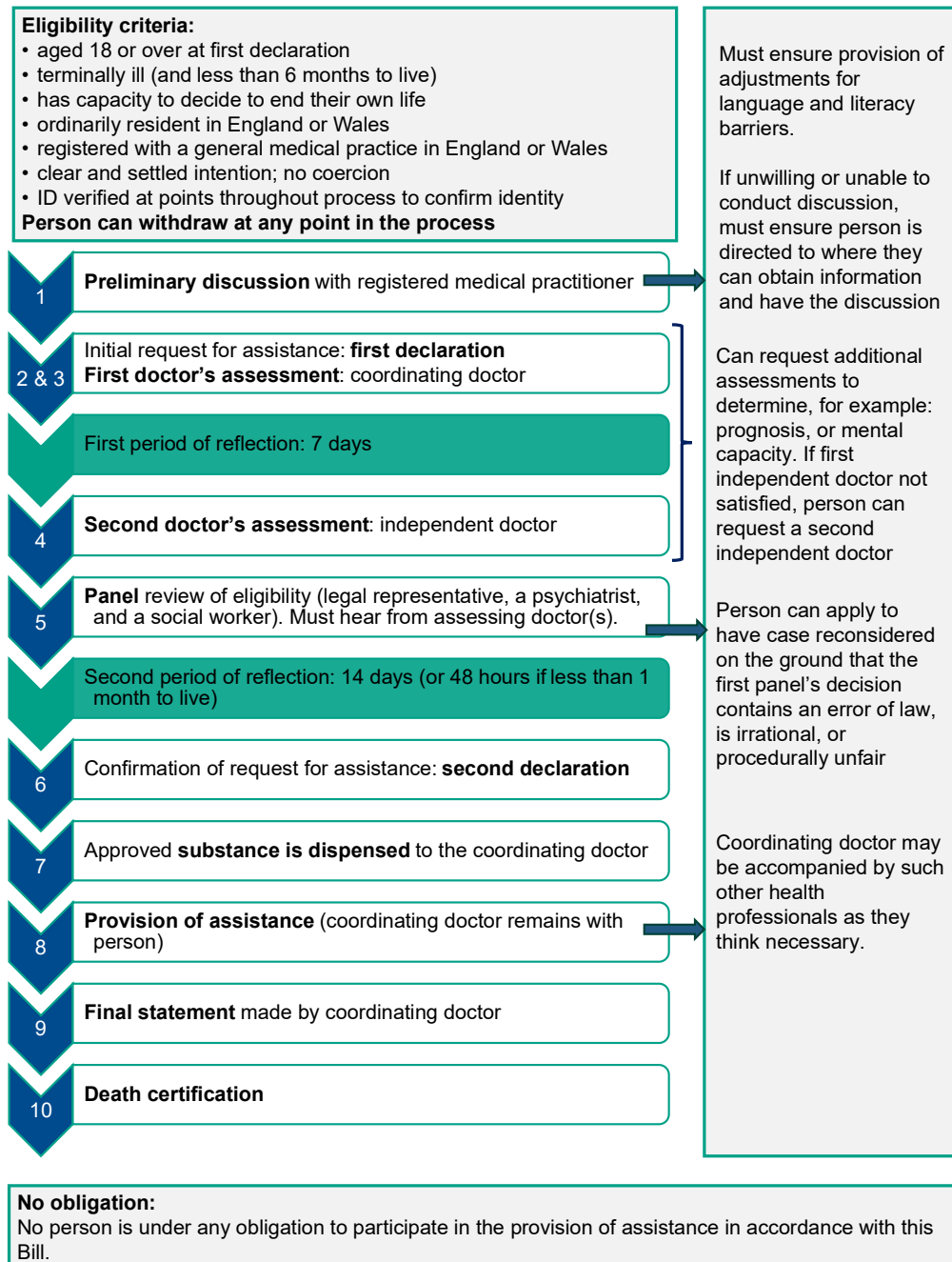
3 - Objectives of the proposal

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. 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

22. 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



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

4.1 - Eligibility criteria

23. To apply to access the VAD service, the applicant must meet all the following criteria:
- be terminally ill
 - have the capacity to make the decision to end their own life
 - be aged 18 years or over at the time they make their first declaration
 - 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
 - be registered as a patient with a general medical practice in England or Wales
 - 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.
24. The Bill defines a person as terminally ill if they have both:
- 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.
25. The Bill excludes from the definition of “terminally ill” any illness or disease caused by the person not eating or drinking, or limiting their eating or drinking, either voluntarily or as a result of a mental disorder.
26. Furthermore, the Bill states that:
- 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
 - 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

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

29. **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.
30. **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).
31. **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.
32. **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".
33. **Each assisted death must be documented and reported for safety, monitoring, and potential research purposes.** A report is to be published by the Secretary of State published regarding implementation one year after the Bill passes and then every 6 months until 6 reporting periods have been completed. The legislation would undergo a review after five years.
34. **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.'
35. **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.
36. **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

37. This IA considers the provisions of the Bill (the “proposed intervention”), in comparison to “Business as Usual” (BAU).
38. As defined in HM Treasury’s Green Book 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.
39. 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.
40. 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.

6 - Appraisal of proposed intervention

6.1 - Summary of approach

41. 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.
42. To inform parliamentary debate, this IA presents illustrative figures for some impacts - for Year 1 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

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

Coverage

44. 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

45. In this IA, Year 1 is set at 2031/32, and Year 10 is set at 2040/41 for both England and Wales. This assumes that Royal Assent would take place in Spring 2027 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 2031/32. 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 Welsh Ministers (for powers about voluntary assisted dying services on devolved matters for Wales) appoint.

46. Annex H sets out a sensitivity analysis where implementation is brought forward a year, so that Year 1 is set at 2030/31 and Year 10 is 2039/40. This assumes that Royal Assent would take place in Spring 2027 and that all provisions of the Bill (if not already enacted) would come into effect 3 years after Royal Assent.
47. 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

48. The price base year is set at the current year, 2026/27, 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 2026/27 prices using the latest available GDP deflator unless otherwise stated.

Number of applicants

49. 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 496 and 4,610 in Year 1 (2031/32), to between 2,278 and 10,428 in Year 10 (2040/41)⁹. See section titled “Cohort Estimates” for further information.

Number of assisted deaths

50. 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 298 and 2,766 in Year 1 (2031/32), rising to between 1,367 and 6,257 in Year 10 (2040/41)¹⁰. See section titled “Cohort estimates” for further information.

Time to complete VAD process

51. 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.

⁹ Since the most recent publication of this IA, the methodology for producing scenarios for assisted deaths applications for England and Wales has been updated and new data added. See section 7.3 for a description of changes to the methodology.

¹⁰ The methodology for producing scenarios for the number of assisted deaths for England and Wales has been updated and new data added. See sections 7.3 and 7.5 for a description of changes to the methodology and sensitivity analysis.

Quality-Adjusted Life-Years (QALYs)

52. 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.

53. 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

54. 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 a total of 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 ¹¹unpublished ¹¹. 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 unclear whether any

¹¹ Clarke, G and others (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 27/07/2026). **Full report is unpublished data [manuscript submitted for publication] – provided via personal communication. See annexe E2 for a description of methodology and list of sources for the secondary data analysis conducted in this study.**

Section	Overview of approach
	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 may 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

7.1 - Summary

55. 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.
56. As shown in Table 2, it is estimated that the total number of applicants would range from between 496 and 4,610 in Year 1, to between 2,278 and 10,428 in Year 10.
57. The total number of assisted deaths is estimated to range from between 298 and 2,766 in Year 1, rising to between 1,367 and 6,257 in Year 10.

Table 2: Estimated number of applicants and assisted deaths, by implementation year, for England and Wales overall¹²

Cohort	Scenario	Year 1: 2031/32	Year 10: 2040/41
Number of applicants	Low	496	2,278
	Central	2,208	5,836
	High	4,610	10,428
Number of assisted deaths	Low	298	1,367
	Central	1,325	3,502
	High	2,766	6,257

7.2 - Availability of international data

58. To estimate the number of potential applicants and assisted deaths in England and Wales, published data from comparable jurisdictions has been considered.
59. A comparable jurisdiction has been defined as one where the person requesting assistance to end their own life:
- is an adult, aged 18 or above
 - has been diagnosed with a terminal illness, from which they are expected to die within 6 months
 - cannot apply solely on the grounds of mental illness or disability (as defined in the respective disability legislation in each jurisdiction).
60. 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

¹² DHSC estimates based on figures found in Annex A and ONS (2026), [National population projections](#) (viewed in July 2026)

the number of applicants, while 8 of 10 published data on the number of assisted deaths (though only 7 did so annually).

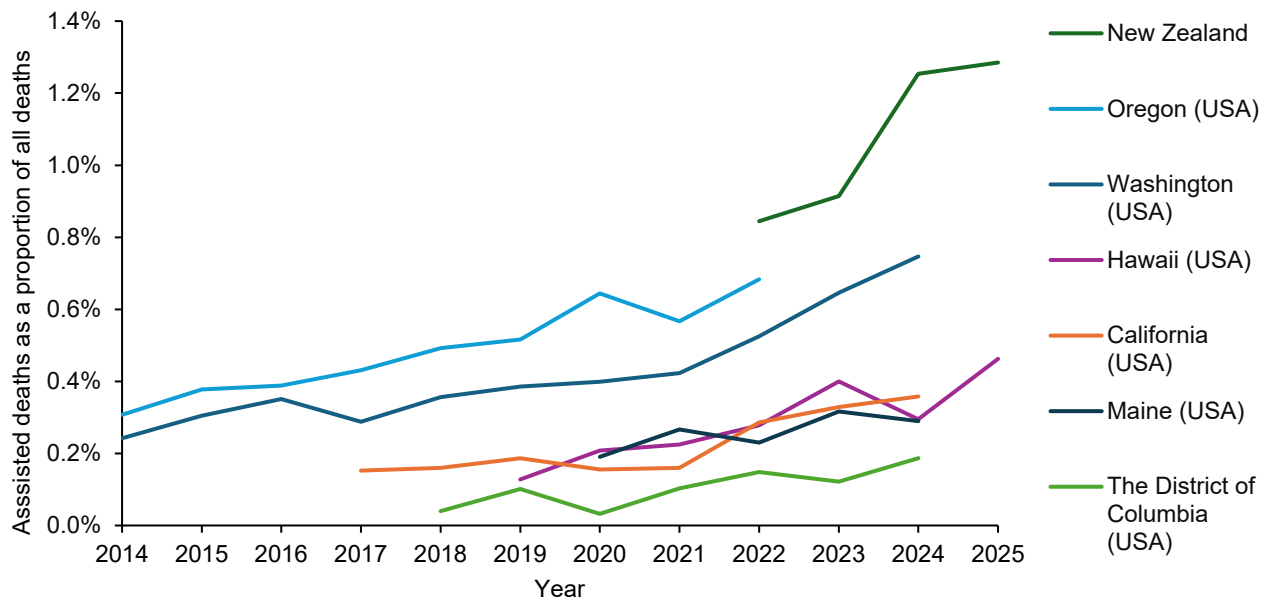
Table 3: Availability of published data on annual number of applicants and assisted deaths, across comparable jurisdictions¹³

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

61. Annex A contains a summary of data published in comparable jurisdictions on the annual total numbers of deaths and total number of assisted deaths. It should be noted that whilst there are eight comparable jurisdictions operating eight independent legal regimes identified with available data, this only comprises two countries and is therefore limited in terms of international coverage.
62. 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 1.5% of total deaths in any reported year¹⁴.

¹³ For data sources, see Annex A

¹⁴ See Table 62 of Annex A for more details



7.3 - Methodology for estimating the number of assisted deaths

63. This IA sets out low, central, and high scenarios for the number of assisted deaths in England and Wales in the first ten years following implementation. These scenarios are drawn from available evidence across comparable jurisdictions but should be considered indicative, given there are multiple factors that could influence the number of assisted deaths. The low and high scenarios should not be considered as outer bounds.

Overview of changes to the methodology

64. Since the publication of the terminally ill adults (end of life) impact assessment in April 2026, the methodology for estimating the number of assisted deaths in England and Wales has been reviewed and minor adjustments made to build on the existing approach and incorporate new international evidence.
65. The eligibility criteria for defining a comparable jurisdiction remain the same. However, the criteria for including the data of jurisdictions in the central scenario calculations has changed from a minimum of 5 years of continuous data to a minimum of 2 years. This is, in part, because there is limited evidence to support a 'levelling off' in the growth rate after 5-years amongst the comparable jurisdictions based on further assessment as additional data has become available. Levelling off may be observed at various points across jurisdictions, but not always within the first 10 years. A 2-year threshold was selected to incorporate the maximum available data, whilst ensuring that

¹⁶ For data sources, see Annex A

scenarios were not overly sensitive to the initial uptake in year one of any new comparable jurisdictions in future.

66. Broadening the criteria for including comparable jurisdictions enables a larger evidence base to inform the scenarios. Under the previous methodology, only six jurisdictions were included, all of which were from the United States. Expanding the inclusion criteria allows New Zealand, a non-US jurisdiction, to be incorporated, providing a broader evidence base and capturing a wider range of international experience. Incorporating additional data points improves the robustness of the analysis, reduces the influence of unusual trends in any single jurisdiction, and provides a better basis for assessing uncertainty by capturing a wider range of observed outcomes. As a result, the scenarios are more reflective of the variation seen internationally and less sensitive to year-to-year fluctuations in individual jurisdictions. Under the revised approach, two additional jurisdictions are included in the scenario calculations: Maine (USA) and New Zealand. Maine now has five years of operational data¹⁰⁵ and would have met the inclusion criteria regardless of this methodological change. New Zealand, which has four years of available data, would not have been included under the previous methodology but would likely have been incorporated in a future update as further data became available.
67. While the approach to calculating the central scenario has remained the same (albeit with more jurisdictions included in the estimates), the approach to calculating the high and low scenarios has also been adjusted. Previously the jurisdiction with the lowest rates for the *first* 10-years of implementation was used as the low scenario (Oregon, USA), and the jurisdiction with the highest rates in the *last* 10 calendar years was used as the high scenario (also Oregon, USA). This has been replaced with the 10th (low scenario) and 90th (high scenario) percentiles¹⁷ of the comparable jurisdictions for the first ten actual or predicted years of operation (see *international data projections* subsection) to ensure that future high and low scenarios are less sensitive to changes in a single jurisdiction.
68. Section 7.2 outlines a range of social, demographic and system factors that may influence the uptake of assisted dying. There is insufficient evidence to recommend basing assumptions about the number of assisted deaths in England and Wales on any single jurisdiction. In addition, the way in which people access the service may affect uptake, and this will not be fully understood unless the Bill is implemented. There is also some evidence to suggest that rates of assisted deaths may be higher and grow faster in jurisdictions that permit physician-administered deaths (often referred to as euthanasia) such as New Zealand versus countries that only permit self-administration or assisted self-administration of substance such as the USA^{18 19}. As a result, using the 10th and 90th percentiles to define the low and high scenarios, rather

¹⁷ Due to the small sample size (8 jurisdictions), the 10th and 90th percentiles fall between observed values and were estimated using linear interpolation between the two nearest jurisdiction values

¹⁸ Sillitti, P., and others (2025), A public health perspective on assisted dying and its different modalities - The Lancet Public Health, (Accessed July 2026)

¹⁹ Mroz, S., and others (2022), Developments Under Assisted Dying Legislation: The Experience in Belgium and Other Countries - PMC (Viewed in July 2026)

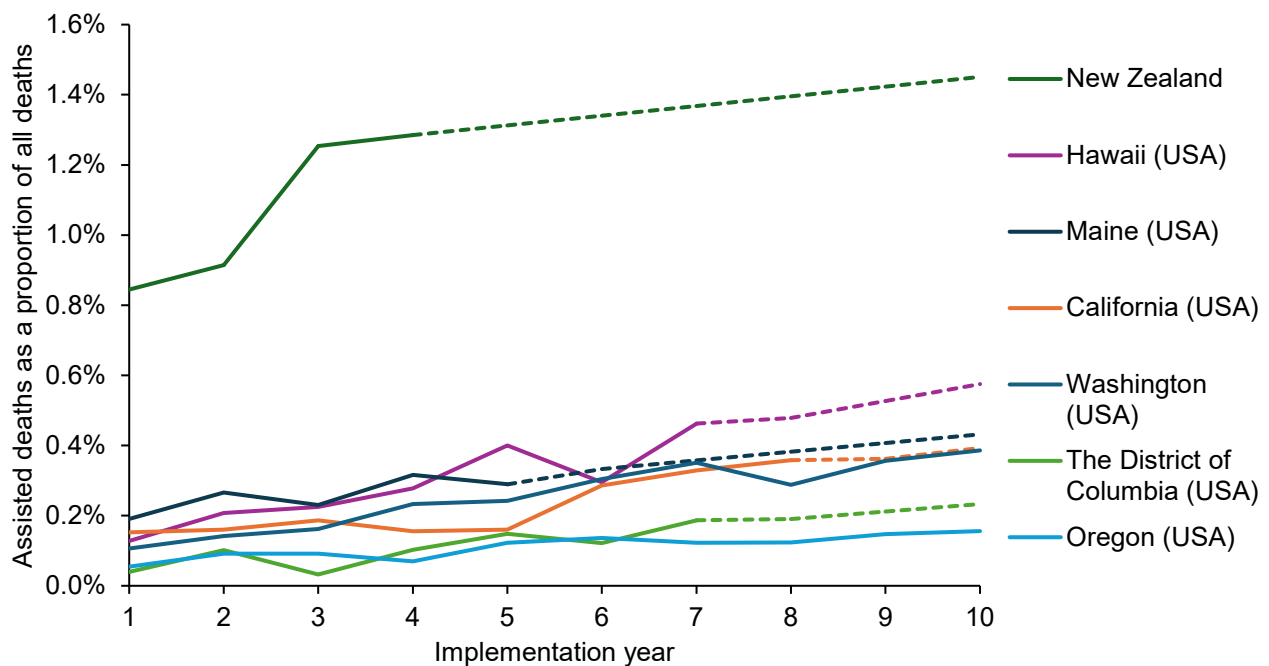
than aligning these scenarios with individual jurisdictions, allows evidence from multiple jurisdictions to be reflected in the range.

69. These changes and the inclusion of the latest data for all jurisdictions have led to a widened range between the scenarios and an increase in the number of assisted deaths in England and Wales under the three scenarios. This is in a large part due to the inclusion of the two new jurisdictions in the data. As scenarios are based on data from 8 jurisdictions, 6 of which have less than 10 years of operational data, the evidence base will continue to evolve as new data become available. Consequently, changes to the estimated scenarios over time should be expected, regardless of the methodology used.

International data projections

70. Of the comparable jurisdictions, only Oregon and Washington have data for at least ten complete implementation years. Therefore, assisted death rates were extrapolated up to 10-years for jurisdictions with less than 10 years of data.
71. Jurisdictions with at least 5 complete years of data were considered to have sufficient observations to estimate a longer-term trend. For each of these jurisdictions, a straight trend line was fitted through the available data, and this was extended to Year 10²⁰. The data did not generally show assisted death rates levelling off during the first 10 years, so a straight-line trend was considered a reasonable approximation. However, these projections are uncertain and should not be taken to mean that assisted death rates would continue to rise at the same rate beyond the 10-year appraisal period.
72. New Zealand only had 4 complete years of data. This was not enough to estimate its own longer-term trend. To extrapolate New Zealand's rate to year 10, the average annual increase seen in the other comparable jurisdictions was used. This means New Zealand is included in the evidence base, without relying on the growth rates in the first few years of implementation to predict future years (which tend to be higher as awareness of the scheme increases).
73. Following this process, each jurisdiction had an actual and/or projected assisted death rate for each of the first ten implementation years. Actual and projected values are shown in Figure 3 and Annex A.

²⁰ A linear trend was fitted to the annual assisted death rates using ordinary least squares. A linear approach was used because it is simple, transparent and can be applied consistently across jurisdictions.

Figure 3: Actual and predicted assisted death rates for comparable jurisdictions

Central estimate

74. For each year, the central scenario was calculated as the average (mean) of the actual and/or projected assisted death rates across the comparable jurisdictions in that year.
75. Each jurisdiction is given equal weight, because the purpose of the analysis is to draw on the range of experience across legally comparable schemes. Although the eligibility criteria are broadly comparable, uptake may also be affected by differences in service design, healthcare funding and delivery, reporting arrangements, population characteristics, practitioner participation and societal attitudes.

