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Impact assessment

Terminally Ill Adults (End of Life) Bill: equality impact assessment - HTML version

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Applies to England and Wales

Contents

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Introduction

The Terminally Ill Adults (End of Life) Bill ('the bill') makes provision for a person who is terminally ill and meets the eligibility criteria to request, and be lawfully provided with, assistance to end their own life. It was introduced to Parliament in October 2024 as a private member's bill by its sponsor, Kim Leadbeater MP. The bill passed committee stage on 26 March 2025.

This equality impact assessment (EQIA) assesses the potential future impacts of the bill, based on available evidence, as it stands after committee stage in the House of Commons. This EQIA considers the impact of this bill on people who share each of the 9 protected characteristics as set out in section 4 of the Equality Act 2010 (https://www.legislation.gov.uk/ukpga/2010/15/section/4), as well as additional dimensions.

The bill is a matter for Parliament, and the government is neutral on the substantive policy questions relevant to how the law in this area could change and on the principle of assisted dying. However, the government has a responsibility to ensure that any legislation that passes through Parliament is lawful, effective and enforceable. Therefore, the government has facilitated the publication of documents that routinely accompany the introduction of legislation, including an EQIA.

The general equality duty, set out in section 149 of the Equality Act 2010, requires public authorities, in the exercise of their functions, to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the act
- advance equality of opportunity between people who share a relevant protected characteristic and those who do not
- foster good relations between people who share a relevant protected characteristic and those who do not

The general equality duty does not apply to the Terminally Ill Adults (End of Life) Bill, as it does not apply to primary legislation. However, the 3 limbs of the duty provide a useful structure for analysing the potential effects of the bill.

Should the bill become law, an updated equality impact assessment will be produced.

Summary of policy or proposal

The Terminally Ill Adults (End of Life) Bill would allow terminally ill adults in England and Wales to request, and be lawfully provided with, assistance to end their own lives in accordance with clauses 7 to 27 of the bill, provided they meet the required criteria.

To be eligible, a person must:

- be terminally ill (as defined in clause 2)
- be aged 18 or over
- be ordinarily resident in England and Wales (and have been for at least 12 continuous months)
- be registered with a GP in England or Wales
- have the mental capacity to make the decision to end their own life (with ‘capacity’ to be read in accordance with the Mental Capacity Act 2005 (https://www.legislation.gov.uk/ukpga/2005/9/contents) (MCA)

The bill, as it stands at the end of committee stage in the House of Commons, sets out the process and requirements for accessing voluntary assisted dying services, including:

- a preliminary discussion between the person and a registered medical practitioner (which must be recorded in their medical records)
- a ‘first declaration’ by the person to confirm that they wish to be provided with assistance to end their own life
- subsequent assessments with a co-ordinating doctor and an independent doctor, which would include an explanation and discussion with the person about:
  - the person’s 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
- referral to an assisted dying review panel to determine a person’s eligibility to be provided with assistance
- a ‘second declaration’ by the person to confirm again that they wish to be provided with assistance to end their own life

The bill contains a number of safeguards to establish that, at various stages in the process (including at the time the approved substance is provided to the person for self-administration):

- the person has capacity to make the decision to end their own life
- they have a clear, settled and informed wish to end their own life

- they have made the decision that they wish to end their own life and/or have requested provision of assistance voluntarily and have not been coerced or pressured by any other person into doing so

If an individual meets the eligibility criteria and has capacity, the relevant assessments have been carried out and approvals have been obtained to access voluntary assisted dying services, they can be provided with an approved substance with which they may end their own life. The decision to self-administer the approved substance, and the final act of doing so, must be taken by the person themselves (clause 23(8)).

The bill introduces criminal offences in respect of inducing another person to make a first or second declaration or inducing a person to self-administer an approved substance (clause 31), and for falsification or destruction of documentation (clause 32). The bill also provides that a person is not guilty of an offence by virtue of providing assistance to a person, in accordance with the bill (clause 29).

The bill also provides that one or more codes of practice must be issued by the Secretary of State (clause 36) in connection with various issues, including:

- assessing whether a person has a clear and settled intention to end their own life
- the information made available to patients on treatment or palliative, hospice or other care
- the provision of information and support to persons with learning disabilities who are eligible to request assistance under this bill
- 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
- arrangements for responding to unexpected complications and arrangements for independent advocates and forms of proof of identity

Clause 37 provides that the relevant chief medical officer (CMO) must prepare and publish guidance relating to the operation of the bill and consult such persons as the CMO considers relevant before preparing this guidance, including consulting persons with learning disabilities, and clauses 45 and 46 set out the requirements for monitoring and review of the bill. Paragraph 8(1) of schedule 2 (assisted dying review panels) to the bill provides that the voluntary assisted dying commissioner (‘the commissioner’) may give guidance about the practice and procedure of the assisted dying review panel (‘the panel’).