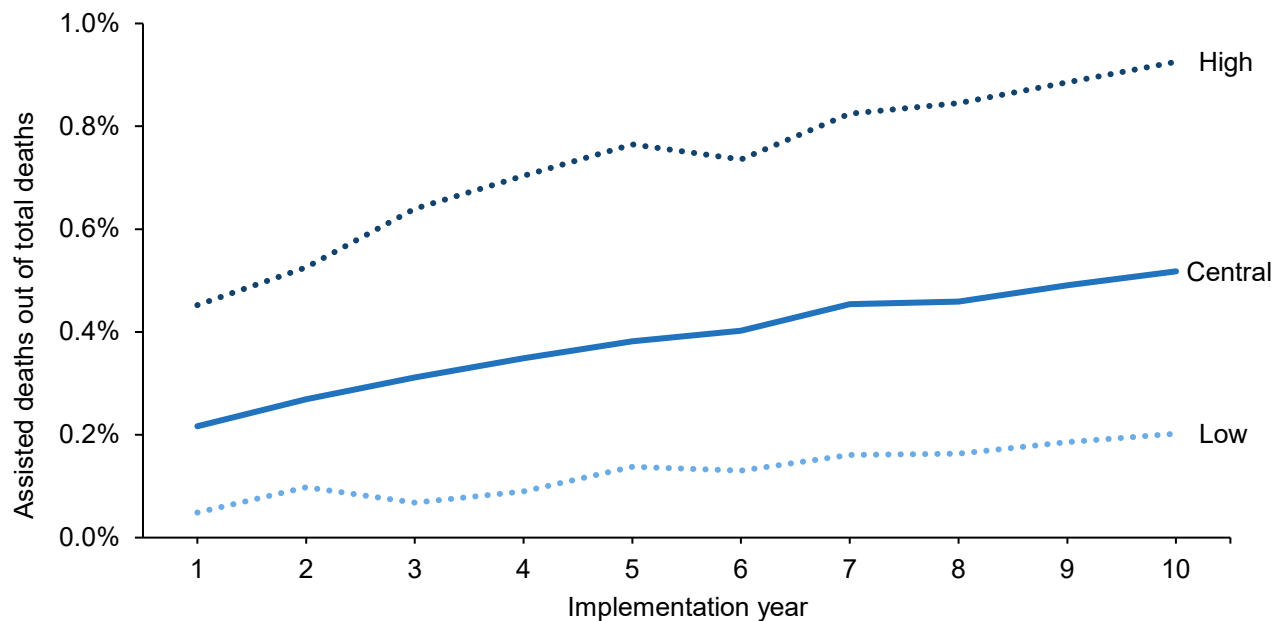
High and low scenarios

76. For each year, the 10th percentile of assisted death rates across the comparable jurisdictions was used for the low scenario, and the 90th percentile for the high scenario.
77. These estimates are scenario assumptions, not statistical confidence intervals. They are based on a small number of jurisdictions and include projected as well as observed rates. They therefore illustrate the available evidence but do not represent definitive lower and upper bounds.
78. The low, central and high assisted death rates were applied to the projected number of deaths in England and Wales for each year of the appraisal period. The resulting scenarios are shown in Figure 4.

Assisted death rates under the low, central and high scenarios

79. The proportion of assisted deaths out of the total number of projected deaths in this scenario range between 0.05% to 0.45% in Year 1, and between 0.20% to 0.93% in Year 10. See Table 4.
80. This scenario equates to between 298 and 2,766 assisted deaths in Year 1, and between 1,367 and 6,257 assisted deaths in Year 10. See Table 5.

Figure 4: Proportion of assisted deaths as a proportion of total deaths per year, by scenario (low, central, high)



81. The impact of the changes to the methodology detailed above mean the estimates have risen since the last impact assessment was published. At year 10 the central scenario has risen from 2,183 to 3,502 assisted deaths (60% increase). The low scenario has risen from 1,042 to 1,367 assisted deaths (31% increase). The high scenario has risen from 4,559 to 6,257 assisted deaths (37% increase).

Table 4: Proportion of assisted deaths out of total deaths per year, by scenario (low, central, high)²¹

Year	1	2	3	4	5	6	7	8	9	10
	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41
Low	0.05%	0.10%	0.07%	0.09%	0.14%	0.13%	0.16%	0.16%	0.19%	0.20%
Central	0.22%	0.27%	0.31%	0.35%	0.38%	0.40%	0.45%	0.46%	0.49%	0.52%
High	0.45%	0.53%	0.64%	0.70%	0.77%	0.74%	0.82%	0.85%	0.89%	0.93%

Table 5: Number of assisted deaths per year, by scenario (low, central, high), and territory²²

Year		1	2	3	4	5	6	7	8	9	10
		2031/32	2032/33	2033/34	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41
England & Wales combined	Low	298	604	424	568	886	848	1,057	1,084	1,245	1,367
	Central	1,325	1,666	1,952	2,210	2,452	2,612	2,979	3,047	3,287	3,502
	High	2,766	3,252	4,007	4,462	4,908	4,776	5,413	5,608	5,932	6,257
England	Low	280	568	399	534	832	796	994	1,019	1,170	1,285
	Central	1,244	1,564	1,833	2,076	2,303	2,454	2,799	2,864	3,090	3,292
	High	2,597	3,054	3,763	4,191	4,611	4,487	5,086	5,270	5,576	5,882
Wales	Low	18	37	26	34	54	51	64	65	75	82
	Central	81	102	119	134	149	158	180	183	197	210
	High	169	198	244	271	297	289	326	337	356	375

²¹ DHSC estimates based on figures found in Annex A and ONS (2026), [National population projections](#) (viewed in July 2026)

²² DHSC estimates based on figures found in Annex A and ONS (2026), [National population projections](#) (viewed in July 2026)

Cohort demographics

82. 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 jurisdictions²³

Jurisdiction (year)	Number of assisted deaths	Number of assisted deaths with a cancer diagnosis	% of assisted deaths with a cancer diagnosis
California, USA (2024)	1,032	619	60%
Oregon, USA (2025)	400	245	61%
Hawaii, USA (2023)	76	57	69%
District of Columbia, USA (2024)	9	4	44%

83. 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 or 60 and above depending on the jurisdiction). See Table 7.

Table 7: The distribution of assisted deaths by age band in comparable jurisdictions²³

Jurisdiction (year of latest available data)	Age band (varies based on data availability)	Age band % of assisted deaths or applications	% of overall assisted deaths or applications
Oregon, USA (2025)	65-74	33%	88%
	75-84	36%	
	85+	19%	
Hawaii, USA (2023)	65-74	33%	90%
	75-84	39%	
	85+	18%	
Washington, USA (2024)	65-74	30%	86%
	75-84	33%	
	85+	24%	
New Zealand (2025/26) (proportion of applicants)	65-84	61%	80%
	85+	19%	
California, USA (2024)	60-89	74%	92%
	90+	18%	
District of Columbia, USA (2024)	65+	78%	78%

²³ For data sources, see Annex A

7.4 - Methodology for estimating the number of applicants

84. 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.
85. 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:
- the person changing their mind and choosing not to have an assisted death
 - the person being assessed as ineligible by medical professionals
 - the person being assessed as losing their mental capacity later in the process
 - the person dying from their underlying terminal illness.
86. The average reported proportion of applicants who were certified as having an assisted death for the most recent three years of data for available jurisdictions was 60%. This however ranged from 42% of applicants completing the process in New Zealand to 71% in California. See Table 8.

Table 8: Reported proportion of applicants who completed process and had an assisted death in comparable jurisdictions three-year average of latest data)²⁴

Jurisdiction	Number of applicants reported	Number of assisted deaths reported	Proportion of applicants completing process
New Zealand (2023/24-2025/26)	3,037	1,286	42%
California (USA) (2022-2024)	4,108	2,897	71%
Maine (USA) (2022-2024)	207	141	68%
Average	/	/	60%

87. It is uncertain how this would translate across to England and Wales. For 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).

²⁴ For data sources, see Annex A.

Estimates

88. Across the three scenarios, the estimated number of applicants ranges from between 496 and 4,610 in Year 1, to between 2,278 and 10,428 in Year 10. See Table 9: Number of applicants per year (assuming 60% complete), by scenario (low, central, high), and territory.

Table 9: Number of applicants per year (assuming 60% complete), by scenario (low, central, high), and territory²⁵

	Year	1	2	3	4	5	6	7	8	9	10
		2031/32	2032/33	2033/34	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41
England & Wales combined	Low	496	1,007	707	947	1,476	1,413	1,762	1,807	2,075	2,278
	Central	2,208	2,776	3,253	3,684	4,086	4,353	4,965	5,079	5,479	5,836
	High	4,610	5,421	6,678	7,437	8,180	7,960	9,021	9,346	9,886	10,428
England	Low	466	946	664	889	1,387	1,327	1,656	1,698	1,950	2,142
	Central	2,073	2,607	3,055	3,460	3,838	4,090	4,665	4,773	5,150	5,487
	High	4,328	5,090	6,272	6,985	7,685	7,479	8,477	8,784	9,293	9,804
Wales	Low	30	61	43	57	89	85	106	109	125	136
	Central	135	169	198	224	248	263	299	306	329	349
	High	281	330	406	451	496	481	544	562	593	624

²⁵ DHSC estimates based on figures found in Annex A and ONS (2026), [National population projections](#) (2024 editions) (viewed in July 2026)

7.5 - Cohort sensitivity analysis

Oregon and New Zealand scenarios for number of deaths

89. There is significant uncertainty over how many people in England and Wales would apply, be successful in applying, and 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.
90. Several approaches for defining the high and low scenarios for the estimated number of assisted deaths were tested, recognising the relatively small number of comparable jurisdictions and the limited time series data available for some jurisdictions. Approaches considered included using the jurisdictions with the highest and lowest observed rates of assisted dying, applying the interquartile range, and constructing bounds based on standard deviations around the central estimate. We concluded that using the 10th and 90th percentiles was a more appropriate approach that captured the majority of observed variation across comparable jurisdictions whilst avoiding the range being determined by a single jurisdiction at either end of the distribution whose rates may be driven by additional jurisdiction-specific factors. The resulting high and low scenarios therefore aim to provide a balanced representation of uncertainty around the central estimate.
91. For complete transparency the proportion of all deaths that are assisted in Oregon and New Zealand has also been modelled for England and Wales. These are the jurisdictions with the lowest and highest rates respectively from available data (see Annex A, Table 10 and Table 11).

Table 10: Oregon sensitivity: estimated number of deaths per year using Oregon's assisted death rates from first year of implementation²⁶

Year	1	2	3	4	5	6	7	8	9	10
	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41
England and Wales	333	569	572	442	784	885	804	817	985	1,054
England	313	535	538	415	737	831	756	768	925	991
Wales	20	35	35	27	48	53	48	49	59	63

Table 11: New Zealand sensitivity: estimated number of deaths per year using New Zealand's actual and projected assisted death rates from first year of implementation²⁶

Year	1	2	3	4	5	6	7	8	9	10
	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41
England and Wales	5,166	5,658	7,853	8,146	8,421	8,699	8,978	9,258	9,535	9,810
England	4,850	5,314	7,375	7,652	7,911	8,173	8,437	8,701	8,963	9,222
Wales	315	345	478	495	510	526	541	557	572	587

²⁶ DHSC estimates based on figures found in Annex A and ONS (2026), [National population projections](#) (viewed in July 2026)

Number of applicants

92. To test the uncertainty around the number of applicants, further scenarios have been run varying the proportion of applications that the number of deaths represent. 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).
93. 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.
94. 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:
 - 94.1. between 372 to 3,457 in Year 1, to between 1,709 to 7,821 in Year 10, across England and Wales (Table 12)
95. 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:
 - 95.1. between 902 to 8,381 in Year 1, to between 4,143 to 18,961 in Year 10, across England and Wales (Table 13).

Table 12: Estimated number of applicants per year, sensitivity analysis (assuming 80% complete the process instead of 60%)²⁷

	Year	1	2	3	4	5	6	7	8	9	10
		2031/32	2032/33	2033/34	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41
England & Wales combined	Low	372	756	530	710	1,107	1,060	1,322	1,355	1,556	1,709
	Central	1,656	2,082	2,440	2,763	3,065	3,265	3,723	3,809	4,109	4,377
	High	3,457	4,066	5,008	5,578	6,135	5,970	6,766	7,009	7,415	7,821
England	Low	350	710	498	667	1,040	996	1,242	1,274	1,463	1,606
	Central	1,555	1,955	2,292	2,595	2,879	3,068	3,499	3,580	3,862	4,115
	High	3,246	3,818	4,704	5,239	5,764	5,609	6,358	6,588	6,970	7,353
Wales	Low	23	46	32	43	67	64	80	82	93	102
	Central	101	127	148	168	186	197	225	229	247	262
	High	211	248	305	339	372	361	408	422	445	468

Table 13: Estimated number of applicants per year, sensitivity analysis (assuming 33% complete the process instead of 60%)²⁷

	Year	1	2	3	4	5	6	7	8	9	10
		2031/32	2032/33	2033/34	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41
England & Wales combined	Low	902	1,832	1,286	1,721	2,684	2,569	3,204	3,286	3,772	4,143
	Central	4,014	5,047	5,915	6,697	7,429	7,915	9,026	9,234	9,961	10,612
	High	8,381	9,856	12,142	13,521	14,873	14,472	16,402	16,993	17,975	18,961
England	Low	847	1,720	1,208	1,617	2,521	2,414	3,011	3,088	3,546	3,895
	Central	3,769	4,739	5,555	6,291	6,979	7,437	8,482	8,679	9,363	9,976
	High	7,869	9,255	11,403	12,700	13,972	13,597	15,413	15,970	16,897	17,826
Wales	Low	55	112	78	104	163	155	193	198	226	248
	Central	245	308	360	407	450	478	544	556	598	635
	High	512	601	739	821	901	875	989	1,022	1,079	1,135

²⁷ DHSC estimates based on figures found in Annex A and ONS (2026), [National population projections](#) (viewed in July 2026)

8 - Impacts on individuals and specific groups of individuals

8.1 - Summary

96. 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.
97. 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'²⁸. 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.
98. 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 2010²⁹ (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

99. 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.
100. 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

²⁸ British Medical Association (2021), [Physician assisted dying](#) (viewed in July 2026)

²⁹ Legislation.gov.uk (2026), [Equality Act 2010](#) (viewed in July 2026)

person 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).

101. 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 89% of applicants in the 2025 annual report³⁰). 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 2025, 43 residents were reported to have travelled from the UK to Dignitas in Switzerland to end their life,³¹ and experimental statistics published by the ONS found elevated rates of suicide among people with severe health conditions (compared to those without)³². The impact of VAD service provision in England and Wales on these outcomes is uncertain.
102. 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 2025 Oregon Annual Report included: being “less able to engage in activities making life enjoyable” (89%), “loss of dignity” (65%), “losing control of bodily functions” (53%), and “inadequate pain control or concern about it” (37%)³³. 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.
103. One of the main reported risks 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 Wales³⁴. 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 2025 Annual Report showed “burden on family, friends/caregivers” (40%) and “financial implications of treatment” (6%)

³⁰ For data source, see Annex A

³¹ Campaign for dying in dignity (2025), [Article by Dignity in Dying](#) (viewed in July 2026)

³² Office for National Statistics (2022), [Suicides among people diagnosed with severe health conditions, England - Office for National Statistics](#) (viewed in July 2026)

³³ Office for National Statistics (2022), [Suicides among people diagnosed with severe health conditions, England - Office for National Statistics](#) (viewed in July 2026)

³⁴ King's College London (2024), [Assisted dying: two-thirds of public back legalisation within this Parliament, study finds | King's College London](#) (viewed in July 2026)

as end-of-life concerns³⁵. In Maine³⁶, 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.

104. Public health systems and palliative care provision vary 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 provision³⁷.

105. HMT's Green Book 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

106. 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.

107. 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^{38 39}. An Australian study reports that for some relatives, a sense of meaning is derived from supporting a loved one to fulfil their wishes,

³⁵ Oregon Health Authority, [Oregon Health Authority : Death with Dignity Act Annual Reports : Death with Dignity Act : State of Oregon](#) (viewed in August 2026)

³⁶ Maine Hospice Council and Centre for End-of-life Care (2016), [Maine Palliative Care and Quality of Life Advisory Council Prevalence of Palliative care in Maine report](#) (viewed in July 2026)

³⁷ UK Parliament (2025), [Expert Panel: Evaluation of Palliative care in England](#) (viewed in July 2026)

³⁸ UK Parliament (2025), [Expert Panel: Evaluation of Palliative care in England](#) (viewed in July 2026)

³⁹ La Brooy, 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 July 2026)

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 death⁴⁰. It is also reported that for some relatives, a loved one choosing to have an assisted death can present significant challenges for grief and bereavement, including the impact on familial relationships where personal views on assisted dying diverge.

108. 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.

109. 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

110. 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 care⁴¹; 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’⁴².

111. 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 impacts⁴³. Providing unpaid care for someone who is terminally ill and at the end of their life, is likely to fall into the ‘higher intensity’

⁴⁰ La Brooy, 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 July 2026)

⁴¹ Office for National Statistics (2023), Unpaid care by age, sex and deprivation, England and Wales - Office for National Statistics (viewed in July 2026)

⁴² Carers Trust (2021), Factsheets for carers looking to get back into work or already in work - Resources - Carers Trust (viewed in July 2026)

⁴³ NHS England (2024), Health Survey for England, 2022 Part 2 - NHS England Digital (viewed in July 2026)

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.

112. 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 systems⁴⁴. 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.
113. It is acknowledged that some unpaid carers are children. According to the 2021 Census, there are approximately 120,000 unpaid carers aged between 5 and 17 years in England and 8,200 in Wales⁴¹. 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

114. 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.
115. In the UK, most professional bodies have adopted a neutral position on assisted dying (see Table 14), though not in specific relation to the VAD service described in this Bill. This includes, for example, the British Medical Association⁴⁵, the Royal College of Nursing,⁴⁶ the Royal College of General

⁴⁴ Fenney, D., Thorstensen-Woll, C. and Bottery, S. (2023), Caring In A Complex World: Perspectives From Unpaid Carers | The King's Fund (viewed in July 2026)

⁴⁵ British Medical Association (2021), Physician assisted dying (viewed in July 2026)

⁴⁶ Royal College of Nursing (2025), RCN position on assisted dying in the UK and Crown Dependencies | Royal College of Nursing (viewed in July 2026)

Practitioners⁴⁷, and the Association of Palliative Care Social Workers⁴⁸. 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 the British Geriatric Society⁴⁹ and the Association for Palliative Medicine of Great Britain and Ireland^[OBJ]).

116. Since first publication in May 2025 of the IA for the Terminally Ill Adults Bill introduced in 2024, the Royal College of Psychiatrists⁵⁰ 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 Bill⁵¹.

Table 14: Official positions and survey results of healthcare professional bodies on assisted dying⁵²

Organisation (year of publication)	Official Position	% Opposed	% Neutral	% For	% Undecided	Sample size
British Medical Association (2021) ⁵³	Neutral	33%	21%	40%	6%	28,986
⁵⁴ (2025) ⁵⁵	Neutral	48%	14%	34%	5%	8,779
Royal College of Physicians (2019) ⁵⁶	Neutral	43%	25%	32%	Not known	6,885
Royal College of Surgeons (2023) ⁵⁷	Neutral	25%	20%	52%	3%	3,268
Royal College of Nursing (2023) ⁵⁸	Neutral	Not known	Not known	Not known	Not known	Not known
Royal Pharmaceutical Society (2025) ⁵⁹	Neutral	Not known	Not known	Not known	Not known	Not known

⁴⁷ Royal College of General Practitioners (2025), [Assisted dying](#) (viewed in July 2026)

⁴⁸ Association of Palliative Care Social Workers (2025), [Assisted Dying – updates on the Terminally Ill Adults \(End of Life\) bill – 14 May 2025 - Association of Palliative Care Social Workers](#) (viewed in July 2026)

⁴⁹ The British Geriatric Society (2024), [BGS Position Statement on Assisted Dying | British Geriatrics Society](#) (viewed in July 2026)

⁵⁰ 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 July 2026)

⁵¹ The Royal College of Pathologists (2025), [Royal College of Pathologists statement on the Terminally Ill Adults \(End of Life\) Bill](#) (viewed in July 2026)

⁵² Figures may not sum to 100% due to rounding.

⁵³ British Medical Association (2021), [Physician assisted dying](#) (viewed in July 2026)

⁵⁵ Royal College of General Practitioners (2025), members vote outcome found in [Assisted dying members survey results](#) (PDF, 688 KB) (viewed in July 2026).

⁵⁶ Royal College of Physicians (2019), [2019 assisted dying survey results. No majority view moves RCP position to neutral | RCP](#) (viewed in July 2026)

⁵⁷ Royal College of Surgeons (2023), [Assisted Dying — Royal College of Surgeons](#) (viewed in July 2026)

⁵⁸ Royal College of Nursing (2023), [RCN position on assisted dying in the UK and Crown Dependencies | Royal College of Nursing](#) (viewed in July 2026)

⁵⁹ Royal Pharmaceutical Society (2025), [Written evidence submitted by the Royal Pharmaceutical Society \(TIAB85\)](#) (viewed in July 2026)

Association for Palliative Medicine (2015) ⁶⁰	Opposed	82%	Not known	12%	Not known	387
British Geriatric Society (2024) ⁶¹	Opposed	50%	Not known	33%	17%	775
Royal College of Psychiatrists (2024) ⁶²	Neutral ⁶³	45%	Not known	45%	Not known	1,474
Association of Palliative Care Social workers (2024) ⁶⁴	Neutral	Not known	Not known	Not known	Not known	Not known
The Royal College of Pathologists (2025) ⁶⁵	Neutral	Not known	Not known	Not known	Not known	Not known

117. 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.

118. 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 wellbeing⁶⁶. 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. Similarly, there may be opportunity benefits for staff involved in palliative care if some patients use the VAD service which reduces their demand for palliative care.

⁶⁰ Association for Palliative Medicine of Great Britain and Ireland (AMP) (2015), [Surveys of Palliative Medicine Clinicians' views about Assisted Dying \(2015\)](#) (viewed in July 2026)

⁶¹ British Geriatric Society (2024), [BGS Position Statement on Assisted Dying | British Geriatrics Society](#) (viewed in July 2026)

⁶² Royal College of Psychiatrists (2024), [RCPsych comments on vote for assisted dying Bill in England and Wales](#) (viewed in July 2026)

⁶³ 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.

⁶⁴ Association of Palliative Care Social Workers (2024), [APCSW Statements on Assisted Dying – November 2024 | Association of Palliative Care Social Workers](#) (viewed in July 2026)

⁶⁵ The Royal College of Pathologists (2025), [Royal College of Pathologists statement on the Terminally Ill Adults \(End of Life\) Bill](#) (viewed in July 2026). While neutral on the principle of assisted dying, they are opposed to the role of medical examiners as currently set out in the Bill.

⁶⁶ Sandham, M. and others (2022), [Nurses' experiences of supporting patients requesting voluntary assisted dying: A qualitative meta-synthesis - PMC](#) (viewed in July 2026)

8.6 - Staff working in the justice system

119. 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.

9 - The approved substance(s)

9.1 - Summary

120. 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

121. The Bill 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.
122. 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

123. There is no single substance or combination of substances that is understood to be the most appropriate for assisting death⁶⁷. 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 substances used to end life between 1989 and 2020 in the Netherlands, the

⁶⁷ Worthington, A, and others (2022), Efficacy and safety of drugs used for 'assisted dying' - PMC (viewed in July 2026)

USA, Belgium, Switzerland and Canada found that a variety of substances are used including opioids, barbiturates, benzodiazepines and other sedatives.⁶⁷

124. 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)⁶⁷. 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 reported⁶⁷ [OBJ] [OBJ].

Illustrative costs for one reported substance combination

125. VAD services in the USA report two main approved substance combinations. These are: 'DDMA' (diazepam, digoxin, morphine sulphate and amitriptyline) in New Jersey and Oregon; and 'DDMP' (diazepam, digoxin, morphine sulfate and propranolol) in Colorado and Hawaii⁶⁷.

126. As an example, Table 15 shows the substances used in the DDMP combination and indicative costs using the latest NHS England reimbursement prices. These costs come with **significant caveats**, including:

- 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,
- the prices relate to the average prescription cost based on the latest prescription cost data for the individual substance, not the cost of the dose needed for use in assisted dying,
- the unit costs for existing use may not be a reliable indicator of the cost when used for assisted dying.

Table 15: Average prescription cost by chemical substance (2025/26⁶⁸ and uplifted 2026/27 prices)

Chemical substance	Cost per Item (2025/26 prices)	Cost per Item (2026/27 prices)
Diazepam	£1.50	£1.53
Morphine Sulfate	£5.95	£6.07
Digoxin	£1.26	£1.29
Propranolol hydrochloride	£3.23	£3.29

⁶⁸ NHS Business Services Authority (2026), [Prescription Cost Analysis – England 2025/26 | NHSBSA](#) (viewed in July 2026)

127. 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

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

- 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 this has been made to date,
- 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,
- 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),
- 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,
- 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.

129. 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

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

131. 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.

132. 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:

- assessing capacity and assessing whether a person has been coerced or pressured by any other person
- domestic abuse, including coercive control and financial abuse

133. 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.

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

- their diagnosis and prognosis
- any treatment available and the likely effect of it
- any available palliative, hospice or other care, including symptom management and psychological support
- 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)

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

135. 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.
136. 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^[OBJ]. 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.
137. The estimated cost of training NHS staff is between £1.42m and £14.0m in Year 1, and £1.90m to £11.76m 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.
138. 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

139. 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 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)).

140. 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 staff. It is further estimated that the annual recurring cost of routine updates and printing could sit at around £50k^[69].
141. 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

142. 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.
143. There is existing provision of mandatory safeguarding training in the NHS⁶⁹, including content on assessing mental capacity⁷⁰. Additionally, the Health and Care Act 2022⁷¹ 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 Training (OMMT)⁷² 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.

⁶⁹ NHS England (2026), [NHS safeguarding assurance - NHS Safeguarding](#) (viewed in July 2026)

⁷⁰ NHS England (2026), [Mental capacity - NHS Safeguarding](#) (viewed in March 2025)

⁷¹ UK Parliament (2022), [The Health and Care Act 2022](#) (viewed March 2025)

⁷² NHS England (2025), [The Oliver McGowan Mandatory Training on Learning Disability and Autism | NHS England | Workforce, training and education](#) (viewed in March 2025)

144. 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.

145. As shown in Table 16, it is assumed that there would be three training tiers, each building on the previous one:

- **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.
- **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.
- **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.

146. 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 16: Costs of training per tier and per person (1 round)⁷³⁷⁴

	Cost per person 2024/25 prices	Costs per person 2026/27 prices	Additional cost compared to Tier 1 2026/27 prices
Tier 1	£25	£26	N/A
Tier 2	£118	£124	£98
Tier 3	£303	£319	£293

147. This only represents one part of the costs involved in designing, testing, delivering, monitoring, and evaluating a training package. There are a range of other direct and indirect costs that have not been possible to quantify in this IA. These include, for example:

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

⁷⁴ DHSC estimates based on unpublished Oliver McGowan Mandatory Training figures and internal analysis). Hourly costs per participant have been calculated based on the staff and facilities costs required to deliver and administer the training.

- the cost of training and/or employing trainers and facilitators to deliver the training
- the cost of travel to and from any in-person training sessions
- the familiarisation costs associated with preparation time for training, reading, and understanding training content
- the opportunity costs associated with attending the training, if during regular working hours, and backfilling of roles to maintain patient care
- the cost of training further cohorts of NHS staff, or the impact of changes to the size of the NHS workforce over time

148. 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

149. 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)

150. 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).

151. This IA considers a scenario where all these NHS professionals receive Tier 1 level training. The estimated overall size of this workforce cohort is 803k across England and Wales. This is based on rounded headcount data from 2025-2026 (and data between 2024-25 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 headcount⁷⁵ (see Table 17).

⁷⁵ 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 17.

152. 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. This equates to up to 401,550 people to be trained across England and Wales.

153. 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 200,775 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)

154. 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 14.4k across England and Wales (see Table 17). As above, this is rounded and may not reflect the actual size of the cohort at the point of implementation.

155. For illustrative purposes, it is assumed that 50% of the round of training is undertaken in Year 1. This equates to up to 7,200 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 3,600 people to be trained across England and Wales in Year 10.

Table 17: Estimated headcount by profession, England and Wales (from latest available data as of June 2026)

Tier	Profession	Headcount England	Headcount Wales	Total headcount
Tier 1	GPs ^{76 77}	50,500	2,500	53,000
	NHS doctors (hospitals) ^{78 79}	164,400	9,400	173,800

⁷⁶ NHS England (2026), [General Practice Workforce, 31 May 2026 - NHS England Digital](#) (viewed in July 2026)

⁷⁷ StatsWales (2026), [Medical and dental staff by specialty and year](#) (viewed in July 2026)

⁷⁸ NHS England (2026), [NHS Workforce Statistics - April 2026 - NHS England Digital](#) (viewed in July 2026)

⁷⁹ StatsWales (2026), [Medical and dental staff by specialty and year](#) (viewed in July 2026)

	Nurses (hospitals and GPs) ^{80 81 82}	434,700	30,300	465,000
	Pharmacists and pharmacy technicians ⁸³	80,800	4,600	85,400
	Social Workers ^{84 85}	21,500	4,400	25,900
Tier 2 ^{86 87}	Clinical Oncology	2,100	100	2,200
	Medical Oncology	1,700	100	1,800
	Geriatric Medicine	6,600	300	6,900
	Palliative Medicine	1,100	100	1,200
	Neurologists	2,200	100	2,300

Note: where headcount data was not available, FTE data was converted to headcount⁸⁸.

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

156. 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.

157. 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^[OBJ.].

158. The proportion of respondents saying they would not be prepared to actively participate varied significantly by profession, ranging from 35% to 76%, see Table 18. 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%.

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

Table 18: 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)

Profession	Base	% yes	% no	% undecided
Palliative medicine	604	10%	76%	14%

⁸⁰ NHS England (2026), [General Practice Workforce](#), 31 May 2026 - NHS England Digital (viewed in July 2026)

⁸¹ NHS England (2026), [NHS Workforce Statistics - April 2026](#) - NHS England Digital (viewed in July 2026)

⁸² StatsWales (2026), [Nursing, midwifery and health visiting staff, by grade and area of work](#) (viewed in July 2026)

⁸³ General Pharmaceutical Council (2026), [GPhC registers data](#) | General Pharmaceutical Council (viewed in July 2026)

⁸⁴ Social Care Wales (2025), [Data and information on the social care workforce...](#) | Social Care Wales (viewed in July 2026)

⁸⁵ Skills for Care (2025), [The state of the adult social care sector and workforce in England](#) (viewed in July 2026)

⁸⁶ StatsWales (2026), [Medical and dental staff by specialty and year](#) (viewed in July 2026)

⁸⁷ NHS England (2026), [NHS Workforce Statistics - April 2026](#) - NHS England Digital (viewed in July 2026)

⁸⁸ 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 17.

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

160. 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.

161. 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-training opt-outs). The number of people receiving Tier 3 training is therefore estimated to range from between 992 to 9,220 people in Year 1, to between 4,556 and 20,856 people in Year 10. See Table 19.

Table 19: Estimated workforce numbers undertaking training in Year 1 and Year 10, by tier and opt-out scenario⁸⁹

	Year 1				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	401,550	269,039	200,775	40,155	200,755	134,519	100,388	20,078
Tier 2	7,200	4,824	3,600	720	3,600	2,412	1,800	360
Tier 3 (low)	992				4,556			
Tier 3 (central)	4,416				11,672			

⁸⁹ DHSC estimates based on figures found in Table 2, Table 17, and Table 18. 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 year.

Tier 3 (high)	9,220	20,856
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Estimated partial training costs

162. 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. Table 20 shows the range of estimated training costs in **Year 1** by tier. The costs for tier 1 range from £1.06m to £10.6m depending on opt-out rates; the costs for tier 3 range from £290k to £2.7m depending on the cohort size.

Table 20: Estimated training costs by tier, Year 1 (2031/32), (values are based on previously rounded figures)⁹⁰

	Year 1			
	No opt-out	33% opt out	50% opt out	90% opt out
Tier 1	£10.6m	£7.10m	£5.30m	£1.06m
Tier 2	£703k	£471k	£351k	£70.3k
Tier 3 (low)	£290k			
Tier 3 (central)	£1.29m			
Tier 3 (high)	£2.7m			

163. Table 21 shows the range of estimated training costs in **Year 10**

Table 21: Estimated training costs by tier, Year 10 (2040/41), (values are based on previously rounded figures)⁹¹

	Year 10			
	No opt-out	Assume 33% opt out	Assume 50% opt out	Assume 90% opt out
Tier 1	£5.30m	£3.55m	£2.65m	£530k
Tier 2	£351k	£235k	£176k	£35.1k
Tier 3 (low)	£1.33k			
Tier 3 (central)	£3.42m			
Tier 3 (high)	£6.11m			

⁹⁰ DHSC estimates based on figures found in Table 16 and Table 19

⁹¹ DHSC estimates based on figures found in Table 16, Table 17, Table 18, and Table 19

164. Table 22 shows the low, central and high estimates of training costs for Year 1 and Year 10. In Year 1, the total costs range from £1.42m to £14.0m. In Year 10, the total costs range from £1.90m to £11.76m.

Table 22: Total estimated training costs by scenario (values are based on previously rounded figures) ⁹¹

	Year 1				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	£11.59m	£7.86m	£5.94m	£1.42m	£6.98m	£5.12m	£4.16m	£1.90m
Central	£12.59m	£8.86m	£6.94m	£2.42m	£9.07m	£7.20m	£6.24m	£3.98m
High	£14.00m	£10.27m	£8.35m	£3.83m	£11.76m	£9.89m	£8.93m	£6.67m

165. 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.

11 - Health and social care staff time

11.1 - Summary

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

167. 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.

168. 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.

169. Specifically, it is assumed:

- 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 23)
- that these are NHS employees who do not opt-out of the process
- that the panel decides to hear from both the coordinating and independent doctor

170. 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.

171. The estimated cost of staff time to deliver VAD services in England and Wales ranges from £788k to £7.32m in Year 1, to between £3.62m and £16.6m 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.

172. 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, including additional time and costs of adding nurses at stage 8 of the process

11.2 - Estimated time required

173. 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.

174. The assumed time for each step and staff member(s) involved are summarised in Table 23. 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).

Table 23: Summary of 10 core VAD service steps and assumed time per step

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) ⁹²	4
9	Final statement	2	1 (coordinating doctor)	2

⁹² Additional sensitivity analysis is conducted in Annexe C4 on the time and cost of including a nurse at this step in the process.

10	Death certification	2	1 (Medical Examiner)	2
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175. In table 23, 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.

Step 1: Preliminary discussion (Clause 5)

176. 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:

- is not under any duty to raise the subject of assisted dying.
- must first ensure provision of adjustments for language and literacy barriers.
- 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.
- must record the discussion in the person's medical records.

177. 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)

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

179. 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.

180. 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)

181. 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.
182. 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.
183. It is assumed Step 4 would take 4 hours of the independent doctor's time (see notes below).

Notes on Steps 3 and 4

184. It is reasonable to assume that Steps 3 and 4 could take longer than Step 1, because in completing their assessments the doctors' must:
- examine the person and their relevant medical records.
 - where appropriate, make enquiries of professionals who are providing or have recently provided health or social care to the person.
 - 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.
 - explain the nature of the substance that is to be provided (including how it would bring about death and how it would be administered).
 - 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.
 - advise the person to inform a registered medical practitioner at their GP practice that they are requesting assistance to end their own life.
 - 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)

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

186. 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.
187. The panel must hear from and may question one or both of the coordinating and independent doctors and (subject to exceptional circumstances) the person.
188. The panel may hear from and may question the person's proxy, and any other person.
189. 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.
190. 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.
191. 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.
192. 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' section⁹³.

Step 6: Second declaration (Clause 19)

193. 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.
194. 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.
195. The second declaration is assumed to take 1 hour of the coordinating doctor's time.

⁹³ The 'VAD Commissioner and Panel' section also separately captures the sitting day fees payable to psychiatrist and social worker panel members.

Step 7: Dispensing the approved substance

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

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

Step 8: Provision of assistance (Clause 25)

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

- the panel has issued the certificate of eligibility.
- 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).
- the person has made a second declaration.
- 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.

199. The coordinating doctor:

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

200. 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.
201. 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)).
202. It is assumed that Step 8 would take 4 hours; however, the time from self-administration of the approved substance to death is uncertain.
203. In 2025 in Oregon, the reported time from ingestion to death ranged from 3 minutes to 123 hours. The average (median) time reported in 2025 was 46 minutes, down from 54 minutes in 2024^[OBJ]. 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).
204. 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)

205. 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.
206. 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.
207. It is assumed Step 9 would take 2 hours of the coordinating doctor's time.

Step 10: Death certification (Clause 38)

208. A death is not to be considered an 'unnatural death' for the purposes of S.1 of the Coroners and Justice Act 2009⁹⁴ solely because the death resulted from the

⁹⁴ UK Government (2009), [Coroners and Justice Act 2009](#) (Viewed in July 2026)

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.

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

All steps

210. 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.

211. There is very limited existing evidence as to the average clinical time required to complete each stage of the assisted dying process in other jurisdictions. Research on doctors' experiences of providing voluntary assisted dying in Victoria, Australia states that around 60 hours of working time may be required⁹⁵. The impact of changing the total average amount of time required is explored as a sensitivity analysis in Annex C.

Use of interpreters

212. 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) word⁹⁶. 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. 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).

213. 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 well⁹⁷.

⁹⁵ 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 July 2026)

⁹⁶ NIHR (2022), Training guides: How to work effectively with interpreters and translators - ARC (viewed in July 2026)

⁹⁷ Language, England and Wales: Census 2021 (2021), Language, England and Wales: Census 2021 (viewed in July 2026)

Use of independent advocates (Clause 22)

214. 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.
215. It is assumed that 2.5% of VAD service applicants might require an independent advocate^{98 99 100 101}. 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.
216. 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

217. 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 assumed to be a DPSI qualified agency worker. Table 24 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 24: Assumed cost per hour including on costs by role^{102 103 104}

⁹⁸ Mencap (2024), [How Common Is Learning Disability In The UK? How Many People Have A Learning Disability? | Mencap](#), (viewed July 2026)

⁹⁹ NHS England (2025), [Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4. - NHS England Digital](#) (viewed July 2026)

¹⁰⁰ National Autistic Society (2026), [What is autism](#) (viewed July 2026)

¹⁰¹ Office for National Statistics (2025), [Population estimates - Office for National Statistics](#) (viewed in July 2026)

¹⁰² Hourly rate calculated from Pay Circular (M&D) (2026), [Pay and conditions circulars for medical and dental staff | NHS Employers](#) (viewed in July 2026)

¹⁰³ NIHR (2025), [How to calculate the costs of involving interpreters and translators in health and social care research](#), (viewed in July 2026)

¹⁰⁴ NHS Employers (2026), [Pay scales for 2026/27 | NHS Employers](#) (viewed in July 2026)

Role	Assumed hourly pay including on costs (2026/27 prices)
Coordinating doctor	£63.64
Independent doctor	£63.64
Psychiatrist panel member	£63.64
Social worker panel member	£34.15
Pharmacist	£34.15
Medical Examiner	£100.46
Interpreter	£37.57
Independent advocate	£34.15

Medical roles (coordinating doctor, independent doctor, ME)

218. Pay for medical roles varies significantly by grade and experience. As shown in Table 25 below, the annual salary can range from £41.2k for a foundation year 1 doctor through to £151k for the most experienced medical consultant¹⁰⁵.

219. 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).

220. 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 (2026/2027) of £63.98 for the coordinating doctor, independent doctor, and psychiatrist (excluding any additional fees paid to sit on the Panel).

221. Medical Examiners (MEs) are often consultant level doctors¹⁰⁶, so the hourly salary plus on costs (2026/2027) of £100.46 was used for them. These costs are illustrative only and do not adjust for regional differences in pay.

Table 25: Estimated hourly salary plus on costs (2026/27) for medical staff

Pay band	Annual salary (26/27) ¹⁰⁵	Hourly salary (26/27)	Hourly salary plus on costs (26/27)
Foundation Doctor Year 1	£41.2k	£19.82	£27.51
Consultant top of scale	£151k	£72.39	£100.46

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

222. 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

¹⁰⁵ Pay Circular (M&D) (2026), [Pay and conditions circulars for medical and dental staff | NHS Employers](#) (viewed in July 2026)

¹⁰⁶ NHS England (2025), [NHS England » National Medical Examiner's guidance for England and Wales](#) (viewed in July 2026)

terms and conditions annual, hourly and HCAS pay scales for 2026/27¹⁰⁷. As above, simple adjustments to add 23.78% pension and 15% NI (marginal for both). An estimated hourly rate plus on costs (2026/2027) of £34.15 was used for the pharmacist, social worker (excluding any additional fees paid to sit on the panel), and independent advocate. See Table 26.