Intended aims

The objective of the bill, as set out by the sponsor, is to establish a lawful framework for eligible, terminally ill adults to be able to voluntarily request to be provided with lawful assistance to end their own lives. The main intended outcomes of the bill, as described by the sponsor in her explanatory notes (see reference 5) and at second reading, are:

- to give those who are already dying a choice over the manner of their death
- for the choice of assisted dying to be part of a holistic approach to end of life care, rather than a substitute for palliative care
- to create a robust legal framework for assisted dying to happen in a manner that is subject to strict eligibility criteria and multiple layers of checks and safeguards
- to protect individuals from fear of and actual criminalisation where they assist another person to end their own life, in accordance with the provisions of the bill

The bill would have impacts on eligible, terminally ill adults by giving them a choice to request, and be lawfully provided with, assistance to end their own lives.

It is estimated that the total number of applicants would range from between 273 to 1,311 in year 1 (2029 to 2030), to between 1,737 and 7,598 in year 10 (2038 to 2039), and that 2 in 3 applicants would complete the process and have an assisted death. While these estimates 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.

For further details on the estimates, please see the accompanying impact assessment. Evidence from other jurisdictions indicates that the majority of applicants had cancer - 64% in California in 2023 (see reference 1) and 66% in New Zealand in 2024 (see reference 2).

The bill could affect a range of professionals involved in this service. No registered medical professional would be required to participate in the provision of assistance under the bill (clause 28) and no registered medical practitioner is under any duty to raise the subject of assisted dying with a person (clause 5(1)). The registered medical practitioners who are willing and able to participate may be involved in:

- initial discussions (clause 5)

- processing the first declaration (clause 7)
- making a first assessment (clause 9) or a second assessment (clause 10), or giving a second opinion (clause 12)
- processing a second declaration (clause 17)
- recording the declarations and statements (clause 21) or cancellations (clause 22)
- providing assistance (clause 23) or authorising another doctor to provide assistance (clause 24)
- completing a final statement (clause 26)

The panel must hear from, and may question, the co-ordinating doctor or independent doctor (see clause 15(4(a))).

The commissioner would be required to make arrangements to ensure that a panel (schedule 2 to the bill) consists of:

- a legal member
- a psychiatrist member
- a social worker member (clause 4 in schedule 2 to the bill)

The main functions of the commissioner would be to receive documents, make appointments to the panels and make arrangements regarding the panels and cases referred to them, determining applications for reconsideration of panel decisions and monitoring of this service. The panel (clause 15) would be required to assess eligibility and process criteria (clause 15(2)), must hear from and may question the co-ordinating and/or independent doctor, may hear from the person seeking to use the service and any other person (clause 15(4)) before issuing a certificate of eligibility or refusing to do so (clause 15(7)), and must notify relevant parties of the decision (clause 15(8)). The members of this panel would self-select for the roles. We do not expect differential impacts on members holding those roles.

Evidence

We have identified 25 jurisdictions where assisted dying is legal and a formal system with regulated processes (such as an established application and approvals process) is in place. These services vary in terms of who can access them, how they are delivered and how long they have been operational for.

Evidence on the impacts of assisted dying policies is limited, and the evidence that does exist may not be transferable to the voluntary assisted dying service proposed in the bill as public health systems, population demographics and service processes vary. This scarcity of evidence was highlighted in a report by the Equality and Human Rights Commission (produced for the House of Commons' second reading of the bill, see reference 11, and references 12 and 13). Furthermore, some of the research on individuals' views towards assisted dying includes people who are not terminally ill, potentially limiting the external validity of the results. In light of the scarcity of applicable evidence, this EQIA is based on research from those jurisdictions with the most comparable assisted dying service (New Zealand and the United States).

There is a reference section at the end of this document, which provides the main sources of evidence used to inform this EQIA.

Analysis of impacts

In this section we consider the impact of this bill on people who share each of the 9 protected characteristics as set out in section 4 of the Equality Act 2010 and 4 additional characteristics which are not covered by the Equality Act 2010.

Disability

The bill provides that a disabled person, who also meets the eligibility and capacity criteria in the bill, would be able to request, and be lawfully provided with, assistance to end their own life.

Section 6 of the Equality Act 2010 (https://www.legislation.gov.uk/ukpga/2010/15/section/6) provides that a person ('P') has a disability if:

- (a) P has a physical or mental impairment, and
- (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities

The impairment must be more than minor and trivial, and it must have lasted for at least 12 months, or be likely to last for at least 12 months or for the rest of the person's life. Some conditions are classed as disabilities from the day of diagnosis (see reference 7). These include HIV, cancer and multiple sclerosis.