Table 26: Estimated hourly salary plus on costs (2026/27) for non-medical staff

Pay band	Hourly salary (26/27) ¹⁰⁸	Hourly salary plus on costs (26/27)
Band 6 (top step point)	£24.61	£34.15

Interpreter

223. 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 2026/27 prices using the GDP deflator. An estimated hourly rate of £37.57 per hour was used for the interpreter.

11.4 - Estimated cohort by step

224. 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).

225. For this IA, it is assumed that:

- 100% of applicants are seen at Step 1: Preliminary discussion
- 95% of applicants are seen at Steps 2 & 3: First declaration and first assessment
- 85% of applicants are seen at Step 4: Second assessment
- 75% of applicants are seen at Step 5: Panel
- 65% of applicants proceed to Step 6 & 7: Second declaration and dispensing of approved substance
- 60% of applicants proceed with Steps 8 to 10 (provision of assistance, final statement, and death certification)

¹⁰⁷ NHS Employers (2026), [Pay scales for 2026/27 | NHS Employers](#) (viewed July 2026)

¹⁰⁸ NHS Employers (2026), [Pay scales for 2026/27 | NHS Employers](#) (viewed July 2026)

226. The cohort estimates by step of the process are set out in Table 27.

Table 27: Cohort estimates by step (England and Wales)¹⁰⁹

Step	Description	Year 1 (2031/32)			Year 10 (2040/41)		
		Low	Central	High	Low	Central	High
1	Preliminary discussion	496	2,208	4,610	2,278	5,836	10,428
2 & 3	First declaration and first doctor's assessment	471	2,097	4,379	2,164	5,545	9,907
4	Second doctor's assessment	422	1,877	3,918	1,937	4,961	8,864
5	Multidisciplinary panel assessment	372	1,656	3,457	1,709	4,377	7,821
6 & 7	Second declaration and dispensing of approved substance	323	1,435	2,996	1,481	3,794	6,779
8, 9 & 10	Provision of assistance, final statement, and death certification	298	1,325	2,766	1,367	3,502	6,257

Estimated cost of staff time to deliver VAD service

227. As set out in Table 28, the estimated costs of health and social care staff time to deliver VAD services in England and Wales in Year 1 is:

- for people who do not require an advocate or interpreter (95.7% of the cohort): between £715k to £6.64m
- for people who require an independent advocate (2.5% of the cohort): between £43k to £396k
- for people who require an interpreter (1.8% of the cohort): between £31k to £285k.

Table 28: Estimated cost of staff time to deliver VAD service in Year 1, England and Wales¹¹⁰

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	£715k	£43k	£31k	£788k

¹⁰⁹ DHSC analysis based on Table 5 and Table 9

¹¹⁰ DHSC estimates based on figures found in Table 23, Table 24 and Table 27

Central	£3.18m	£190k	£136k	£3.51m
High	£6.64m	£396k	£285k	£7.32m

228. This gives a total estimated staff time cost of between £788k to £7.32m in Year 1, excluding panel fees.

229. 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.

230. A breakdown of the costs per step of the process is contained in Table 29. 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.

29^[OBJ]: Estimated cost of staff time to deliver VAD service in Year 1, by step, ¹¹¹[OBJ]

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	2,208	£268.9k	£17.6k	£12.6k	£299.2k
2 & 3	First declaration and first doctor's assessment	2,097	£511k	£33.4k	£24.0k	£568k
4	Second doctor's assessment	1,877	£457.3k	£29.9k	£21.5k	£509k
5	Multidisciplinary panel assessment	1,656	£1.07m	£69.9k	£50.3k	£1.19m
6	Second declaration	1,435	£87.4k	£5.7k	£4.1k	£97.2k
7	Dispensing the approved substance	1,435	£46.9k	£1.2k	£882	£49.0k

¹¹¹ DHSC estimates based on figures found in Table 2, Table 23, Table 24, Table 27 and Table 30

8	Provision of assistance (remain with person)	1,325	£322.8k	£21.1k	£15.2k	£359.0k
9	Final statement	1,325	£161.4k	£4.2k	£3.0k	£168.6k
10	Death certification	1,325	£254.8k	£6.7k	£4.8k	£266.2k

231. Table 30, the estimated costs of health and social care staff time to deliver VAD services in England and Wales in Year 10 is:

- for people who do not require an advocate or interpreter (95.7% of the cohort): between £3.28m to £15.0m
- for people who require an independent advocate (2.5% of the cohort): between £196k to £895k
- for people who require an interpreter (1.8% of the cohort): between £141k to £645k.

232. This gives a total estimated staff time cost of between £3.62m to £16.6m in Year 10, excluding panel fees.

Table 30: Estimated cost of staff time to deliver VAD service in Year 10, England and Wales¹¹²

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	£3.28 m	£196k	£141k	£3.62 m
Central	£8.41 m	£501k	£361k	£9.27 m
High	£15.0 m	£895k	£645k	£16.6 m

233. 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.

234. **Table 31** 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

¹¹² DHSC estimates based on figures found in Table 23, Table 24 and Table 27

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.

31^[OBJ]: 113 (central cohort)¹¹⁴

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	5,836	£711k	£46.4k	£33.4k	£791k
2 & 3	First declaration and first doctor's assessment	5,545	£1.35m	£88.2k	£63.5k	£1.50m
4	Second doctor's assessment	4,961	£1.21m	£78.9k	£56.8k	£1.34m
5	Multidisciplinary panel assessment	4,377	£2.83 m	£185k	£133.0k	£3.15 m
6	Second declaration	3,794	£231k	£15.1k	£10.9k	£257k
7	Dispensing the approved substance	3,794	£124.0k	£3.2k	£2.3k	£129.6k
8	Provision of assistance (remain with person)	3,502	£853k	£55.7k	£40.1k	£949k
9	Final statement	3,502	£427k	£11.1k	£8.0k	£446k
10	Death certification	3,502	£673k	£17.6k	£12.7k	£704k

235. 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.

236. 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).

¹¹⁴ DHSC estimates based on figures found in Table 2, Table 23, Table 24, Table 27 and Table 30

11.5 - Resourcing implications

237. 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

238. The Bill states that there would be a Voluntary Assisted Dying Commissioner, appointed by the Prime Minister. Before making an appointment under this section, the Prime Minister must also consult the Welsh Ministers. The 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.
239. 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, 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.
240. 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 £2,100 per day; amounting to an average annual cost of between £1.1m and £6.2m 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 £11.2m to £16.6m per year, with a central estimate of £13.5m per year.

12.2 - Implementation costs

241. 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.
242. 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 and so on. 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

243. 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 Panels¹¹⁵

244. 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 2025-26¹⁰⁰, therefore, it would cost approximately £2,100 per day. This does not include any wider administrative costs of convening and running the panels, or the estates costs.
245. 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 the process and receive assistance to die. A range of reasons are reported to explain this including:

- the person deciding to withdraw from the process

- the person being assessed as ineligible by medical professionals at various assessment points (depending on the scheme)
- the person being assessed as losing their mental capacity later in the process
- the person dying from their underlying terminal illness

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

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

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

249. 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.

250. 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.

251. Table 32 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 32: Estimated number at the panel stage per year, by scenario (low, central, high), England and Wales¹¹⁶

Scenario	Year 1	Year 5	Year 10
	2031/32	2035/36	2040/41
Low	372	1,107	1,709
Central	1,656	3,065	4,377
High	3,457	6,135	7,821

¹¹⁶ MoJ estimates based on cohort numbers estimated from figures found in Annex A

252. 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, however demand for the service and capacity are uncertain.
253. Applying these costs to the applications in Table 27, the panels are estimated to incur average costs of £1.0m - £6.0m per year over the 10-year appraisal period (see Table 33).

Table 33: Estimated annual panel costs 2031/32 – 2040/41, England and Wales¹¹⁷

Year	Year 1	Year 5	Year 10	Average Annual Cost
	2031/32	2035/36	2040/41	
Low	£0.4m	£1.2m	£1.8m	£1.1m
Central	£1.7m	£3.2m	£4.6m	£3.3m
High	£3.6m	£6.4m	£8.2m	£6.2m

12.4 - Resource considerations

254. 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.
255. Panels would be made up of one legal member, one psychiatrist and one social worker.
256. 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.
257. In the first year of implementation, there are estimated to be between 370 and 3,520 (with a central estimate of 1,670) applications assessed by the panel, which would require 185-1,760 (with a central estimate of 835) panels (based on the assumption a panel reviews 2 applications per day
258. If there are 220 working days in a year¹¹⁸ and panellists worked full time this is estimated to be between 2.5 – 24 Full Time Equivalent (FTE) staff (with a central estimate of 11 staff) in 2031/32, equivalent to between 1 and 8 of each staff member). After 10 years it is estimated that this could rise to 11 - 54 FTE (with a central estimate of 30 staff), equivalent to between 4 and 18 of each staff member.

¹¹⁷ MoJ estimates based on figures found in Table 32 and in Ministry of Justice and Senior Salaries Review Body (2026), [Judicial salaries and fees 2025 to 2026 - GOV.UK](#) (viewed in July 2026)

¹¹⁸ 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.

259. 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 – 360 panellists (with a central estimate of 170 panellists) would be required in 2031/32. This would rise to 170-790 (with a central estimate of 440 panellists) of each profession) by 2040/41.
260. As of 1 April 2026, there were 2,201 KCs and 229 High Court and Deputy High Court Judges¹¹⁹. This includes all KCs, both publicly and privately funded, but does not include any retired judges who may chair panels.
261. There are an estimated 21,5¹²⁰ social workers¹²¹411¹²² in Wales. Social Workers working in adult social care have high vacancy rates and turnover. As of September 24/25, the vacancy rate for social workers in local authority departments was 8.8%. The annual turnover rate was 12.8%.
262. The number of full-time equivalent psychiatry consultants working in all NHS trusts and other core organisations in England has increased by around 17% since 2010, from 4,121 in September 2010 to 4,824 in March 2026¹²². Over the last year, the number of FTE psychiatry consultants has increased by 178 (3.8%) from 4,646 in March 2025 to 4,824 in March 2026.
263. 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.

¹¹⁹ GOV.UK (2026). [Diversity of the judiciary: 2026 statistics](#) (Viewed in July 2026)

¹²⁰ Skills for Care (2025), [The state of the adult social care sector and workforce in England](#) (viewed in July 2026)

¹²¹ Social Care Wales (2025), [Data and information on the social care workforce...](#) | Social Care Wales (viewed in July 2026)

¹²² NHS England (2026), [NHS Workforce Statistics - March 2026 - NHS England Digital](#), NHS HCHS Workforce Statistics, Trust and core organisations – data tables, March 2026, Table 4 (Psychiatry group, All specialities, HCHS doctors - Consultant), (viewed August 2026)

13 - Healthcare costs at end-of-life

13.1 - Summary

264. 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.
265. 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.
266. 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.
267. 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.
268. The estimated reduced cost from unutilised healthcare ranges from between £1.73m to £37.47m in Year 1, to between £7.94m to £84.76m 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

269. 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 illness¹²³. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and 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.

¹²³ World Health Organization (2020), [Palliative care](#) (viewed in July 2026)

270. 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 family¹²⁴.

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

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

272. Findings from Marie Curie’s *Better End of Life* report 2024 indicate that patterns of provision are similar in England and Wales¹²⁵.

273. 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.

274. 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.

275. Delivery is the responsibility of health boards in their respective areas. Local authorities are responsible for the delivery of social care. Regional Partnership Boards bring together health boards, local authorities and the third sector to meet the care and support needs of people in their area.

¹²⁴ NHS (2022), *What end of life care involves* - NHS (viewed in July 2026)

¹²⁵ Marie Curie (2024), *Better End of Life Report* | Marie Curie (viewed in July 2026)

13.3 - Estimating healthcare costs at end-of-life

276. 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^[OBJ].
277. 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 £17.1k (uplifted for 2026/27). 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 34 and Table 35 below.
278. 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.
279. 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.
280. 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.
281. 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.

Table 34: Estimated healthcare cost per person by time to death in 2026/27 prices (unpublished data), England and Wales¹²⁶

Category	Total in last 6 months	Month 6	Month 5	Month 4	Month 3	Month 2	Month 1
Hospital	£13,847	£1,493	£1,500	£1,595	£2,042	£2,585	£4,632
Primary and community care	£1,423	£177	£186	£197	£215	£289	£359
Hospice	£1,093	< £0	< £0	£3	£125	£326	£640
Other	£758	£107	£111	£114	£119	£129	£178
Total healthcare costs	£17,121	£1,777	£1,797	£1,908	£2,501	£3,219	£5,808

Table 35: Estimated healthcare costs per person each month, as proportion of total costs in last 6 months (unpublished data), England and Wales¹²⁶

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%

¹²⁶ 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: [Costs and cost-effectiveness of palliative and end-of-life care - Evidence briefing summary](#) (Accessed July 2026). **Full report is unpublished data [manuscript submitted for publication] – provided via personal communication. See annexe E2 for a description of methodology and list of sources for the secondary analysis of costs conducted in this study.**

13.4 – Estimating unutilised healthcare costs

282. The palliative and end-of-life care costs for 1 month and 4 months of unutilised care have been estimated in Table 36 and Table 37.
283. 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 36 this amounts to a potential reduction in spend of between £4.04m to £37.47m in Year 1 and £18.52m and £84.76m in Year 10 (in 2026/27 prices).
284. 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 37 this amounts to a potential reduction in spend of between £1.73m and £16.07m in Year 1 and £7.94m and £36.34m in Year 10 (in 2026/27 prices).
285. 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^[OB]. 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 patients¹²⁷ who may have higher hospital care costs^[OB]. Therefore, it may be considered that the 'high' scenario is more likely than the 'low' scenario, although this is uncertain.

Table 36: Estimated palliative and end-of-life care expenditure not required, for 4 months of unutilised care, Year 1 (2031/32) and Year 10 (2040/41), in 2026/27 prices, England and Wales¹²⁸

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	Low	298	£3.23m	£316k	£326k	£161k	£4.04m
	Central	1,325	£14.38m	£1.40m	£1.45m	£715k	£17.95m
	High	2,766	£30.02m	£2.93m	£3.02m	£1.49m	£37.47m
Year 10	Low	1,367	£14.84m	£1.45m	£1.49m	£738k	£18.52m
	Central	3,502	£38.01m	£3.71m	£3.83m	£1.89m	£47.44m
	High	6,257	£67.91m	£6.63m	£6.84m	£3.38m	£84.76m

Note: Table 36 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.

¹²⁷ Balasubramanian and others (2024), [Why is end-of-life inpatient cost high among cancer patients? A prospective cohort study](#) - PMC (viewed July 2026)

¹²⁸ 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. London: National Institute for Health and Care Research (NIHR) Policy Research Unit (PRU) for Palliative and End-of-Life Care. Summary available at: [Costs and cost-effectiveness of palliative and end-of-life care - Evidence briefing summary](#) (Accessed July 2026). Full report is unpublished data [manuscript submitted for publication] – provided via personal communication. See annexe E2 for a description of methodology and list of sources for the secondary data analysis conducted in this study.

Table 37: Estimated palliative and end-of-life care expenditure not required, for 1 month of unutilised care, Year 1 (2031/32) and Year 10 (2040/41), in 2026/27 prices, England and Wales¹²⁹

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	Low	298	£1.38m	£107k	£191k	£53k	£1.73m
	Central	1,325	£6.14m	£476k	£848k	£236k	£7.70m
	High	2,766	£12.81m	£993k	£1.77m	£493k	£16.07m
Year 10	Low	1,367	£6.33m	£491k	£875k	£243k	£7.94m
	Central	3,502	£16.22m	£1.26m	£2.24m	£624k	£20.34m
	High	6,257	£28.98m	£2.25m	£4.00m	£1.11m	£36.34m

Note: Table 37 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

286. 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 expenditure¹³⁰.

287. 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.

288. 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.

289. 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.

¹²⁹ 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. London: National Institute for Health and Care Research (NIHR) Policy Research Unit (PRU) for Palliative and End-of-Life Care. Summary available at: [Costs and cost-effectiveness of palliative and end-of-life care - Evidence briefing summary](#) (Accessed July 2026). Full report is unpublished data [manuscript submitted for publication] – provided via personal communication. See annexe E2 for a description of methodology and list of sources for the secondary analysis of costs conducted in this study.

¹³⁰ Health and Social Care Select Committee (2025), [Expert Panel: Evaluation of Palliative care in England](#), page 26 (viewed July 2026)

290. There are also likely to be impacts on organisations delivering palliative and end-of-life care, as explored in the NIHR study^{[[OBI](#)]}. 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.

14 - Social care sector

14.1 - Summary

291. This section sets out the potential impacts of delivering VAD services on the social care sector; specifically, care homes and domiciliary care.
292. 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).
293. In other jurisdictions, people with end-stage cancer are reported to make up the majority of assisted deaths¹³¹. There is some available data on place of death for adults who died of cancer in England in 2024: 34.8% died at home, 33.4% in hospital, 16.5% in a hospice, 13.6% in a care home, and 1.7% in other places¹³². These proportions are applied to the estimated number of assisted deaths in England and in Wales.
294. 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.
295. It is estimated that between 41 to 376 care home residents would have an assisted death in England and Wales in Year 1, rising to between 186 and 851 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 £46k to £3.1m in Year 1, to between £209k and £7.01m in Year 10.
296. It is estimated that in Year 1 in England and Wales, between 52 and 481 people in receipt of domiciliary care would have an assisted death at home, rising to between 238 and 1,089 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 £15k to £557k in Year 1, to between £69k and £1.26m in Year 10.
297. 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.

¹³¹ For data source, see Annex A

¹³² Department of Health & Social Care (2026), [Palliative and end of life care factsheet: Patterns of care, England 2024](#) (viewed July 2026)

14.2 - Place of death

298. 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.
299. Of all deaths occurring in England in 2024, 42.3% took place in a hospital, 28.1% took place at home, 21.5% in a care home, 5.5% in a hospice and 2.6% in other places¹³³. For people who died of cancer specifically, 34.8% died in their own home, 33.4% in hospital, 13.6% in a care home, and 16.5% in a hospice¹³². 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 deaths¹³⁰; and second, because 37.3% of all deaths in care homes in England in 2024 were from dementia¹³³. 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

300. It is estimated that between 41 and 376 people who have an assisted death in Year 1 will be care home residents, rising to between 186 to 851 people in Year 10 (see Table 38). 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.
301. 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.
302. There is regional variation in the proportion of local authority and self-funded clients. The ONS¹³⁴ states that in 2022-23 the South East had the highest proportion of self-

¹³³ Department of Health and Social Care (2026), Palliative and end of life care factsheet: Patterns of care, England 2024 (viewed July 2026)

¹³⁴ Office for National Statistics (2023), Care homes and estimating the self-funding population, England - Office for National Statistics (viewed July 2026)

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 funded¹³⁴.

303. As shown in Table 38, if this split is applied to the total estimated number of assisted deaths in care homes across England and Wales, there would be:

303.1. between 15 and 139 assisted deaths among self-funded care home residents in Year 1, rising to between 69 and 315 in Year 10.

303.2. between 26 and 237 assisted deaths among local authority funded care home residents in Year 1, rising to between 117 and 536 in Year 10.

Table 38: Estimated number of assisted deaths among self-funded and local authority funded care home residents in Year 1 and Year 10, England and Wales¹³⁵

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	Low	41	15	26
	Central	180	67	114
	High	376	139	237
Year 10	Low	186	69	117
	Central	476	176	300
	High	851	315	536

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

Estimated care home fees

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

305. Carterwood’s 2025 self-funded fee report¹³⁶ prices suggest that in Great Britain, the average self-funded fee (per person, per week) was £1,302 without nursing care, and £1,696 with nursing care. There is variation across Great Britain, with the average nursing care self-funded fee in Wales reported to be £1,499, London reported at £1,949 and North East England at £1,457. Personal care self-funded fees (without nursing care) are lower, with the average in Wales at £1,143, London at £1,570 and North East England at £1,147. This illustrates the range of weekly fee rates paid in England and Wales.

¹³⁵ DHSC estimates based on figures found in Table 2 and Place of death information in Department of Health and Social Care (2026), *Palliative and end of life care factsheet: Patterns of care, England 2024* (viewed July 2026)

¹³⁶ Carterwood (2025), *2025 Self-funded fee and trading performance review - Carterwood, improve decision making* (viewed July 2026)

306. DHSC's 2025/26 provider fee report¹³⁷ estimates that the average fee paid (per person per week) by local authorities to external providers of care homes ranged from £956 (care homes for residents aged 65+ without nursing) to £1,835 (care homes for residents aged 18 to 64 without nursing). Average fees with nursing range from £1,089 for clients above the age of 65, and £1,486 for clients aged 18-64. Neither average local authority reported fee includes the NHS Funded Nursing Care payment of £254.06 per week from April 2025. 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.

307. These fees were uplifted to 2026/27 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 39).

Table 39: Average self-funded and local authority funded care home fees 2025/26

Scenario	Self-funded care home fee ¹³⁸		Local authority funded care home fee ¹³⁹	
	2025/26 prices	2026/27 prices	2025/26 prices	2026/27 prices
Lower bound	£1,143	£1,166	£956	£975
Upper bound	£1,949	£1,988	£1,835	£1,872

Estimated reduction in care home payments

308. 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.

309. 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.

Self-funders

¹³⁷ Department of Health and Social Care (2025), [Market Sustainability and Improvement Fund 2025 to 2026: care provider fees - GOV.UK](#) (viewed July 2026)

¹³⁸ Carterwood (2025), [2025 Self-funded fee and trading performance review - Carterwood, improve decision making](#) (viewed July 2026)

¹³⁹ Department of Health and Social Care (2025), [Market Sustainability and Improvement Fund 2025 to 2026: care provider fees - GOV.UK](#) (viewed July 2026)

310. As shown in Table 40, the reduction in care home payments from self-funders is estimated to be:

- in Year 1, between £70k and £4.43m
- in Year 10, between £321k and £10.02m.

Table 40: Estimated reduction in fees paid to care homes by self-funders, England and Wales¹⁴⁰

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	Low	15	£70k	£280k	£119k	£477k
	Central	67	£311k	£1.24m	£530k	£2.12m
	High	139	£649k	£2.60m	£1.11m	£4.43m
Year 10	Low	69	£321k	£1.28m	£547k	£2.19m
	Central	176	£822k	£3.29m	£1.40m	£5.61m
	High	315	£1.47m	£5.87m	£2.50m	£10.02m

Local authorities

311. As shown in Table 41, the reduction in care home payments from local authorities is estimated to be:

- in Year 1, between £100k and £7.1m
- in Year 10, between £457k and £16.06m.

Table 41: Estimated reduction in fees paid to care homes by local authorities, England and Wales^{141 142}

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	Low	26	£100k	£398k	£191k	£765k
	Central	114	£443k	£1.77m	£850k	£3.40m
	High	237	£924k	£3.70m	£1.77m	£7.10m
Year 10	Low	117	£457k	£1.83m	£877k	£3.51m
	Central	300	£1.17m	£4.68m	£2.25m	£8.99m
	High	536	£2.09m	£8.37m	£4.01m	£16.06m

312. 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 on 31 March 2026 there were 408,985 people

¹⁴⁰ DHSC estimates based on figures found in Table 36 and Table 38

¹⁴² DHSC estimates based on figures found in Table 36 and Table 38

awaiting for an assessment, care or direct payments, or reviews^[OBJ]. 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

313. Table 42 presents the total estimated reduction in care home revenue from both self-funded and local authority funded individuals. The impact is expected to be:

- in Year 1, between £170k and £11.53m
- in Year 10, between £778k and £26.07m

Table 42: Total estimated reduction in care homes revenue from both self-funded and local authority funded individuals, England and Wales¹⁴³

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	Low	41	£170k	£678k	£310k	£1.24m
	Central	180	£754k	£3.02m	£1.38m	£5.52m
	High	376	£1.57m	£6.29m	£2.88m	£11.53m
Year 10	Low	186	£778k	£3.11m	£1.42m	£5.70m
	Central	476	£1.99m	£7.97m	£3.65m	£14.59m
	High	851	£3.56m	£14.24m	£6.52m	£26.07m

Estimated reduction in care home profits

314. 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 359,215 care home residents (as of May 2026), with an occupancy rate of 86.1%^[OBJ]. In Wales, there were an estimated 23,000 care beds for the elderly (in 2017)^b To illustrate this using a very broad estimate, based on a high scenario estimate of 376 care home residents using the VAD service in year 1, less than 0.1% of care home residents are estimated to use the VAD service.

315. 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 impact¹⁴⁴.

316. 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

¹⁴³ DHSC estimates based on figures found in Table 40 and Table 41

¹⁴⁴ 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 2024/25* (viewed in July 2026)

Rent and Management (EBITDARM) margin in March 2024¹⁴⁴. 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.

317. For 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.

318. As shown in Table 43, the estimated reduction in care home profits ranges from:

318.1. in Year 1, between £46k and £3.10m

318.2. in Year 10, between £209k and £7.01m

Table 43: Total estimated reduction in care homes profits, England and Wales¹⁴⁵

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	Low	41	£46k	£182k	£84k	£334k
	Central	180	£203k	£811k	£371k	£1.49m
	High	376	£423k	£1.69m	£775k	£3.10m
Year 10	Low	186	£209k	£837k	£383k	£1.53m
	Central	476	£536k	£2.14m	£981k	£3.93m
	High	851	£958k	£3.83m	£1.75m	£7.01m

14.4 - Impact on domiciliary care providers

Estimated number of people receiving domiciliary care

319. It is estimated that the number of people having an assisted death in their own home would range from between 104 and 963 in Year 1, to between 476 and 2,177 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.

320. 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

¹⁴⁵ DHSC estimates based on figures found in Table 42 and profit assumptions from Care Quality Commission (2025), The state of health care and adult social care in England 2024/25 (viewed in July 2026)

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.

321. 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, DHSC reported in the quarterly update that as of March 2026, there were 489,640 local authority arranged or supported community care users¹⁴⁶, and the Policy Research Unit in Adult Social Care reported that in 2022, there were 119,000 older people self-funding community care¹⁴⁷. 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-funded¹⁴⁸. 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 44.

Table 44: Estimated number of people having an assisted death at home and receiving domiciliary care, England and Wales¹⁴⁹

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	Low	104	52	12	40
	Central	461	231	53	178
	High	963	481	111	371
Year 10	Low	476	238	55	183
	Central	1,219	609	140	469
	High	2,177	1,089	250	838

Estimated domiciliary care fees

322. 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 £25.05 per hour in 2025/26¹⁴⁹. People who self-fund are likely to pay more but there is limited

¹⁴⁶ Department of Health and Social Care (2026), Adult social care client level data, England: quarterly update to March 2026 - GOV.UK (long-term support, data to March 2026) (viewed in July 2026)

¹⁴⁷ 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 July 2026)

¹⁴⁸ Office for National Statistics (2023), Estimating the size of the self-funding population in the community, England - Office for National Statistics (viewed in July 2026)

¹⁴⁹ DHSC estimates based on Table 2 and figures in Place of Death in Department of Health and Social Care (2026), (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 July 2026)

data available on this. As an example, the Homecare Association suggest in 2025/26 the “minimum price for homecare” in England is £32.14¹⁵⁰ hour¹⁵¹.

323. 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 2026/27 prices, assuming an average of 35 hours per week are shown in Table 45.

Table 45: Average self-funded and local authority funded domiciliary care fee

Scenario	Local authority funded domiciliary care fee ¹⁵²	Self-funded domiciliary care fee ¹⁵³		
	2025/26 prices	2026/27 prices	2025/26 prices	2026/27 prices
Average fee per hour	£25.05	£25.55	£32.14	£32.79
Average weekly fees paid assuming 35 hours per week	£876.75	£894.37	£1,124.90	£1,147.51

Estimated reduction in domiciliary care payments

324. 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.

325. 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 funded¹⁵⁴. The estimated number of people having an assisted death, who would have been receiving self-funded or local authority funded

¹⁵¹ Homecare Association (2025), [Minimum Price for Homecare 2026/2027](#) (viewed in July 2026)

¹⁵² Department of Health and Social Care (2025), [Market Sustainability and Improvement Fund 2025 to 2026: care provider fees - GOV.UK](#) (viewed in July 2026)

¹⁵³ Homecare Association (2025), [Minimum Price for Homecare 2026/2027](#) (viewed in July 2026)

¹⁵⁴ Office for National Statistics (2023), [Estimating the size of the self-funding population in the community, England - Office for National Statistics](#) (viewed in July 2026)

domiciliary care, is multiplied by the estimated weekly average fee (assuming 35 hours of care per week).

Self-funded care

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

- between £55k and £2.03m in Year 1
- between £251k and £4.6m in Year 10.

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

Table 46: Estimated reduction in fees paid to domiciliary care organisations by self-funders, England and Wales¹⁵⁵

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	Low	12	£55k	£219k
	Central	53	£243k	£974k
	High	111	£508k	£2.03m
Year 10	Low	55	£251k	£1.00m
	Central	140	£643k	£2.57m
	High	250	£1.15m	£4.60m

Local authority funded care

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

- between £143k and £5.3m in Year 1
- between £655k and £12.0m in Year 10.

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

¹⁵⁵ DHSC estimates based on figures found in Table 44 and Homecare Association (2025), [Minimum Price for Homecare 2026/2027](#) (viewed in July 2026)

Table 47: Estimated reduced spend by local authorities on domiciliary care, England and Wales¹⁵⁶

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	Low	40	£143k	£571k
	Central	178	£635k	£2.54m
	High	371	£1.33m	£5.30m
Year 10	Low	183	£655k	£2.62m
	Central	469	£1.68m	£6.71m
	High	838	£3.00m	£12.00m

330. 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) 2026 spring survey reports that are 408,985 people waiting for an assessment, care or direct payments to begin or a review of their care plan, which is an increase from last year's figure of 372,113¹⁵⁷. 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

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

331.1. in Year 1, between £198k and £7.34m

331.2. in Year 10, between £906k and £16.59m

Table 48: Total estimated reduced revenue for domiciliary care organisations, England and Wales¹⁵⁸

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	Low	52	£198k	£790k
	Central	231	£878k	£3.51m

¹⁵⁶ DHSC estimates based on figures found in Table 44 and Department of Health and Social Care (2025), Market Sustainability and Improvement Fund 2025 to 2026: care provider fees - GOV.UK (viewed in July 2026)

¹⁵⁷ Directors of Adult Social Services (ADASS) (2026), ADASS Spring Survey 2026 - ADASS (viewed in July 2026)

¹⁵⁸ DHSC estimates based on figures found in Table 46 and Table 47

	High	481	£1.83m	£7.34m
Year 10	Low	238	£906k	£3.63m
	Central	609	£2.32m	£9.29m
	High	1,089	£4.15m	£16.59m

Domiciliary care provider profits

332. 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)^[OBJ] 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 ¹⁵⁹ also do not adjust for any change in demand to adult social care services which may increase with an ageing population^[OBJ]. However, this very broad calculation does offer an indication of the scale of profit impacts.

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

333.1. in Year 1, between £15k and £557k

333.2. in Year 10, between £69k and £1.26m

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

Table 49: Total estimated reduced profit for domiciliary care organisations, England and Wales¹⁶⁰

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	Low	52	£15k	£60k
	Central	231	£67k	£267k
	High	481	£139k	£557k
Year 10	Low	238	£69k	£276k
	Central	609	£176k	£706k
	High	1,089	£315k	£1.26m

¹⁵⁹ 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 July 2026)

¹⁶⁰ DHSC estimates based on figures found in Table 48 and profit assumptions from LaingBuisson (2024), Adult Social Care in the UK Scale, Structure, Funding and Financial Performance of the Independent Sector (PDF, 1,873 KB), (viewed in July 2026)

15 - Wider impacts on state pensions and state benefits

15.1 - Summary

335. 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”¹⁶¹ 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.

336. 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”¹⁶². This section looks at the following social security payments which individuals who have an assisted death could be in receipt of:

- State Pension (including the basic state pension and the new state pension)
- State Benefits available under the Special Rules for people at end of life
- Carer’s Allowance

337. 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 Table 52 and Table 55 respectively. Carers Allowance is also a classed as a state benefit; however, this impact has not been quantified and is described qualitatively.

338. 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 87% of those who have an assisted death would be in receipt of state pension and Attendance Allowance¹⁶³. It is then assumed that the remaining 13% of people who have an assisted death would be under pension age and in receipt of Personal Independence Payment (PIP).

339. 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.

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

¹⁶¹ HM Treasury and Government Finance Function (2026), *The Green Book (2026)* - GOV.UK (viewed in July 2026)

¹⁶² House of Commons Library (2022), *An introduction to social security in the UK* - House of Commons Library (viewed in July 2026)

¹⁶³ This is the median of the average proportion of assisted deaths reported among those aged 65+, across comparable jurisdictions. See ‘cohort demographics’ for further detail.

- 340.1. for state pensions, between £252k and £9.35m in Year 1, to between £1.65m and £30.24m in Year 10;
- 340.2. for Attendance Allowance, between £119k and £4.43m in Year 1, to between £547k and £10.01m in Year 10; and
- 340.3. for PIP, between £29.5k and £1.10m in Year 1, to between £135k and £2.48m in Year 10.

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

342. There may also be wider impacts on private pensions as a result of someone using the assisted dying service. However, the impacts on private pensions are highly uncertain at this stage.

15.2 - State pension

Estimated number of state pension recipients

343. As of November 2025¹⁶⁴~~[OBJ]~~ there were 11.07 million people receiving State Pension in England and Wales. Of these, 6.64 million received the basic State Pension and 4.43 million people received the new State Pension.

344. 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.

345. 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 87%¹⁶⁵ 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. Based on these assumptions, the estimated number of assisted deaths among people who are of pension age ranges from 260 to 2,413 in Year 1, to between 1,193 to 5,459 in Year 10. This maximum would represent less than 0.05% of the total number of state pension claimants in 2025 referenced.

¹⁶⁴ Stat-Xplore (2026), [Stat-Xplore](#) (login required) (viewed in July 2026). Dataset: State Pension – Data from May 2018. Table: SP 1 – Category of Pension. Filters: by Geography >National – Regional – LA – OAs > Great Britain, and Category of Pension > tick all.

¹⁶⁵ This is the median of the average proportion of assisted deaths reported among those aged 65+, across comparable jurisdictions. See 'cohort demographics' for further detail.

Table 50: Estimated number of assisted deaths of people who are of state pension age, England and Wales¹⁶⁶

Estimate	Year 1: 2031/32	Year 10: 2040/41
Low	260	1,193
Central	1,156	3,055
High	2,413	5,459

Estimated state pension payments

346. The full rate of the basic State Pension as of 2026/27 is £184.90¹⁶⁷ 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 is £241.30¹⁶⁸ per week, and claimants may be eligible for a “protected payment” paid on top of the full rate.

347. 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.

348. 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 DWP¹⁶⁹ have been used to determine the average entitlement per individual until 2031/32 (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 51.

Table 51: Estimated average entitlement per individual, from DWP forecast data¹⁷⁰

Metric	2030/31
State pension forecast expenditure (real terms, 2026/27 prices)	£167.4bn
State pension forecast caseload	13.7m
Average entitlement per individual (annually)	£12.2k
Average entitlement per individual (weekly)	£235.10

349. The average weekly state pension is uprated each year in line with the ‘triple lock’¹⁷¹, which assumes it will rise by the highest of CPI inflation, average earnings growth, or 2.5 per cent^{OBJ}. The average weekly entitlement per individual is therefore estimated at £242.12 (2026/27 prices) in Year 1, and £346.18 (2026/27 prices) in Year 10.

¹⁶⁶ DHSC estimates based on figures found in Table 2 and Table 7

¹⁶⁷ UK Government (2026), [The basic State Pension: How much you get](#) - GOV.UK (viewed in July 2026)

¹⁶⁸ UK Government (2026), [The new State Pension: What you'll get](#) - GOV.UK (viewed in July 2026)

¹⁶⁹ UK Government (2026), [Benefit expenditure and caseload tables 2026](#) - GOV.UK (viewed July 2026)

¹⁷⁰ UK Government (2026), [Benefit expenditure and caseload tables 2026](#) - GOV.UK (viewed July 2026)

¹⁷¹ Office for Budget Responsibility (2026), [Economic and fiscal outlook – March 2026](#) - Office for Budget Responsibility (viewed in July 2026)

Estimated state pension economic transfer

350. 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.

351. As shown in Table 52, it is estimated that unutilised state pension would represent an economic transfer of:

351.1. in Year 1 between £252k and £2.34m (for 1 month of unutilised state pension), to between £1.01m and £9.35m (for 4 months of unutilised state pension)

351.2. in Year 10 between £1.65m and £7.56m (for 1 month of unutilised state pension), to between £6.61m and £30.24m (for 4 months of unutilised state pension).

352. 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 another¹⁷².

Table 52: Estimated state pension economic transfer, England and Wales¹⁷³

	1 month (4 weeks) not required		4 months (16 weeks) not required	
	Y1 - 2031/32	Y10 - 2040/41	Y1 - 2031/32	Y10 - 2040/41
Low	£252k	£1.65m	£1.01m	£6.61m
Central	£1.12m	£4.23m	£4.48m	£16.92m
High	£2.34m	£7.56m	£9.35m	£30.24m

15.3 - State benefits available through Special Rules End of Life

Estimated number of state benefit recipients

353. 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 assessment¹⁷⁴. 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).

¹⁷² HM Treasury and Government Finance Function (2026), *The Green Book* - GOV.UK (viewed in July 2026)

¹⁷³ DHSC estimates based on figures found in Table 50 and Table 51

¹⁷⁴ Department for Work and Pensions (2024), *The 'Special Rules': how the benefit system supports people nearing the end of life* - GOV.UK (viewed in July 2026)

354. 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 Allowance¹⁷⁵. 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 Payment¹⁷⁶. Both are available under SREL to people with a life-limiting illness, disability, or condition. The assumption that 87% of assisted deaths are among people of state pension age is carried across from the previous section, and so 13% are assumed to be under pension age.

Estimated state benefit payments to people of pension age

355. It is estimated that between 260 and 2,413 people of state pension age having an assisted death in Year 1, increasing to between 1,193 and 5,459 in Year 10.

356. People claiming Attendance Allowance under the special rules for end of life get the higher rate at £114.60 per week (as of 2026/27)¹⁷⁷. For illustrative purposes, it is assumed that a person receiving Attendance Allowance (SREL) would receive the same payment in Year 1 as in Year 10.

357. 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).

358. As shown in Table 53, it is estimated that unutilised Attendance Allowance (SREL) would represent an economic transfer of:

358.1. between £119k and £1.11m (1 month not required), to between £477k and £4.43m (4 months not required) in Year 1.

358.2. between £547k and £2.50m (1 month not required), to between £2.19m and £10.01m (4 months not required) in Year 10.

Table 53: Estimated economic transfer, individuals over pension age, Attendance Allowance (SREL), England and Wales¹⁷⁸

	1 month (4 weeks) not required		4 months (16 weeks) not required	
	Y1 - 2031/32	Y10 - 2040/41	Y1 – 2031/32	Y10 – 2040/41
Low	£119k	£547k	£477k	£2.19m
Central	£530k	£1.40m	£2.12m	£5.60m
High	£1.11m	£2.50m	£4.43m	£10.01m

¹⁷⁵ UK Government (2025) [Attendance Allowance](#) (viewed July 2026)

¹⁷⁶ UK Government (2025) [Personal Independence Payment \(PIP\)](#), (viewed July 2026)

¹⁷⁷ UK Government, [Attendance Allowance: Claiming Attendance Allowance if you're nearing the end of life - GOV.UK](#) (viewed in July 2026)

¹⁷⁸ DHSC estimates based on figures found in Table 50 and UK Government, [Attendance Allowance: Claiming Attendance Allowance if you're nearing the end of life - GOV.UK](#) (viewed in July 2026)

Estimated state benefit payments to people under pension age

359. It is estimated that between 38 and 353 people under pension age would have an assisted death in Year 1, and between 174 and 798 in Year 10.

360. 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 £194.26 in April 2026. It is unclear whether or by how much benefit entitlements would change in the future. For illustrative purposes, it is assumed that the value of the payment in Year 1 would be the same as Year 10.