The bill at the end of committee stage in the House of Commons defines ‘terminal illness’ at clause 2(1) as “an inevitably progressive illness or disease which cannot be reversed by treatment” and “the person’s death in consequence of that illness or disease can reasonably be expected within 6 months”. Clause 2(3) of the bill provides that a person is not to be considered terminally ill only because they are a disabled person or person with a mental disorder (or both). However, nothing in clause 2(3) results in a person not being regarded as terminally ill (for the purpose of the bill) if they meet the criteria in clause 2(1) (see clause 2(3)).

As with other healthcare service areas, some disabled people may face barriers in accessing this voluntary assisted dying service. The bill makes some provisions that would seek to mitigate this risk. Further mitigation would be likely required during the implementation of this bill if it became law. Service providers are already required to comply with the existing statutory duty to make reasonable adjustments (see sections 20 and 21 of, and schedules to, the Equality Act 2010). This includes a requirement, where a disabled person is put at a substantial disadvantage, to take reasonable steps to avoid that disadvantage, and to take steps to ensure a person is provided with information in an accessible format.

Disabled people are not a homogenous group - different people may have different circumstances, wishes and needs.

The bill establishes a number of safeguards to protect people who may be more vulnerable. These include:

Capacity

Clause 1(1)(a) provides that a person must have the capacity to make a decision to end their own life in order to be able to request and be provided with assistance to end their own life in accordance with the bill.

The bill relies on the framework of mental capacity set out in the MCA. The MCA presumes that every adult has the capacity to make their own decisions unless established otherwise. This means that people should not be presumed to lack capacity simply because they have a medical condition or disability (or make an unwise decision).

There are various capacity assessments required throughout the bill. The co-ordinating doctor and independent doctor must be satisfied that the person has capacity to make the decision to end their own life when conducting the first and second assessments respectively (see clauses 9 and 10). If either doctor has doubt as to the capacity of the person being assessed, they must refer the person for assessment by a registered medical practitioner who is a practising psychiatrist, or who otherwise holds qualifications in, or has experience of, the assessment of capacity (see clause 11(6)(b)).

Clause 15(2)(c) also provides that the panel, in determining a person's eligibility for assisted dying, must be satisfied that the person has capacity to make the decision to end their own life. Furthermore, the co-ordinating doctor must be satisfied, at the time the approved substance is provided to the person, that the person to whom it is provided has capacity to make the decision to end their own life (clause 23(5)(a)).

A professional who acts as a co-ordinating doctor and independent doctor under the bill must meet the requirements for training, qualifications and experience (which the Secretary of State must make provision about by regulations). These regulations must include training about assessing capacity (see clause 7(7)(a) in respect of the co-ordinating doctor and clause 10(10)(a) in respect of the independent doctor). Regulations made under clause 7(6) must also include training on reasonable adjustments and safeguards for autistic people and disabled people (clause 7(7)).

Before making any regulations under clause 7 (as well as clauses 9, 10, 17, 24 or 26), the Secretary of State must consult the Equality and Human Rights Commission and such other persons as the Secretary of State considers appropriate, which must include persons appearing to the Secretary of State to have expertise in matters relating to whether persons have capacity (clause 51).

Coercion and pressure

Evidence suggests that disabled people may be more susceptible to feeling as though they are a burden on those around them. Pressure is not necessarily felt or applied by other people - disabled people may feel subtle pressure due to attitudinal barriers or a lack of alternative appropriate services and support (for example, when accessing palliative care).

Disabled people are also twice as likely (compared to non-disabled people) to be victims of domestic abuse which includes coercive behaviour (see reference 9). Clauses 7 to 27 of the bill in particular require a number of steps to be taken to establish that the person:

- (a) has a clear, settled and informed wish to end their own life
- (b) has made the decision that they wish to end their own life voluntarily and has not been coerced or pressured by any other person (clause 1(2))

These steps include:

- a declaration, as part of the first declaration, that the person has not been coerced or pressured by another person into making the decision (clause 7(3)(b)(iv))
- a requirement for the co-ordinating doctor and independent doctor to be satisfied that the person has made the first declaration voluntarily and has not been coerced or pressured by another person into making it (see clauses 9(2)(h) and 10(2)(e))

- the panel must be satisfied that the person made the first declaration voluntarily and was not coerced or pressured by any other person into making that declaration (see clause 15(2)(i))
- the second declaration must also include a declaration that a person is making the second declaration voluntarily and has not been coerced or pressured by another person into making it (see clause 17(4)(b)(iii))
- a requirement that the co-ordinating doctor may only witness the second declaration if they are satisfied that the person is making the decision voluntarily and has not been coerced or pressured by another person into making it (clause 17(5)(d))
- a requirement for the co-ordinating doctor to be satisfied, at the time the approved substance is given to the person, that the person is requesting provision of assistance voluntarily and has not been coerced or pressured by another person into doing so (clause 23(5)(c))

Potential barriers for disabled people in accessing assisted dying services

Some examples of potential barriers for disabled people in accessing assisted dying services are detailed below.