361. As shown in Table 54, it is estimated that unutilised Personal Independence Payment (SREL) would represent an economic transfer of:

361.1. in Year 1, from between £29.5k and £274k (1 month not required), to between £118k and £1.10m (4 months not required), based on between 38 and 353 individuals under state pension age using VAD.

361.2. in Year 10, from between £135k and £620k (1 month not required), to between £542k and £2.48m (4 months not required), based on between 174 and 798 individuals under state pension age using VAD.

Table 54: Estimated economic transfer, individuals under state pension age, Personal Independence Payment (SREL), England and Wales¹⁷⁹

	1 month (4 weeks) not required		4 months (16 weeks) not required	
	Y1 - 2031/32	Y10 - 2040/41	Y1 - 2031/32	Y10 - 2040/41
Low	£29.5k	£135k	£118k	£542k
Central	£131k	£347k	£525k	£1.39m
High	£274k	£620k	£1.10m	£2.48m

Estimated state benefits economic transfer

362. The estimated economic transfer for state benefits payments has been calculated by summing the estimated state benefit payments for individuals under pension age (Table 54) and the estimated state benefit payments for individuals of pension age (Table 53).

363. As shown in Table 55, it is estimated that unutilised state benefits would represent an economic transfer of:

363.1. In year 1, from between £149k and £1.38m (1 month not required) to between £595k and £5.52m (4 months not required).

363.2. In year 10, from between £682k and £3.12m (1 month not required) to between £2.73m and £12.49m (4 months not required).

¹⁷⁹ DHSC estimates based on figures found in Table 50 and Stat Xplore (2026), [Stat-Xplore - Home](#) (login required) (viewed in July 2026). 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).

Table 55: Estimated state benefit economic transfer, total, England and Wales¹⁸⁰

	Lower bound 1 month (4 weeks)		Upper bound 4 months (16 weeks)	
	Y1 – 2031/32	Y10 – 2040/41	Y1 – 2031/32	Y10 – 2040/41
Low	£148.7k	£682k	£595k	£2.73m
Central	£661k	£1.75m	£2.64m	£6.99m
High	£1.38m	£3.12m	£5.52m	£12.49m

15.4 - Carer's Allowance

364. 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 £86.45 a week if they care for someone for at least 35 hours a week¹⁸¹. 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.

¹⁸⁰ DHSC estimates based on figures found in Table 53 and Table 54

¹⁸¹ UK Government (2025), [Carer's Allowance: How it works - GOV.UK](#) (viewed in July 2026)

16 – Wider impacts on the justice system, and death certification and registration

365. 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)

366. 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.

367. 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 2025, there were 224 deaths in custody due to natural causes¹⁸², 135 of which occurred in hospitals, hospices or nursing homes¹⁸³. Between 2010 - 2023, there were an average of 10 early releases on compassionate grounds per year¹⁸⁴.

368. Whilst this IA is unable to accurately estimate the number of prisoners who would seek to access VAD, it is notable that the proportion of older prisoners in prison has increased. In 2025, 18% of prisoners were over the age of 50 compared to 9% in 2010¹⁸⁵. The number of prisoners over 50 forecast to increase until at least 2029^[OBJ].

369. 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

370. 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

¹⁸² Ministry of Justice and HM Prison & Probation Service (2025), [Safety in custody: quarterly update to December 2025 - GOV.UK](#) viewed in July 2026)

¹⁸³ Ministry of Justice and HM Prison & Probation Service (2025), [Safety in custody: quarterly update to December 2025 - GOV.UK](#) viewed in July 2026)

¹⁸⁴ Ministry of Justice (2024), [Written questions and answers - Written questions, answers and statements - UK Parliament](#) (viewed in March 2025)

¹⁸⁵ UK Parliament, House of Commons Library (2026), Research Briefing: [Prison population statistics - House of Commons Library](#) (Accessed July 2026)

diligence to avoid committing 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

371. Between April 2014-March 2026, there have been an average of 51 police recorded crimes per year for the offence of encouraging or assisting suicide under the Suicide Act 1961.

Table 56: Police recorded crime for encouraging or assisting suicide from year ending March 2014 to year ending March 2026¹⁸⁶

Financial Year	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Aiding suicide	19	32	29	26	37	48	73	49	53	51	91	104

372. 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)

373. According to the CPS¹⁸⁷: “From 1 April 2009 up to 31 March 2026, our manual records indicate there have been 209 cases referred to the CPS by the police that have been recorded as assisted suicide. Of these 209 cases, 131 were not proceeded with by the CPS and 42 cases were withdrawn by the police. There are currently 13 ongoing cases. Six cases of encouraging or assisting suicide have been successfully prosecuted, and two cases have been charged and acquitted after trial. Eight cases were referred onwards for prosecution for homicide or other serious crime”.

374. As set out in Table 57 there are seven cases with an unknown outcome; excluding these and the thirteen ongoing cases, there have been 189 cases over the past 15 years with a known outcome.

Table 57: CPS Assisted Suicide Cases from 1st April 2009 – 31st March 2026¹⁸⁷

Type	Number
Cases referred to Crown Prosecution Service	209
Cases not proceeded	131
Cases withdrawn by police	42
Cases ongoing	13

¹⁸⁶ Home Office (2025), [Police recorded crime and outcomes open data tables](#) - GOV.UK (viewed in July 2026)

¹⁸⁷ Crown Prosecution Service (2024), [Assisted Suicide | The Crown Prosecution Service](#) (viewed in July 2026)

Cases successfully prosecuted	6
Cases acquitted after trial	2
Cases referred onwards for homicide or more serious crime	8
Unknown Outcome	7

375. Over the past 17 years, 92% of cases have not been proceeded by the CPS or been withdrawn by the police (see Table 58). The remaining 8% have been brought to trial or referred on for a more serious crime.

376. Averaging this data over the 17 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 58: CPS Encouraging or Assisting Suicide Cases with a known outcome from 1st April 2009 – 31st March 2026¹⁸⁸

Cases	No. of Cases	% of Cases
Cases referred to CPS	189	100%
Cases not proceeded	131	69%
Cases withdrawn by police	42	22%
Cases successfully prosecuted	6	3%
Cases acquitted after trial	2	1%
Cases referred onwards for homicide or more serious crime	8	%

377. 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.

Impact on Ministry of Justice (including HMCTS, the Legal Aid Agency and HMPPS)

378. Between 2010-2025, ten individuals were proceeded against (including one of which was sentenced in 2010 but proceedings began before then) for encouraging or assisting suicide (as the principal offence). Six of these individuals were convicted and sentenced¹⁸⁹, and of those sentenced: 1 received a conditional discharge in 2010; 1 received a suspended sentence in 2017 and 4 have been sentenced to custody in

¹⁸⁸Crown Prosecution Service (2024), [Assisted Suicide | The Crown Prosecution Service](#) (viewed in July 2026)

¹⁸⁹ Ministry of Justice (2024), [Criminal Justice System statistics quarterly: June 2024 - GOV.UK](#) (viewed in July 2026)

2013 (Over 10 years and up to and including 15 years), 2018, (4 years) 2021 (4 years) and 2025 (Over 8 years and up to and including 9 years) respectively.

379. 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

380. The Bill creates several criminal offences which could impact on the justice system.

381. 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 Test is met'¹⁹⁰.

382. Where there is sufficient evidence to justify a prosecution, prosecutors must then determine whether a prosecution is required in the public interest.

383. According to the CPS¹⁹⁰ a prosecution under the Suicide Act 1961 is more likely if (among other factors):

- 'the victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide';
- 'the victim had not reached a voluntary, clear, settled and informed decision to commit suicide';
- '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';
- 'the suspect pressured the victim to commit suicide';
- 'the suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide';

384. 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.

¹⁹⁰ Crown Prosecution Service (2014), [Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide | The Crown Prosecution Service](#) (viewed in July 2026)

385. 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.
386. 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

387. 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

388. According to the Bill, 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.
389. 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.
390. 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

391. The estimated impacts of the VAD service on social care organisations are detailed in the 'Social care' section. 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 -£46k and -£3.10m in Year 1 and between -£209k and -£7.01m in Year 10. It is estimated that the total impact on domiciliary care sector profit would be between -£15k and -£557k in Year 1 and between -£69k and -£1.26m in Year 10. All estimates are in 2026/27 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.
392. 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.
393. 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 1.5% of deaths in comparable jurisdictions¹⁹¹.
394. 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. 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

395. No potential trade implications are anticipated from the assisted dying policy.

¹⁹¹ See table 62 in Annex A for more details.

19 - Equality Impact Assessment (EQIA)

396. 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 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

397. 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.

398. 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.

399. 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

400. 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.

401. 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. A survey conducted by the British Medical Association suggests that this could range

from 35% to 76% for specific groups of staff^[OBJ]. 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.

Oversight, regulation, and data

402. 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.
403. 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 care¹⁹². 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

404. 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 considered¹⁹³. Moreover, certain suppliers may

¹⁹² Oregon Health Authority (2022), [Oregon Health Authority : Frequently Asked Questions : Death with Dignity Act : State of Oregon](#) (viewed in July 2026)

¹⁹³ Worthington, A., Finlay, I. and Regnard, C. (2022), [Efficacy and safety of drugs used for 'assisted dying' - PMC](#) (Viewed in July 2026)

not want their medication to be used for assisted dying purposes. This is a risk that has not been formally assessed.

Timelines

405. 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 few 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.
406. 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:
- 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.
 - 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)
407. 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

408. 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.

409. 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:

- Progress made in that period in connection with the implementation of the Bill, and
- The Secretary of State's plans for implementing the Bill in subsequent reporting periods (including in the expected timetable for implementation)

410. 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 (where the sixth reporting period is the last reporting period).

411. 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.

412. 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, including:

- pain and symptom management;
- psychological support for those persons and their families; and
- information about palliative care and how to access it.

413. Clause 49 of the Bill sets out that the Voluntary Assisted Dying Commissioner is required to:

- monitor the operation of the Bill;
- 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
- submit an annual report to the Secretary of State or, in Wales, the Welsh Ministers on the operation of the Bill.

414. 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:

- 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;
- 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;
- 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.
- any concerns with the operation of this Bill which have been raised; and
- 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).

415. 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

416. 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.

417. 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.

418. 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.

419. It is possible that, along with this data, more may need to be collected. Monitoring questions could include but would not be limited to:

- How many people are accessing assisted dying at each stage of the process?
- What are the characteristics of those requesting assisted dying?
- What are the outcomes for people who do not proceed with assisted dying (due to withdrawal or unassisted death)?
- What are the key procedural and clinical details of assisted deaths?
- How is the assisted dying process being implemented by healthcare professionals?

420. 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.

421. This data collection would help assess the legislation's impact during implementation and for the five-year review.

422. 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:

- Have assisted dying services been implemented as intended?
- Are there any barriers to assisted dying services?
- What areas of assisted dying services are working more or less well, and why?

423. 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:

- Have assisted dying services achieved the expected outcomes and to what extent?
- Have assisted dying services resulted in any unintended outcomes?
- To what extent have different populations been impacted by the Bill and in what way?

424. 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

425. 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. There are further jurisdictions that have legalised assisted dying, but which are not listed here because an assisted dying service is not yet in operation, for example, due to the fact that legislation has only recently passed or is undergoing legal challenge.

426. 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 59: Information on other jurisdictions with an operational assisted dying service^{194 195 196}

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 2025: SB 403 removed the Act’s sunset clause and made the End of Life Option Act permanent
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

¹⁹⁴ Health and Social Care Committee (2024), [Assisted Dying/Assisted Suicide - Health and Social Care Committee](#) (viewed in July 2026)

¹⁹⁵ Death with Dignity (2026), [Death with Dignity U.S. Legislative Status State Map](#) (viewed in July 2026)

¹⁹⁶ Life Issues Institute (2024), [Euthanasia and Assisted Suicide Global Timeline - Life Issues Institute](#) (viewed in July 2026)

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
										2024: Legislation to extend the temporary exclusion of eligibility for MAID in circumstances where a person's sole underlying medical condition is a mental illness received royal assent. The eligibility date for persons suffering solely from a mental illness is now March 17, 2027.
*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, 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 (12 months for neurodegen erative diseases)	No	No	No	Yes	Yes	No	No changes but in 2024, an amendment was tabled that would waive the 15 day waiting period for medical aid in dying under certain circumstances.
*New Mexico (USA)	2021	Yes	6 months	No	No	No	Yes	Yes	No	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
New South Wales (Aus)	2023	Yes	6 months (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) Comparable until 2023	1998	Yes	6 months	No	No	No	No (Yes until 2023)	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
Queensland (Aus)	2023	Yes	12 months	No	No	No	Yes	Yes	Yes	None
South Australia (Aus)	2023	Yes	6 months (12 months for neurodegenerative diseases)	No	No	No	Yes	Yes	Yes	None
Spain	2021	Not established	Not established	Yes	No	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 neurodegen	No	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
			enerative diseases)							
*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.
*Vermont (USA) Comparable until 2023	2013	Yes	6 months	No	No	No	No (Yes until 2023)	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 (12 months for neurodegenerative diseases)	No	No	No	Yes	Yes	Yes	None
*Washington (USA)	2009	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)

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
Western Australia (Aus)	2021	Yes	6 months (12 months for neurodegen erative diseases)	No	No	No	Yes	Yes	Yes	None

Table 60: Total number of all deaths (not just assisted deaths) in comparable jurisdictions, by year assisted dying service was implemented

Jurisdiction	Washington (USA) ¹⁹⁷	California (USA) ¹⁹⁸	New Zealand ¹⁹⁹	Oregon (USA) ²⁰⁰	Hawaii (USA) ²⁰¹	District of Columbia (USA) ²⁰²	Maine (USA) ²⁰³	Vermont (USA) ²⁰⁴
Implementation year	2009	2016	2021	1997	2019	2017	2019	2013
First full year of data²⁰⁵	2010	2017	2022	1998	2019	2018	2020	2014
Year 1	47,980	268,385	38,835	29,346	11,736	5,008	15,740	5,627
Year 2	49,385	269,154	37,623	29,356	12,027	4,927	17,269	5,919
Year 3	51,239	270,092	37,647	29,541	12,877	6,198	17,364	5,908
Year 4	51,038	320,128	37,821	30,128	13,307	5,833	16,750	6,010
Year 5	52,034	333,573	NA	31,082	12,751	5,385	16,595	6,027
Year 6	54,513	313,199	NA	30,813	12,883	4,916	NA	5,956
Year 7	54,748	294,706	NA	30,201	12,758	4,817	NA	6,461
Year 8	57,012	288,184	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	63,173	NA	NA	32,020	NA	NA	NA	6,707
Year 12	68,749	NA	NA	31,547	NA	NA	NA	NA
Year 13	69,113	NA	NA	31,899	NA	NA	NA	NA
Year 14	66,083	NA	NA	32,731	NA	NA	NA	NA
Year 15	65,755	NA	NA	32,475	NA	NA	NA	NA

¹⁹⁷ For Years 1-13: Washington State Department of Health, [Washington Tracking Network, All Cause Mortality](#) (viewed July 2026)

For Years 14-15: Washington State Department of Health, [All Deaths Dashboards | Washington State Department of Health](#) (viewed in July 2026)

¹⁹⁸ California Health & Human Services Agency (CalHHS) (2026), [Statewide Death Profiles - 2014-2024 Final Resident Deaths by Year Statewide - California Health and Human Services Open Data Portal](#) (viewed in July 2026). Deaths statistics reported in this table are for those of California residents which differ from the number of deaths occurring in state.

¹⁹⁹ Stats NZ (2026), [Stats NZ Births and Deaths: Year ended March Tauranga Aotearoa](#) (viewed in July 2026). For New Zealand financial year deaths data is used for consistency with New Zealand assisted deaths data, which is also published in financial years

²⁰⁰ For Years 1-20: Oregon Health Authority (2019), [Oregon Vital Statistics Annual Reports Archive](#) (viewed in July 2026)

For Years 20-27: Oregon Health Authority (2026), [Oregon Health Authority : Oregon Death Data : Vital Records and Certificates : State of Oregon](#), (viewed in July 2026)

²⁰¹ For data from 2019-2024: Hawai'i Health Data Warehouse, [Hawai'i Health Data Warehouse, Death Data](#),

For data from 2025: State of Hawaii, Department of Health (2026), [Preliminary Vital Statistics for 2025 | Vital Statistics](#) (viewed in July 2026)

²⁰² Centers for Disease Control (CDC), [Underlying Cause of Death, 2018-2024, Single Race Request](#), (viewed in July 2026)

²⁰³ Centers for Disease Control (CDC), [Underlying Cause of Death, 2018-2024, Single Race Request](#), (viewed in July 2026)

²⁰⁴ Vermont Department of Health (2026), [Vital Statistics Annual Reports, Resident Deaths Data](#) (viewed in July 2026)

²⁰⁵ A full year of data may be a calendar year or financial year, depending on the jurisdiction's protocols.

Jurisdiction	Washington (USA) ¹⁹⁷	California (USA) ¹⁹⁸	New Zealand ¹⁹⁹	Oregon (USA) ²⁰⁰	Hawaii (USA) ²⁰¹	District of Columbia (USA) ²⁰²	Maine (USA) ²⁰³	Vermont (USA) ²⁰⁴
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	44,981	NA	NA	NA	NA
Year 25	NA	NA	NA	44,618	NA	NA	NA	NA
Year 26	NA	NA	NA	42,592	NA	NA	NA	NA
Year 27	NA	NA	NA	42,253	NA	NA	NA	NA

Note: the data in this table was correct as of July 2026 and quality assured by DHSC analysts.

Table 61: Total number of assisted deaths in comparable jurisdictions, by year assisted dying service was implemented

Jurisdiction	Washington (USA) ²⁰⁶	California (USA) ²⁰⁷	New Zealand ²⁰⁸	Oregon (USA) ²⁰⁹	Hawaii (USA) ²¹⁰	District of Columbia (USA) ²¹¹	Maine (USA) ²¹²	Vermont (USA) ²¹³
Implementation year	2009	2016	2021	1997	2019	2017	2019	2013
First full year of data²¹⁴	2010	2017	2022	1998	2019	2018	2020	2014
Year 1	51	409	328	16	15	2	30	29
Year 2	70	431	344	27	25	5	46	
Year 3	83	504	472	27	29	2	40	
Year 4	119	497	486	21	37	6	53	
Year 5	126	534	NA	38	51	8	48	28
Year 6	166	896	NA	42	38	6	66 ²¹⁵	
Year 7	192	969	NA	37	59	9	NA	
Year 8	164	1,032	NA	38	NA	NA	NA	17
Year 9	203	NA	NA	46	NA	NA	NA	70 ²¹⁶
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	491	NA	NA	85	NA	NA	NA	NA

²⁰⁶ Washington State Department of Health (July 2025), [Death with Dignity Data | Washington State Department of Health](#) (viewed in July 2026)

²⁰⁷ California Department for Public Health (2026), [RAB End of Life Option Act](#) (viewed in July 2026)

²⁰⁸ Ministry of Health New Zealand (2025), [Assisted Dying Service data and reporting – Health New Zealand | Te Whatu Ora](#) (viewed in July 2026)

²⁰⁹ Oregon Health Authority (June 2026), [Oregon Health Authority : Death with Dignity Act Annual Reports : Death with Dignity Act : State of Oregon](#) (viewed in July 2026)

²¹⁰ State of Hawaii Department of Health (May 2026), [OUR CARE, OUR CHOICE ACT \(OCOCA\) LEGISLATIVE REPORTS | Office of Planning Policy and Program Development](#) (viewed in July 2026)

²¹¹ DC Health (May 2026), [Death with Dignity Annual Reports | doh](#) (viewed in July 2026)

²¹² Maine Death with Dignity, [State Reports - Maine Death with Dignity](#) (viewed in July 2026)

²¹³ Vermont Department of Health (November 2025), [Patient Choice & Control at End of Life | Vermont Department of Health](#) (viewed in July 2026). Vermont did not publish reports on a regular, annual basis.

²¹⁴ A full year of data may be a calendar year or financial year, depending on the jurisdiction's protocols.

²¹⁵ Data on the number of Assisted deaths in Maine in 2025 was published in July 2026. However, data on the total number of deaths in state in Maine had not yet been released at the time of publication of this IA, so rates could not be calculated to develop the cohort

²¹⁶ 2/84 events in 2024 in Vermont were from non-residents. However, only 72 of these died from assisted dying. We assume the 2 non-residents died in AD events.