Persons with learning disabilities or deaf persons are examples of disabled people who may struggle to understand the information provided to them in written or oral form. People with learning disabilities are likely to have a lower level of health literacy (see reference 14). British Sign Language (BSL) (https://www.gov.uk/government/publications/the-british-sign-language-bsl-report-2022/the-british-sign-language-bsl-report-2022) is not a translation of English, which makes written or verbal communication in English difficult for those who use BSL (see reference 40).

As above, service providers are under an explicit statutory duty to make reasonable adjustments for disabled people and to provide information in an accessible format. As drafted at the end of committee stage in the House of Commons, clause 5(4) provides that if a registered medical practitioner conducts a preliminary discussion with a person (under clause 5), the practitioner must first ensure the provision of adjustments for language and literacy barriers, including the use of interpreters. This barrier could extend to interactions with the commissioner and panels to which the public sector equality duty (Equality Act 2010) applies.

Disabled people may have some restrictions on expressing their wishes, for example due to difficulty speaking (dysarthria) (https://www.nhs.uk/conditions/dysarthria/) affecting their ability to have the initial conversation as set out in clause 5, or difficulty writing caused by neurological conditions such as dyslexia and dysgraphia (see reference 41) or mobility problems as a consequence of conditions such as Parkinson's disease (https://www.nhs.uk/conditions/parkinsons-disease/) (see reference 42).

This could impact their ability to complete the first declaration (clause 7(2)) and second declaration (clause 17(3)) in writing.

Clause 19 would help to mitigate this risk by providing an option for the person to authorise a proxy to sign the declaration on their behalf, where they are unable to sign their own name. A proxy is defined in clause 19(5) as being a person who has known the person making the declaration personally for at least 2 years, or a person of a description specified in regulations made by the Secretary of State. The proxy would also have to specify why the person was unable to sign their name (clause 19(3)(d)).

Clause 48(2) excludes certain individuals from serving as proxies:

- if the individual stood to benefit under a person’s will, or otherwise financially or materially from a person’s death
- a relative
- if they were involved in the care of a person as health professionals
- if they were under the age of 18

Clause 23(8) provides that the decision to self-administer the approved substance and the final act of doing so must be taken by the person to whom the approved substance has been provided. The co-ordinating doctor would be authorised to prepare the approved substance for self-administration by the person, to prepare a medical device to enable that person to self-administer the substance and to assist that person to ingest or otherwise self-administer the substance.

However, the co-ordinating doctor would not be authorised to administer the approved substance to another person with the intention of causing that person’s death. This reflects the fact that, as the bill is drafted at the end of committee stage in the House of Commons, it would be for the person alone to self-administer the approved substance. This is intended as a safeguard. The co-ordinating doctor would also have to explain to the person that they can still cancel their declaration and not self-administer the substance (clause 23(4)).

Some disabled people may be unable to self-administer the approved substance. Dysphagia (problems swallowing) (https://www.nhs.uk/conditions/swallowing-problems-dysphagia/) could prevent some people from ingesting medication and may be caused by a variety of conditions and illnesses which may be classed as disabilities, such as learning disabilities, and cancers. If the substance is to be self-administered intravenously, some individuals (who are terminally ill and otherwise meet the eligibility criteria for accessing voluntary assisted dying services) may not be able to do so due to their disability. For example, a coexisting disability such as Parkinson’s disease, muscular dystrophy (https://www.nhs.uk/conditions/muscular-dystrophy/) or multiple sclerosis (https://www.nhs.uk/conditions/multiple-sclerosis/)) can impact their mobility and prevent them from self-administering a substance.

Clause 36(1)(d) requires the Secretary of State to issue a code 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.

Disabled people are overall less likely to hold forms of photographic identification (see reference 22) (such as those accepted for voting) according to a 2021 Cabinet Office survey. The bill, as drafted at the end of committee stage in the House of Commons, states that the person must provide 2 forms of proof of identity to the co-ordinating doctor and witness before signing the declaration (clause 8(2)). In clause 8(3) the bill provides the Secretary of State with the power to make regulations which make provision about the forms of proof of identity that are acceptable for the purposes of clause 8(2). The bill does not specifically require photographic identification to be provided as drafted at the end of committee stage in the House of Commons.

Certain disabled groups may feel disadvantaged if they have a long-term health condition or disability which results in frailty and loss of mobility (for example, motor neurone disease (https://www.nhs.uk/conditions/motor-neurone-disease/)) which diminishes their quality of life, but they do not meet the definition of ‘terminally ill’ in clause 2(1). This bill intends to limit eligibility to only those who meet the definition of ‘terminally ill’ as per clause 2 of the bill as drafted after committee stage in the House of Commons.