Jurisdiction	Washington (USA) ²⁰⁶	California (USA) ²⁰⁷	New Zealand ²⁰⁸	Oregon (USA) ²⁰⁹	Hawaii (USA) ²¹⁰	District of Columbia (USA) ²¹¹	Maine (USA) ²¹²	Vermont (USA) ²¹³
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	305	NA	NA	NA	NA
Year 26	NA	NA	NA	389	NA	NA	NA	NA
Year 27	NA	NA	NA	421	NA	NA	NA	NA
Year 28	NA	NA	NA	400	NA	NA	NA	NA

Table 62: Actual and projected rates of assisted dying in comparable jurisdictions, for the first 10 full years of implementation²¹⁷

Jurisdiction	Washington (USA)	California (USA)	New Zealand	Oregon (USA)	Hawaii (USA)	The District of Columbia (USA)	Maine (USA)
Implementation year	2009	2016	2021	1997	2019	2017	2019
First full year of data ²¹⁸	2010	2017	2022	1998	2019	2018	2020
Year 1	0.11%	0.15%	0.84%	0.05%	0.13%	0.04%	0.19%
Year 2	0.14%	0.16%	0.91%	0.09%	0.21%	0.10%	0.27%
Year 3	0.16%	0.19%	1.25%	0.09%	0.23%	0.03%	0.23%
Year 4	0.23%	0.16%	1.29%	0.07%	0.28%	0.10%	0.32%

²¹⁷ Based on DHSC analysis of assisted deaths data and all cause deaths data for each jurisdiction, Table 60 and Table 61.²¹⁸ A full year of data may be a calendar year or financial year, depending on the jurisdiction's protocols.

Jurisdiction	Washington (USA)	California (USA)	New Zealand	Oregon (USA)	Hawaii (USA)	The District of Columbia (USA)	Maine (USA)
Year 5	0.24%	0.16%	**1.31%	0.12%	0.40%	0.15%	0.29%
Year 6	0.30%	0.29%	**1.34%	0.14%	0.29%	0.12%	*0.33%
Year 7	0.35%	0.33%	**1.37%	0.12%	0.46%	0.19%	*0.36%
Year 8	0.29%	0.36%	**1.40%	0.12%	*0.48%	*0.19%	*0.38%
Year 9	0.36%	*0.36%	**1.42%	0.15%	*0.53%	*0.21%	*0.41%
Year 10	0.39%	*0.39%	**1.45%	0.16%	*0.58%	*0.23%	*0.43%

* Projected rates based on the jurisdiction's own trend line

** Projected rates based on average growth rate of all other jurisdictions

Annex B Training cost sensitivities

427. 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

428. 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 63: Estimated cost of training in Year 1, England and Wales, (values are based on previously rounded figures)²¹⁹

	Year 1			
Scenario	No opt-out	33% opt out	50% opt out	90% opt out
Low	£34.3m	£23.1m	£17.3m	£3.69m
Central	£35.3m	£24.1m	£18.3m	£4.69m
High	£36.7m	£25.5m	£19.7m	£6.10m

Table 64: Estimated cost training in Year 10, England and Wales, (values are based on previously rounded figures)²¹⁹

	Year 10			
Scenario	No opt-out	33% opt out	50% opt out	90% opt out
Low	£18.3m	£12.7m	£9.83m	£3.03m
Central	£20.4m	£14.8m	£11.9m	£5.12m
High	£23.1m	£17.5m	£14.6m	£7.81m

B2 - Variation to assume GPs receive Tier 2 training

429. 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 65: Estimated cost of training in Year 1, England and Wales, (values are based on previously rounded figures)²¹⁹

	Year 1			
Scenario	No opt-out	33% opt out	50% opt out	90% opt out
Low	£14.2m	£9.6m	£7.2m	£1.7m
Central	£15.2m	£10.6m	£8.2m	£2.7m
High	£16.6m	£12.0m	£9.6m	£4.1m

²¹⁹ DHSC estimates based on figures found in Table 16, Table 17 and Table 19

Table 66: Estimated cost training in Year 10, England and Wales, (values are based on previously rounded figures)²²⁰

Scenario	Year 10			
	No opt-out	33% opt out	50% opt out	90% opt out
Low	£8.3m	£6.0m	£4.8m	£2.0m
Central	£10.4m	£8.1m	£6.9m	£4.1m
High	£13.0m	£10.8m	£9.6m	£6.8m

B3 - Variation to change cohort numbers (impacting Tier 3)

430. 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 67: 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)²²¹

Scenario	Year 1				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
Low	£11.8m	£8.10m	£6.18m	£1.66m	£8.07m	£6.21m	£5.25m	£2.99m
Central	£13.6m	£9.92m	£8.00m	£3.48m	£11.86m	£10.00m	£9.04m	£6.78m
High	£16.2m	£12.48m	£10.56m	£6.04m	£16.75m	£14.89m	£13.93m	£11.67m

Table 68: 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)²²²

Scenario	Year 1				Year 10			
	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	£11.5m	£7.79m	£5.87m	£1.35m	£6.65m	£4.79m	£3.82m	£1.57m
Central	£12.3m	£8.54m	£6.62m	£2.10m	£8.21m	£6.35m	£5.39m	£3.13m
High	£13.3m	£9.59m	£7.67m	£3.15m	£10.23m	£8.36m	£7.40m	£5.15m

²²⁰ DHSC estimates based on figures found in Table 16, Table 17 and Table 19

²²¹ DHSC estimates based on figures found in Table 13, Table 16, Table 17 and Table 19

²²² DHSC estimates based on figures found in Table 12, Table 16, Table 17 and Table 19

Annex C Health and social care staff time supplementary tables and sensitivity analysis

431. 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

432. 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 69: Estimated cost of health and social care staff time, England and Wales, Year 1, low cohort scenario²²³

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	496	£60.4k	£3.9k	£2.8k	£67.2k
2 & 3	First declaration and first doctor's assessment	471	£114.7k	£7.5k	£5.4k	£127.6k
4	Second doctor's assessment	422	£102.8k	£6.7k	£4.8k	£114.4k
5	Multidisciplinary panel assessment	372	£240.4k	£15.7k	£11.3k	£267k
6	Second declaration	323	£19.7k	£1.3k	£925	£21.9k
7	Dispensing the approved substance	323	£10.6k	£276	£199	£11.0k
8	Provision of approved substance (remain with person)	298	£72.6k	£4.7k	£3.4k	£80.7k
9	Final statement	298	£36.3k	£948	£683	£37.9k
10	Death certification	298	£57.3k	£1.5k	£1.1k	£59.9k
Total			£715k	£42.6k	£30.7k	£788k

²²³ DHSC estimates based on figures found in Table 2, Table 27 and Table 28

Table 70: Estimated cost of health and social care staff time, England and Wales, Year 10, low cohort scenario²²⁴

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	2,278	£277k	£18.1k	£13.0k	£309k
2 & 3	First declaration and first doctor's assessment	2,164	£527k	£34.4k	£24.8k	£586k
4	Second doctor's assessment	1,937	£472k	£30.8k	£22.2k	£525k
5	Multidisciplinary panel assessment	1,709	£1.10m	£72.1k	£51.9k	£1,228k
6	Second declaration	1,481	£90.2k	£5.9k	£4.2k	£100.3k
7	Dispensing the approved substance	1,481	£48.4k	£1.3k	£910	£50.6k
8	Provision of approved substance (remain with person)	1,367	£333k	£21.7k	£15.7k	£370k
9	Final statement	1,367	£167k	£4.4k	£3.1k	£174k
10	Death certification	1,367	£263k	£6.9k	£4.9k	£275k
Total			£3.28 m	£195.6k	£140.8k	£3.62 m

²²⁴ DHSC estimates based on figures found in Table 2, Table 27 and Table 28

High cohort scenario

433. 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 71: Estimated cost of health and social care staff time, England and Wales, Year 1, high cohort scenario²²⁵

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	4,610	£562k	£36.7k	£26.4k	£625k
2 & 3	First declaration and first doctor's assessment	4,379	£1.07m	£69.7k	£50.2k	£1.19m
4	Second doctor's assessment	3,918	£954k	£62.3k	£44.9k	£1.06m
5	Multidisciplinary panel assessment	3,457	£2.23m	£145.9k	£105.0k	£2.49m
6	Second declaration	2,996	£182.5k	£11.9k	£8.6k	£203.0k
7	Dispensing the approved substance	2,996	£97.9k	£2.6k	£1.8k	£102.3k
8	Provision of approved substance (remain with person)	2,766	£674k	£44.0k	£31.7k	£750k
9	Final statement	2,766	£336.9k	£8.8k	£6.3k	£352.0k
10	Death certification	2,766	£532k	£13.9k	£10.0k	£556k
Total			£6.64 m	£395.7k	£284.9k	£7.32 m

²²⁵ DHSC estimates based on figures found in Table 2, Table 27 and Table 28

Table 72: Estimated cost of health and social care staff time, England and Wales, Year 10, high cohort scenario²²⁶

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	10,428	£1.27m	£83.0k	£59.7k	£1.41m
2 & 3	First declaration and first doctor's assessment	9,907	£2.41 m	£158k	£113.5k	£2.68 m
4	Second doctor's assessment	8,864	£2.16 m	£141.0k	£101.5k	£2.40 m
5	Multidisciplinary panel assessment	7,821	£5.05 m	£330k	£238k	£5.62 m
6	Second declaration	6,779	£413k	£27.0k	£19.4k	£459k
7	Dispensing the approved substance	6,779	£222k	£5.8k	£4.2k	£232k
8	Provision of approved substance (remain with person)	6,257	£1.52m	£99.5k	£71.7k	£1.70m
9	Final statement	6,257	£762k	£19.9k	£14.3k	£796k
10	Death certification	6,257	£1.20m	£31.4k	£22.6k	£1.26m
Total			£15.02 m	£895k	£645k	£16.56 m

²²⁶ DHSC estimates based on figures found in Table 2, Table 27 and Table 28

C2 - Supplementary tables (England only)

434. The following table provides a breakdown of the estimated size of the cohort by step, for England only.

Table 73: Cohort estimates by step, England only, Y1 and Y10²²⁷

Step	Description	Year 1 (2031/32)			Year 10 (2040/41)		
		Low	Central	High	Low	Central	High
1	Preliminary discussion	466	2,073	4,328	2,142	5,487	9,804
2 & 3	First declaration and first doctor's assessment	443	1,969	4,112	2,035	5,213	9,314
4	Second doctor's assessment	396	1,762	3,679	1,821	4,664	8,333
5	Multidisciplinary panel assessment	350	1,555	3,246	1,606	4,115	7,353
6 & 7	Second declaration, dispensing of approved substance	303	1,348	2,813	1,392	3,567	6,373
8, 9 & 10	Provision of approved substance, final statement, and death certification	280	1,244	2,597	1,285	3,292	5,882

435. The following table provides the total estimated cost of health and social care staff time to deliver the VAD service, for England only.

Table 74: Estimated cost of staff time to deliver VAD service, England only, Year 1²²⁸

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	£671.8k	£40.0k	£28.8k	£740.7k
Central	£2.99m	£178.0k	£128.1k	£3.29m
High	£6.23m	£371.6k	£267.5k	£6.87m

²²⁷ DHSC estimates based on figures found in Annex A and ONS (2026), [National population projections](#) (viewed in July 2026)

²²⁸ DHSC estimates based on figures found in Table 23, Table 24, and Table 81

C3 - Supplementary tables (Wales only)

436. The following table provides a breakdown of the estimated size of the cohort by step, for Wales only.

Table 75: Cohort estimates by step, Wales only, Y1 and Y10²²⁹

Step	Description	Year 1 (2031/32)			Year 10 (2040/41)		
		Low	Central	High	Low	Central	High
1	Preliminary discussion	30	135	281	136	349	624
2 & 3	First declaration and first doctor's assessment	29	128	267	130	332	593
4	Second doctor's assessment	26	115	239	116	297	531
5	Multidisciplinary panel assessment	23	101	211	102	262	468
6 & 7	Second declaration, dispensing of approved substance	20	88	183	89	227	406
8, 9 & 10	Provision of approved substance, final statement, and death certification	18	81	169	82	210	375

437. The following table provides the total estimated cost of health and social care staff time to deliver the VAD service, for Wales only.

Table 76: Estimated cost of staff time to deliver VAD service, Wales only, Year 1²³⁰

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	£43.8k	£2.6k	£1.9k	£48.3k
Central	£194.3k	£11.6k	£8.3k	£214.2k
High	£405.2k	£24.2k	£17.4k	£447k

²²⁹ DHSC estimates based on figures found in Annex A and ONS (2026), [National population projections](#) (viewed in July 2026)

²³⁰ DHSC estimates based on figures found in Table 23, Table 24, and Table 81

C4 - Sensitivity analysis – variation to add additional staff member

438. The two tables below show the costs of an additional nurse attending step 8 to deliver the VAD service.

Table 77: Estimated cost of an additional nurse attending step 8 to deliver VAD service, Year 1 England and Wales²³¹

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	£788.0k	£39.1k	£827.1k
Central	£3.51m	£173.7k	£3.68m
High	£7.32m	£362.6k	£7.68m

Table 78: Estimated cost of an additional nurse attending step 8 to deliver VAD service, Year 10 England and Wales²³²

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	£3.62m	£179.2k	£3.80m
Central	£9.27m	£459.1k	£9.73m
High	£16.56m	£820.3k	£17.38m

²³¹ DHSC estimates based on figures found in Table 2, Table 23, Table 24 and Table 27

²³² DHSC estimates based on figures found in Table 2, Table 23, Table 24 and Table 27

C5 - Sensitivity analysis – variation to increase staff salary or time

439. The two tables below show the total estimated cost of health and social care staff time to deliver the VAD service by:

439.1. 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)

439.2. 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 79: Sensitivity analysis of cost of providing base VAD in Year 1, England and Wales²³³

Cohort	Total costs (100% of cohort)	Sensitivity – staff wages		Sensitivity – staff time	
		Consultant wages	Junior doctor wages	50% more time	50% less time
Low	£788.0k	£1.18m	£396.6k	£1.18m	£394.0k
Central	£3.51m	£5.25m	£1.76m	£5.26m	£1.75m
High	£7.32m	£10.96m	£3.68m	£10.98m	£3.66m

Table 80: Sensitivity analysis of cost of providing base VAD in Year 10, England and Wales²³⁴

Cohort	Total costs (100% of cohort)	Sensitivity – staff wages		Sensitivity – staff time	
		Consultant wages	Junior doctor wages	50% more time	50% less time
Low	£3.62m	£5.42m	£1.82m	£5.43m	£1.81m
Central	£9.27m	£13.87m	£4.66m	£13.90m	£4.63m
High	£16.56m	£24.79m	£8.33m	£24.84m	£8.28m

²³³ DHSC estimates based on figures found in Table 25 and Table 27

²³⁴ DHSC estimates based on figures found in Table 25 and Table 27

C6 – Sensitivity analysis – varying number of applicants

440. 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 81: Estimated cost of health and social care staff time, England and Wales, Year 1, central cohort scenario²³⁵

Step	Description	Y1 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	4,014	£489k	£32k	£23k	£544k
2&3	First declaration and first doctor's assessment	3,412	£831k	£54k	£39k	£925k
4	Second doctor's assessment	2,810	£685k	£45k	£32k	£761k
5	Multidisciplinary panel assessment	2,409	£1.56m	£102k	£73k	£1.73m
6	Second declaration	1,806	£110k	£7k	£5k	£122k
7	Dispensing the approved substance	1,806	£59k	£1542	£1110	£62k
8	Provision of assistance (remain with person)	1,325	£323k	£21k	£15k	£359k
9	Final statement	1,325	£161k	£4k	£3k	£169k
10	Death certificate	1,325	£255k	£7k	£5k	£266k
Total			£4.47m	£273k	£197k	£4.94m

Table 82: Estimated cost of health and social care staff time, England and Wales, Year 10, central cohort scenario²³⁶

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	10,612	£1.29m	£84k	£61k	£1.44m

²³⁵ DHSC estimates based on figures found in Table 13 and Table 28

²³⁶ DHSC estimates based on figures found in Table 13 and Table 28: Estimated cost of staff time to deliver VAD service in Year 1, England and Wales

2&3	First declaration and first doctor's assessment	9,020	£2.20m	£144k	£103k	£2.44m
4	Second doctor's assessment	7,428	£1.81m	£118k	£85k	£2.01m
5	Multidisciplinary panel assessment	6,367	£4.11m	£269k	£193k	£4.58m
6	Second declaration	4,775	£291k	£19k	£14k	£323k
7	Dispensing the approved substance	4,775	£156k	£4k	£2936	£163k
8	Provision of assistance (remain with person)	3,502	£853k	£56k	£40k	£949k
9	Final statement	3,502	£427k	£11k	£8k	£446k
10	Death certificate	3,502	£673k	£18k	£13k	£704k
Total			£11.81m	£722k	£520k	£13.06m

441. 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 83: Estimated cost of health and social care staff time, England and Wales, Year 1, central cohort scenario²³⁷

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	1,656	£202k	£13k	£9k	£224k
2&3	First declaration and first doctor's assessment	1,623	£395k	£26k	£19k	£440k
4	Second doctor's assessment	1,490	£363k	£24k	£17k	£404k
5	Multidisciplinary panel assessment	1,457	£941k	£61k	£44k	£1.05m
6	Second declaration	1,391	£85k	£6k	£4k	£94k
7	Dispensing the approved substance	1,391	£45k	£1,188	£855	£48k
8	Provision of assistance (remain with person)	1,325	£323k	£21k	£15k	£359k
9	Final statement	1,325	£161k	£4k	£3k	£169k
10	Death certificate	1,325	£255k	£7k	£5k	£266k
Total			£2.77m	£163k	£117k	£3.05m

Table 84: Estimated cost of health and social care staff time, England and Wales, Year 10, central cohort scenario²³⁸

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	4,377	£533k	£35k	£25k	£593k
2&3	First declaration and first doctor's assessment	4,290	£1.05m	£68k	£49k	£1.16m
4	Second doctor's assessment	3,940	£960k	£63k	£45k	£1.07m

²³⁷ DHSC estimates based on figures found in Table 12 and Table 28

²³⁸ DHSC estimates based on figures found in Table 12 and Table 30

5	Multidisciplinary panel assessment	3,852	£2.49m	£163k	£117k	£2.77m
6	Second declaration	3,677	£224k	£15k	£11k	£249k
7	Dispensing the approved substance	3,677	£120k	£3k	£2,261	£126k
8	Provision of assistance (remain with person)	3,502	£853k	£56k	£40k	£949k
9	Final statement	3,502	£427k	£11k	£8k	£446k
10	Death certificate	3,502	£673k	£18k	£13k	£704k
Total			£7.32m	£431k	£310k	£8.06m

Annex D Assisted Dying Review Panels Sensitivity

442. The sensitivity analysis in this Annex pertains to the main IA section 'Voluntary Assisted Dying Commissioner and Panels'. Please refer to this section for description of main assumptions.

Table 85: Changing the average time per hearing, England and Wales²³⁹

	1 hearing per day	2 hearings per day
Scenario	Average Annual Cost	
Low	£2.2m	£1.1m
Central	£6.6m	£3.3m
High	£12.4m	£6.2m

Table 86: Changing the proportion of applications the panel hears, whilst holding the projected number of deaths constant, England and Wales²³⁹

	60% of applications heard by panel	75% of applications heard by panel	88% of applications heard by panel
Scenario	Average Annual Cost		
Low	£0.9m	£1.1m	£1.3m
Central	£2.6m	£3.3m	£3.9m
High	£5.0m	£6.2m	£7.3m

443. 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.

²³⁹ MoJ estimates based on figures found in Table 32 and in Ministry of Justice and Senior Salaries Review Body (2025), Judicial salaries and fees 2025 to 2026 - GOV.UK (viewed in July 2026)

Annex E Healthcare costs at end-of-life

444. This Annexe contains supplementary tables showing sensitivity analysis for the 'Healthcare costs at end-of-life' section in the IA. Table 88 show the total healthcare spend along with a high scenario and a low scenario to reflect cost fluctuations.

445. Additionally, this annex provides additional information on the methodology and sources used in the as yet unpublished NIHR study, which forms the basis of the cost estimates used in the 'Healthcare Costs at End of Life' section in the IA and this annex.

Annexe E1 – Sensitivity analysis - Healthcare costs at end-of-life

446. 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 costs²⁴⁰. Therefore, it may be assumed that the 'high' scenario is more likely than the 'low' scenario, although this is uncertain.