Training, qualifications and experience of registered medical practitioners

As referenced above in relation to capacity, the Secretary of State must, by regulations, make provision about the training, qualifications and experience that a registered medical practitioner must have in order to carry out the functions of the co-ordinating or independent doctor (clause 7(6) and (7) and clause 10(9) and (10)). These regulations must also include training on assessing whether a person has been coerced or pressured by another person and specific and up-to-date training on reasonable adjustments and safeguards for autistic people and disabled people. Regulations made under clause 10(9) must specify that training in respect of domestic abuse, including coercive control and financial abuse, is mandatory (clause 10(13)).

Disability advisory board

Clause 44 of the bill requires the commissioner to set up a disability advisory board to advise on the implementation and impact of the bill on disabled people. The board must report to the Secretary of State and commissioner within 6 months of its appointment, and then annually, on the impact of the bill’s operation on disabled people (clause 44(3)). In addition to the reporting by this board, clause 46(3)(c) provides that the Secretary of

State’s review of the bill (after the initial 5-year period) must include an assessment of the impact of the bill on persons with learning disabilities.

Independent advocates
Clause 20 provides that qualifying persons (which includes those with learning disabilities, mental disorders, autism or other ‘substantial difficulties’ in understanding processes or information) have access to an independent advocate to provide support and advocacy on end of life care, including access to assisted dying. The bill provides that the Secretary of State must make regulations which make provision on the appointment of persons as independent advocates.

Criminal offences
The bill provides for the creation of criminal offences. A person who, by dishonesty, coercion or pressure, induces another person to make a first or second declaration, or not to cancel such a declaration, would commit an offence (clause 31(1)), and a person who, by dishonesty, coercion or pressure, induces another person to self-administer an approved substance provided under the bill commits an offence (clause 31(2)). These offences carry a sentence of up to 14 years or life respectively.

Under clause 32 there are 3 offences. A person also commits an offence if they make or knowingly use a false instrument which purports to be (i) a first declaration, (ii) a second declaration, or (iii) a certificate of eligibility, or (b) intentionally or recklessly conceals or destroys a first declaration or a second declaration by another person (clause 32(1)). A person would also commit an offence if, in relation to another person who has made a first declaration under this bill, they knowingly or recklessly provide a medical or other professional opinion in respect of a relevant matter which is false or misleading in a material particular (clause 32(2)). A person would commit an offence if they intentionally or recklessly fail to comply with an obligation under (a) section 18(2) or (3) (notification of cancellation of declaration), or (b) section 22 (recording of cancellations). These offences would carry a sentence, (a) on summary conviction, to imprisonment for a term not exceeding the general limit in a magistrates’ court or a fine, or both; (b) on conviction on indictment to imprisonment for a term not exceeding 5 years or a fine, or both.

Safeguards and necessary adjustments
The safeguards provided for in the bill, which apply at every stage of the process for seeking an assisted death, would help to minimise the risk of any eligible person, including disabled people, from being coerced or pressured by another person into requesting or proceeding with an assisted death.

As with other healthcare services, there would likely be barriers to access for disabled people unless necessary adjustments are made. Some of these adjustments are already set out in the bill after committee stage in the House Commons, to allow disabled people who are eligible for this service to access it. Mechanisms are set in place to monitor the impact on disabled people (clause 44). These provisions seek to prevent discrimination against disabled people and to give eligible disabled people equal opportunity to access this service. Further adjustments would need to be considered during the implementation phase if this bill became law.

Sex

The bill provides that an eligible, terminally ill adult, acting of their own free will, would be able to request, and be provided with, lawful assistance to end their own life in accordance with the bill, regardless of their sex or gender.

In jurisdictions with assisted dying policies comparable to this bill (for example Oregon (see reference 3) and New Zealand (see reference 2)), men have proportionately submitted more applications for assisted dying or died via these means, though this was only by a small margin. We are not able to accurately determine whether this would be the case in England and Wales.

Women tend to disproportionately provide unpaid care and end of life care, both professionally - 91% of hospice staff in 2022 to 2023 were female (see reference 24) - and as unpaid carers (see reference 36). Women may be more impacted in terms of the intersectional impact on female carers.

Women are more likely to be victims of domestic abuse (1.6 million women compared to 712,000 men in the year ending March 2024, see reference 37), which can manifest as physical, emotional and sexual abuse, and can include coercive behaviour. We do not have evidence on how many victims of domestic abuse have a terminal illness and would or would not want to request assistance to end their own life. The bill requires the co-ordinating doctor (clause 9) and the independent doctor (clause 10), as well as the panel (clause 15) to be satisfied that the person is making their declaration voluntarily, without coercion or pressure from another person. See ‘Coercion and pressure’ under ‘Disability’ in this publication for details on the relevant safeguards.