Table 87: 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 Wales²⁴¹

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	Low	298	£1.73m	£1.38m	£2.08m
	Central	1,325	£7.70m	£6.16m	£9.24m
	High	2,766	£16.07m	£12.85m	£19.28m
Year 10	Low	1,367	£7.94m	£6.35m	£9.53m
	Central	3,502	£20.34m	£16.27m	£24.41m
	High	6,527	£36.34m	£29.07m	£43.61m

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 88: 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 Wales²⁴¹

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	Low	298	£4.04m	£3.23m	£4.84m
	Central	1,325	£17.95m	£14.36m	£21.54m
	High	2,766	£37.47m	£29.98m	£44.96m
Year 10	Low	1,367	£18.52m	£14.81m	£22.22m

²⁴⁰ Nuffield Trust (2014), [Exploring the cost of care at the end of life](#) | Nuffield Trust (viewed in July 2026)

²⁴¹ DHSC estimates based on figures from Table 34 and secondary data analysis in 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. 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> Cost effectiveness of palliative care | King's College London Accessed in July 2026. **Full report is unpublished data [manuscript submitted for publication] – provided via personal communication. See annexe E2 for a description of methodology and list of sources for the secondary data analysis conducted in this study.**

	Central	3,502	£47.44m	£37.95m	£56.93m
	High	6,257	£84.76m	£67.81m	£101.71m

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.

Annexe E2 – Source data on healthcare costs at end-of-life

447. The average healthcare costs during the final 4 months of life have been estimated using an (as yet) unpublished NIHR-funded study. This study analysed secondary data to capture hospital (both emergency and non-emergency care), primary and community care, hospice, medicines and other care costs, but does not distinguish between funding avenues.
448. To estimate healthcare costs in the last year of life for an adult in England and Wales, NIHR researchers identified the best available data on utilisation of key services: acute hospital emergency department visits and overnight stays [Sources a, b, c, d, e, f] outpatient appointments [Sources a, b, c], general practice and community care [Sources a, b], prescriptions [Source b], ambulance [Sources a, d], hospice care [sources a, g, h, i], and unpaid family care [Source j]. Researchers then modelled frequency of use monthly over the last year of life to capture trajectories of use [Source b] and combined frequency data with reference costs for services [Sources b, c, k, l, m].
449. **Sources:**
- Johansson, T., and others (2024) Time to care: Findings from a nationally representative survey of experiences at the end of life in England and Wales (viewed Aug 2026)
 - Luta, X., and others (2020), Healthcare trajectories and costs in the last year of life: a retrospective primary care and hospital analysis (viewed Aug 2026)
 - Nuffield Trust (2023), End-of-Life Care - QualityWatch (viewed Aug 2026).
 - Mason, B., and others (2020), Unscheduled and out-of-hours care for people in their last year of life: a retrospective cohort analysis of national datasets (viewed Aug 2026)
 - Cavallaro, F., and others (2023), Longer hospital stays and fewer admissions: How NHS hospital care changed in England between 2019 and 2022 (viewed Aug 2026)
 - Office for Health Improvement and Disparities (2024), Palliative and end of life care factsheet: Patterns of care, England 2022 (viewed Aug 2026)
 - Hospice UK (2023), Hospice Accounts Report 2023 (viewed Aug 2026)
 - Hospice UK (2023), Statistics about hospice care in each UK nation (viewed Aug 2026)
 - von Petersdorff, C., and others (2021), Modelling demand and costs for palliative care services in England (viewed Aug 2026)
 - Johnson, M.J., and others (2024), The cost of providing care by family and friends (informal care) in the last year of life: A population observational study (viewed Aug 2026)
 - Personal Social Services Research Unit (2023), Unit Costs of Health and Social Care 2023 (viewed Aug 2026)
 - NHS England (2024), NHS England » National Cost Collection for the NHS (viewed Aug 2026)
 - Murtagh, F.E.M., and others (2023), A casemix classification for those receiving specialist palliative care during their last year of life across England: the C-CHANGE research programme (viewed Aug 2026)

Annex F Social care sector supplementary table

450. This annex contains a supplementary table showing, based on evidence on the location of deaths in England in 2024²⁴², estimates of the number of assisted deaths that may take place in different locations.

Table 89: Estimated number of assisted deaths in each location in England and Wales²⁴³

	Scenario	Care homes	Home	Hospice	Hospital	Other places	Total
Year 1: 2031/32	Low	41	104	49	100	5	298
	Central	180	461	219	443	23	1,325
	High	376	963	456	924	47	2,766
Year 10: 2040/41	Low	186	476	226	457	23	1,367
	Central	476	1,219	578	1,170	60	3,502
	High	851	2,177	1,032	2,090	106	6,257

²⁴² Department of Health & Social Care (2026), Palliative and end of life care factsheet: Patterns of care, England 2024 (viewed in July 2026)

²⁴³ DHSC estimates based on figures found in Table 2 and Place of death in Department of Health and Social Care (2026) Palliative and end of life care factsheet: Patterns of care, England 2024 (viewed in July 2026)

Annex G Wider impacts on state pensions and state benefits supplementary table

451. This annex shows the eligibility of the state benefits that are part of the Special Rules for end of life (SREL)²⁴⁴.

Table 90: 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 themselves²⁴⁵.	As of November 2025, there were 104,337 ²⁴⁶ 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 November 2025 was £103.97²⁴⁷. There is no published data on the SREL, however, those eligible under the special rules will automatically get the higher rate of £114.60 per week (as of 2026/27)²⁴⁸.
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 condition²⁴⁹.	As of April 2026, there were 34,868 ²⁵⁰ people across England and Wales receiving special rules end of life (SREL) PIP payments. Of these 34,868 people, 27,415 were under state pension age.	The average SREL PIP payment for all recipients was £191.45 per week in April 2026. The average SREL PIP payment for those under state pension age was £194.26.
Universal Credit Universal Credit is a payment to help support individuals with their cost of living²⁵¹.	As of March 2026, there were 12,376 ²⁵² 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.

²⁴⁴ UK Government (2025), [DWP factual medical reports: guidance for healthcare professionals](#) (viewed in July 2026)

²⁴⁵ UK Government (2025), [Attendance Allowance: Overview - GOV.UK](#) (viewed in July 2026)

²⁴⁶ Stat-Xplore (2026), [Stat-Xplore](#) (viewed in July 2026). 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)

²⁴⁷ Stat-Xplore (2025), [Stat-Xplore](#) (viewed in July 2026). 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)

²⁴⁸ 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 July 2026). Note that people will a malignant disease or a terminal illness received different average weekly AA payments. A weighted average of the two averages was calculated based on the size of each group.

²⁴⁹ UK Government (2025), [Personal Independence Payment \(PIP\): What PIP is for - GOV.UK](#) (viewed in July 2026)

²⁵⁰ Stat-Xplore (2026), [Stat-Xplore](#) (viewed in July 2026). 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)

²⁵¹ UK Government (2025), [Universal Credit: What Universal Credit is - GOV.UK](#) (viewed in July 2026)

²⁵² Stat-Xplore (2026), [Stat-Xplore](#) (viewed in July 2026). 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). Note that data on 16-19 year olds are included in this figure and cannot be broken down into data for individual years as numbers are too small and redacted in the data. The total number of individuals in England and Wales aged 16-19 receiving DLA payments was 16.

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 eligible²⁵³.	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 November 2025, there were 9,217²⁵⁴ 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 £136.36 per week, as of November 2025²⁵⁴.
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²⁵³ UK Government (2025), [Disability Living Allowance \(DLA\) for adults: Overview - GOV.UK](#) (viewed in July 2026). Please note DLA is changing, some adults are still receiving DLA.

²⁵⁴ Stat-Xplore (2026), [Stat-Xplore](#) (viewed in July 2026). 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 2030/31

452. The main IA text shows the scenario where the VAD service would be implemented in 2030/31. 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 2030/31.

H1 - Cohort estimates

Table 91: Estimated number of applicants and assisted deaths, by implementation year, for England and Wales combined²⁵⁵

Cohort	Estimate	Year 1:	Year 10:
		Spring 2030 – Spring 2031	Spring 2039 – Spring 2040
Number of applicants	Low	491	2,258
	Central	2,183	5,783
	High	4,558	10,334
Number of assisted deaths	Low	294	1,355
	Central	1,310	3,470
	High	2,735	6,200

H2 - Training

Table 92: Estimated training costs Year 1, (values are based on previously rounded figures)²⁵⁶

Scenario	Year 1			
	No opt-out	Assume 33% opt out	Assume 50% opt out	Assume 90% opt out
Low	£11.58m	£7.86m	£5.94m	£1.42m
Central	£12.57m	£8.85m	£6.93m	£2.41m
High	£13.97m	£10.24m	£8.32m	£3.80m

Table 93: Estimated training costs Year 10, (values are based on previously rounded figures)²⁵⁶

Scenario	Year 10			
	No opt-out	Assume 33% opt out	Assume 50% opt out	Assume 90% opt out
Low	£6.97m	£5.11m	£4.15m	£1.89m
Central	£9.03m	£7.17m	£6.21m	£3.95m
High	£11.70m	£9.84m	£8.88m	£6.62m

²⁵⁵ DHSC estimates based on figures found in Annex A and ONS (2026), [National population projections](#) (viewed in July 2026)

²⁵⁶ DHSC estimates based on figures found in Table 17, Table 18 and Table 91

H3 - Health and social care staff time

Table 94: Estimated cost of staff time to deliver VAD service in Year 1, England and Wales²⁵⁷

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	£707k	£42k	£30k	£779k
Central	£3.14m	£187k	£135k	£3.47m
High	£6.57m	£391k	£282k	£7.24m

Table 95: Estimated cost of staff time to deliver VAD service in Year 10, England and Wales²⁵⁷

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	£3.25m	£194k	£140k	£3.59m
Central	£8.33m	£497k	£357k	£9.18m
High	£14.88m	£887k	£639k	£16.41m

H4 - Voluntary Assisted Dying Panels

Table 96: Estimated annual panel costs 2030/31 – 2039/40, England and Wales²⁵⁸

	Year 1	Year 5	Year 10	Average Annual Cost
	2030/31	2034/35	2039/40	
Low	£0.4m	£1.1m	£1.8m	£1.1m
Central	£1.7m	£3.2m	£4.6m	£3.2m
High	£3.6m	£6.4m	£8.1m	£6.2m

H5 - Healthcare costs at end-of-life

Table 97: Estimated palliative and end-of-life care costs for 1 month of unutilised care, by implementation Year 1 (2030/31) and Year 10 (2039/40) in 2026/27 prices, England and Wales²⁵⁹

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	Low	294	£1.36m	£106k	£188k	£52k	£1.71m

²⁵⁷ DHSC estimates based on figures found in Table 23, Table 24 and Table 91

²⁵⁸ MoJ estimates based on figures estimating the number of applications at the panel stage based on Annex A and Ministry of Justice and Senior Salaries Review Body (2025), [Judicial salaries and fees 2025 to 2026 - GOV.UK](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/111111/judicial-salaries-and-fees-2025-to-2026.pdf) (viewed in July 2026)

²⁵⁹ DHSC estimates based on Table 91 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. 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 July 2026). Full report is unpublished data [manuscript submitted for publication] – provided via personal communication. See annexe E2 for a description of methodology and list of sources for the secondary data analysis conducted in this study.

Year 10	Central	1,310	£6.07m	£470k	£838k	£233k	£7.61m
	High	2,735	£12.67m	£982k	£1.75m	£487k	£15.89m
	Low	1,355	£6.28m	£486k	£867k	£241k	£7.87m
	Central	3,470	£16.07m	£1.25m	£2.22m	£618k	£20.15m
	High	6,200	£28.72m	£2.23m	£3.97m	£1.10m	£36.01m

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 98: Estimated palliative and end-of-life care costs for 4 months of unutilised care, by implementation Year 1 (2030/31) and Year 10 (2039/40) in 2026/27 prices, England and Wales²⁵⁹

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	Low	294	£3.19m	£312k	£321k	£159k	£3.98m
	Central	1,310	£14.22m	£1.39m	£1.43m	£707k	£17.75m
	High	2,735	£29.68m	£2.90m	£2.99m	£1.48m	£37.05m
Year 10	Low	1,355	£14.71m	£1.44m	£1.48m	£731k	£18.36m
	Central	3,470	£37.66m	£3.68m	£3.79m	£1.87m	£47.01m
	High	6,200	£67.29m	£6.57m	£6.78m	£3.35m	£83.99m

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.

H6 - Social care sector

Care homes

Reduced fees paid by self-funders

Table 99: Estimated reduction in fees paid to care homes by self-funders, England and Wales– 2030/31 implementation²⁶⁰

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	Low	15	£69k	£276k	£118k	£471k
	Central	66	£307k	£1.23m	£524k	£2.10m
	High	138	£642k	£2.57m	£1.09m	£4.38m
Year 10	Low	68	£318k	£1.27m	£542k	£2.17m
	Central	175	£814k	£3.26m	£1.39m	£5.55m
	High	312	£1.46m	£5.82m	£2.48m	£9.92m

Reduced fees paid by local authorities

Table 100: Estimated reduction in fees paid to care homes by local authorities, England and Wales – 2030/31 implementation²⁶¹

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	Low	25	£98k	£393k	£189k	£754k
	Central	112	£438k	£1.75m	£840k	£3.36m
	High	234	£914k	£3.66m	£1.75m	£7.02m
Year 10	Low	116	£453k	£1.81m	£869k	£3.48m
	Central	297	£1.16m	£4.64m	£2.23m	£8.90m
	High	531	£2.07m	£8.29m	£3.98m	£15.91m

²⁶⁰ DHSC estimates based on figures found in Table 91 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 July 2026) and Carterwood (2025), [2025 Self-funded fee and trading performance review - Carterwood, improve decision making](#) (viewed in July 2026)

²⁶¹ DHSC estimates based on figures found in Table 91 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 July 2026) and Department of Health and Social Care (2025), [Market Sustainability and Improvement Fund \(MSIF\): provider fee reporting 2025 to 2026 - GOV.UK](#) (viewed in July 2026)

Reduced care home revenue

Table 101: Total estimated reduction in care homes revenue from both self-funded and local authority funded individuals, England and Wales – 2030/31 implementation²⁶²

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	Low	40	£167k	£669k	£306k	£1.23m
	Central	178	£745k	£2.98m	£1.36m	£5.46m
	High	372	£1.56m	£6.22m	£2.85m	£11.40m
Year 10	Low	184	£771k	£3.08m	£1.41m	£5.65m
	Central	472	£1.97m	£7.90m	£3.61m	£14.46m
	High	843	£3.53m	£14.11m	£6.46m	£25.83m

Reduced care home profit

Table 102: Total estimated reduction in care home profit, England and Wales – 2030/31 implementation²⁶³

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	Low	40	£27k	£108k	£50k	£198k
	Central	178	£121k	£483k	£221k	£884k
	High	372	£252k	£1.01m	£462k	£1.85m
Year 10	Low	184	£125k	£500k	£229k	£915k
	Central	472	£320k	£1.28m	£586k	£2.34m
	High	843	£571k	£2.29m	£1.05m	£4.19m

²⁶² DHSC estimates based on figures found in Table 99 and Table 100

²⁶³ DHSC estimates based on figures found in Table 101 and profit assumptions from Care Quality Commission (2025), The state of health care and adult social care in England 2024/25 (viewed in July 2026)

Domiciliary care

Reduced fees paid by self-funders

Table 103: Estimated reduction in fees paid to domiciliary care organisations by self-funders, England and Wales – 2030/31 implementation²⁶⁴

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	Low	12	£54k	£216k
	Central	52	£241k	£963k
	High	109	£502k	£2.01m
Year 10	Low	54	£249k	£996k
	Central	139	£637k	£2.55m
	High	248	£1.14m	£4.56m

Reduced fees paid by local authorities

Table 104: Estimated reduced spending by local authorities on domiciliary care, England and Wales – 2030/31 implementation²⁶⁵

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	Low	39	£141k	£564k
	Central	176	£628k	£2.51m
	High	366	£1.31m	£5.24m
Year 10	Low	182	£649k	£2.60m
	Central	465	£1.66m	£6.65m
	High	831	£2.97m	£11.89m

²⁶⁴ DHSC estimates based on figures found in Table 91 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 July 2026) 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 July 2026) and Homecare Association (2024), [Minimum Price for Homecare - England 2025-2026](#) (viewed in July 2026)

²⁶⁵ DHSC estimates based on figures found in Table 91 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 July 2026) 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 July 2026), and Department of Health and Social Care (2025), [Market Sustainability and Improvement Fund \(MSIF\): provider fee reporting 2025 to 2026 - GOV.UK](#) (viewed in July 2026)

Reduced domiciliary care revenue**Table 105: Total estimated reduced revenue for domiciliary care organisations, England and Wales – 2030/31 implementation²⁶⁶**

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	Low	51	£195k	£780k
	Central	228	£869k	£3.47m
	High	476	£1.81m	£7.25m
Year 10	Low	236	£898k	£3.59m
	Central	604	£2.30m	£9.20m
	High	1,079	£4.11m	£16.44m

Reduced domiciliary care profit**Table 106: Total estimated reduced profit for domiciliary care organisations, England and Wales – 2030/31 implementation²⁶⁷**

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	Low	51	£15k	£59k
	Central	228	£66k	£264k
	High	476	£138k	£551k
Year 10	Low	236	£68k	£273k
	Central	604	£175k	£699k
	High	1,079	£312k	£1.25m

²⁶⁶ DHSC estimates based on figures found in Table 103 and Table 104²⁶⁷ DHSC estimate based on Table 105 and profit assumptions from LaingBuisson (2024), Adult Social Care in the UK Scale, Structure, Funding and Financial Performance of the Independent Sector (PDF, 1,873 KB), (viewed in July 2026)

H7 - Wider impacts on state pensions and state benefits

State pension

Table 107: Estimated state pension economic transfer, England and Wales - 2030/31 implementation²⁶⁸

	Lower bound 1 month (4 weeks)		Upper bound 4 months (16 weeks)	
	Y1 - 2030/31	Y10 - 2039/40	Y1 - 2030/31	Y10 - 2039/40
Low	£236k	£1.53m	£942k	£6.12m
Central	£1.05m	£3.92m	£4.19m	£15.68m
High	£2.19m	£7.00m	£8.75m	£28.01m

State benefits

Table 108: Estimated state benefits economic transfer, state pension age individuals, Attendance Allowance (SREL), England and Wales - 2030/31 implementation²⁶⁹

	Lower bound 1 month (4 weeks) not required		Upper bound 4 months (16 weeks) not required	
	Y1 - 2030/31	Y10 - 2039/40	Y1 - 2030/31	Y10 - 2039/40
Low	£118k	£542k	£471k	£2.17m
Central	£524k	£1.39m	£2.10m	£5.55m
High	£1.09m	£2.48m	£4.38m	£9.92m

Table 109: Estimated state benefits economic transfer, individuals under state pension age, Personal Independence Payment (SREL), England and Wales - 2030/31 implementation²⁷⁰

	Lower bound 1 month (4 weeks) not required		Upper bound 4 months (16 weeks) not required	
	Y1 - 2030/31	Y10 - 2039/40	Y1 - 2030/31	Y10 - 2039/40
Low	£29k	£134k	£117k	£537k
Central	£130k	£344k	£519k	£1.38m
High	£271k	£614k	£1.08m	£2.46m

Table 110: Estimated state benefit economic transfer, total, England and Wales - 2030/31 implementation²⁷¹

	Lower bound 1 month (4 weeks)		Upper bound 4 months (16 weeks)	
	Y1 - 2030/31	Y10 - 2039/40	Y1 - 2030/31	Y10 - 2039/40
Low	£147k	£676k	£588k	£2.70m
Central	£654k	£1.73m	£2.61m	£6.93m
High	£1.36m	£3.09m	£5.46m	£12.38m

²⁶⁸ DHSC estimates based on Table 91, adjusted for state pension recipients, and Department for Work and Pensions (2025), [Benefit expenditure and caseload tables 2026](#) - GOV.UK (viewed in July 2026)

²⁶⁹ DHSC estimates based on figures found in Table 91, 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 July 2026)

²⁷⁰ DHSC estimates based on figures found in Table 91, adjusted for those not claiming state pension, and Stat Xplore (2026), [Stat-Xplore - Home](#) (viewed in July 2026). 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).

²⁷¹ DHSC estimates based on figures found in Table 108 and Table 109

Version control table

Version	Date	Description of changes
1.0	28/08/2026	n/a – first publication, reflecting the Bill as introduced to Parliament on 17 June 2026 by Lauren Edwards MP.