Evidence suggests that healthcare professionals lack ‘training and education’ regarding domestic abuse and may be ‘unwilling to engage in conversations about domestic abuse’ (see reference 15). We have no evidence on this in the context of assisted dying. See information under ‘Disability’ in this publication for details on mandatory training for any healthcare professional who would act as a co-ordinating or independent doctor, which includes training on domestic abuse, coercive control and financial abuse. See ‘Coercion and pressure’ under ‘Disability’ in this publication for details on the relevant safeguards. Additionally, the bill also mandates that the panel would consist of a social worker, a psychiatrist and legal member to support the medical opinion, for example a social worker will have specific knowledge about safeguarding vulnerable adults (see reference 20), including in cases of domestic abuse (schedule 2(2)(b) to the bill).

The bill would apply equally to all sexes and there is no strong evidence that it would have a substantial differential impact on any sex.

Sexual orientation

The bill provides that an eligible, terminally ill adult acting of their own free will would be able to request, and be lawfully provided with, assistance to end their own life in accordance with the bill, regardless of sexual orientation.

Evidence suggest that lesbian, gay, bisexual, transgender and queer (LGBTQ+) people often access palliative and end of life care services late, or not at all, due to fear of discrimination (see reference 25).

This bill would apply to everyone regardless of their sexual orientation and overall aligns with the 3 aims of the public sector equality duty in this regard.

Race - ethnic groups, nationalities, Gypsy, Roma, Travellers and language barriers

The bill provides that an eligible, terminally ill adult acting of their own free will would be able to request, and be lawfully provided with, assistance to end their own life in accordance with the bill, regardless of race or nationality.

Members of the travelling community and recent immigrants could fulfil eligibility criteria regarding having been ordinarily resident in England or Wales for at least 12 months and registered with a GP as per clause 1(1)(c) and (d).

People from minority ethnic groups experience health inequalities in terms of access, outcomes and experiences (see reference 23) which may extend to this service (see also ‘Socioeconomic background’ in this publication) and which the NHS is addressing through for example the NHS Race and Health Observatory. We currently have no evidence as to how many members of specific ethnicities may or may not want to access assisted dying in England and Wales. Some ethnic groups are less likely to have 2 valid proof of identity documents (as required when making a first declaration in clause 8(2)). Data from the 2011 Census (used in the Elections Bill EQIA (see reference 10)) shows only 66% of those identifying as White Gypsy or Irish Traveller said they had a passport, compared to 86% across all ethnicities. The bill at the end of committee stage in the House of Commons, however, does not specify the forms of identity to be photographical and provides the Secretary of State with the power to make regulations about the forms of proof of identity that are acceptable for the purposes of clause 8(2).

Translations and easy-read options should be considered to help support those whose first language is not English. This includes migrants born or not born in the UK - analysis from the Migration Observatory shows just under 1 in 5 of those born in Pakistan and ‘other South Asia’ say they ‘cannot speak English well or at all’ (see reference 27) - or whose reading ability is impaired. In the bill, as drafted at the end of committee stage in the House of Commons, clause 5(4) requires a registered medical practitioner who conducts a preliminary discussion with a person under clause 5 to first ensure the provision of adjustments for language and literacy barriers, including the use of interpreters. Clause 47 provides that a person seeking assistance under this bill must be provided with the service in English or Welsh depending on their preference. The Secretary of State must, within 6 months of the passing of this bill, issue one or more codes of practice about arrangements for ensuring effective communication in connection with the provision of assistance to persons in accordance with the bill, including the use of interpreters (clause 36 (3)).

Doctors are expected to, irrespective of this bill, adhere to existing professional standards published by regulators (such as Good medical practice (https://www.gmc-uk.org/professional-standards/the-professional-standards/good-medical-practice), published by the General Medical Council) when supporting patients’ decision-making. For example, ‘decision-making and consent content’ in good medical practice provides that ‘patients need relevant information to be shared in a way they can understand and retain’. This standard sets out various steps a doctor can take to help ensure information is understood and retained, including:

- use of an interpreter or translation service
- sharing in a format the patient prefers
- accommodating requests for recording the discussion

See information under ‘Disability’ in this publication for further safeguards relating to access to independent advisors for which those with ‘substantial difficulties’ in understanding the processes or information qualify.

While some may experience difficulties in accessing this service, this bill makes specific provision to try to ensure equal opportunity for accessing assisted dying.

Age

The bill provides that an eligible, terminally ill adult acting of their own free will would be able to request, and be lawfully provided with, assistance to end their own life in accordance with the bill. Those who are under the age of 18 would not be able to access assisted dying, as one of the eligibility criteria provided for in clause 1(1)(b) is that the person is aged 18 or over at the time the person makes a first declaration.

Access to assisted dying, as provided for in the bill, is restricted to adults. Those under the age of 18, even if otherwise eligible, are excluded. The majority of people that use assisted dying services in other jurisdictions are over the age of 65, and very few are younger than 50 (see references 1 to 4 for Oregon, Washington, New Zealand and California). We have no evidence on how many terminally ill people under the age of 18 with a life expectancy of 6 months or less may want to access assisted dying in England and Wales.

Elderly people, who are in all other jurisdictions the main recipients of assisted dying, are often dependent on those who care for them (see reference 34), putting them at increased risk of elder abuse, although we have no data on this in the context of assisted dying. Pre-pandemic data (2018) from the Crime Survey for England and Wales estimates 210,000 adults between 60 and 74 years experienced domestic abuse (see reference 38).

The Equality and Human Rights Commission highlights that coercion or pressure may not only be applied directly via other individuals (see reference 11) but that older persons ‘may feel subtly pressured to end their lives prematurely’. The bill includes safeguards aiming to mitigate the risk of undue influence on any person seeking assistance in accordance with the bill (see paragraph ‘Coercion and pressure’ under ‘Disability’ in this publication for details on the relevant safeguards).

The bill applies to all adults and provides equal opportunity to access this service for adults.

Gender reassignment (including transgender)

The bill provides that an eligible, terminally ill adult acting of their own free will would be able to request, and be lawfully provided with, assistance to end their own life in accordance with the bill, regardless of whether they have undergone gender reassignment.

As noted in the section on ‘sexual orientation’, however, some members of the LGBTQ+ community may not feel comfortable accessing end-of-life care and may require additional support. We do not have evidence of barriers experienced by transgender people in the context of assisted dying in England and Wales.

The bill does not discriminate against transgender people and provides equal opportunity to access this service.

Religion or belief

The bill provides that an eligible, terminally ill adult acting of their own free will would be able to request, and be lawfully provided with, assistance to end their own life in accordance with the bill, regardless of their religion or belief.

Some health professionals may not want to provide assisted dying because they consider it contrary to their religion or belief. A 2019 survey of more than 6,600 members of the Royal College of General Practitioners showed 2 in 3 (66%) said they had a ‘moral objection to assisted dying’ with 53% saying this is due to their religious beliefs (see reference 28).

The bill, as written at the end of committee stage in the House of Commons, provides at clause 28(1) that there is no duty on any registered medical practitioner or other health professional to participate in the provision of assistance in accordance with the bill, and that an employer must not subject an employee to any detriment for exercising their right under clause 28(1) not to participate in the provision of assistance in accordance with the bill or for participating in the provision of assistance to a person in accordance with the bill. Conscientious objection is available for all registered medical practitioners and other health professionals, should they object to participating in provision of assistance in relation to assisted dying under the bill due to religious, or other, beliefs.

Similarly, no registered medical practitioner would be under any duty to raise the subject of assisted dying with a person or to conduct a preliminary discussion under clause 5, however, a registered medical practitioner who is unwilling or unable to conduct the preliminary discussion must ensure that the person is directed to where they can obtain information and have the preliminary discussion (clause 5(6)).

The bill applies equally to people of all religions and beliefs. The bill provides for conscientious objection for medical professionals who do not wish to participate in assisted dying, as well as providing protection for any detriment in refusing to participate (or similarly for choosing to participate). This may help to mitigate the risk of discrimination against a person for their religion or belief in the context of assisted dying.

Pregnancy and maternity

As drafted at the end of committee stage in the House of Commons, a pregnant person who also meets the eligibility criteria in the bill, would not be explicitly excluded from seeking assistance to end their own life.

Notwithstanding, clinicians may use their right to conscientious objection and not assist an eligible pregnant person or recent mother to access assisted dying. We have no data on how many pregnant people are also terminally ill and therefore may be interested in accessing voluntary assisted dying services in England and Wales.

Marriage and civil partnership

The bill provides that an eligible, terminally ill adult acting of their own free will would be able to request, and be lawfully provided with, assistance to end their own life in accordance with the bill, irrespective of their relationship status.

The bill makes provisions to exclude relatives (which can include spouses) from being able to witness a first or second declaration by a person, or from being a proxy for a person intending to have a document signed by a proxy under clause 19, if that person is a beneficiary under a will of the person, or if they may otherwise benefit financially or in any other material way from the death of a person (clause 48). These safeguards are intended to help minimise the risk of a person being coerced or pressured by any other person into requesting or using voluntary assisted dying services.

We do not expect any differential impacts on, discrimination of, or unequal access for people who are married or in a civil partnership.

Other identified groups (these are not covered by the Equality Act 2010)

In addition to the 9 protected characteristics, the government has also considered the potential impact on others who may experience differential impacts.

Socioeconomic background and geography are routinely included in considerations on health and social care policy. This is due to health inequalities, which are differences in health outcomes that are unfair and avoidable and which are rooted in socio-economic background and geography (see figure 1 in Health disparities and health inequalities: applying All Our Health (https://www.gov.uk/government/publications/health-disparities-and-health-inequalities-applying-all-our-health)).

Poor mental health is considered to be closely linked to health inequalities (see reference 29) and is one of the top 4 conditions contributing to ill-health in England (measured in ‘disability adjusted life years’, see reference 16). It is therefore also routinely included in considerations of health and care policy.

Socioeconomic background

Any eligible, terminally ill adult acting of their own free will would be able to request, and be lawfully provided with, assistance to end their own life in accordance with the bill, regardless of their socioeconomic background. The bill requires the Secretary of State to make regulations which secure that arrangements are made for the provision of voluntary assisted dying services in England (clause 38). The bill would also confer a power on Welsh ministers to make regulations which make provision about voluntary assisted dying services in Wales (clause 39).

According to a King’s Fund (see reference 30), people living in poverty or deprived areas:

- are experiencing poorer quality healthcare
- are more likely to wait longer for non-urgent treatment
- have a higher patient to GP ratio
- have worse continuity of care
- are more likely to struggle with navigating the healthcare system

Poverty is an important factor in health inequalities (see reference 31) and intersects with some of the protected characteristics. For example, disabled people compared to non-disabled people and people of Pakistani and Bangladeshi ethnicity compared to White people are more likely to be in poverty.

While assisted dying is not legal in England and Wales, some British citizens travel abroad to seek assistance, for example to Dignitas, a Swiss organisation. In 2023, Dignitas stated to have 1,528 British members, and that 33 British people had an assisted death at Dignitas in 2022 (see reference 35). Legalising assisted dying in England and Wales would remove the costs and fees associated with travel and provision of assisted dying abroad, if the person is eligible under the criteria set out in clause 1 of this bill. This would make assisted dying more accessible to those from a lower socioeconomic background.

Conversely, the requirement of 2 forms of identification documents may have a cost impact on some people living in poverty and those classed as homeless or rough sleeping. The Secretary of State may, by regulations, make provision about the forms of identity that are acceptable, therefore the extent of this financial burden is not possible to assess at this stage.

The bill provides that the Secretary of State must make provision securing that arrangements are made for the provision of voluntary assisted dying services and that these services would be free at the point of access (except where expressly provided otherwise), therefore allowing equal opportunity to access and not discriminating against people based on their socioeconomic background. Although we are unable to quantify the extent of any impact, the bill may have a positive impact on those from lower socioeconomic backgrounds by making assisted dying available without incurring cost.

Geography

The bill provides that an eligible, terminally ill adult acting of their own free will would be able to request, and be lawfully provided with, assistance to end their own life in accordance with the bill, regardless of where they are based in England or Wales. However, implementation of this voluntary assisted dying service would be delivered through different powers in England (clause 38) and Wales (clause 39) therefore provision may differ.

According to Lord Darzi’s independent investigation of the NHS, primary care provision is under pressure in England, with more than 1,300 GP practices having closed between 2015 and 2024 (see reference 21). Data analysis from the BMA shows a full-time GP being responsible for more than 2,200 patients in 2024 (see reference 32). In particular, rural areas may struggle to access GP services in a timely manner (see reference 17). A report shows that 2 in 3 older people in Wales struggle to make suitable appointments or communicate with their GP (see reference 18). Patients in rural areas or areas with particularly stretched primary care provision in England and Wales may not be able to access a healthcare professional who is willing to assist in a timely manner (and also have access to an independent doctor who has not been involved in their care as per clause 10(8)), or may struggle to access palliative care (see reference 26).

The Equality and Human Rights Commission notes that regional variation in palliative care could be a reason for some patients to consider assisted dying (see reference 11) where they may not have done so if appropriate palliative care was available. The bill aims to mitigate this risk by requiring the co-ordinating and independent doctors to explain and discuss with the person all appropriate palliative, hospice or other care (including symptom management and psychological support) during the preliminary discussion and during the first and second assessments. Clause 36(1)(b) of the bill (Codes of Practice) also provides that the Secretary of State may issue codes of practice in connection with the information made available in relation to treatment or palliative, hospice or other care available to the person.

Clause 46 requires the Secretary of State to undertake a review of the operation of the bill (once passed) and prepare a report on that review which is published and laid before Parliament as soon as reasonably practicable (within 12 months after 5 years of the bill passing). This report must set out an assessment of the availability, quality and distribution of appropriate health services to persons with palliative care needs, including:

- (i) pain and symptom management
- (ii) psychological support for those persons and their families
- (iii) information about palliative care and how to access it (clause 46(3)(b))

As per the bill at the end of committee stage in the House of Commons, eligible adults in England and Wales would be able to request, and be lawfully provided with, assistance to end their own life. If this bill were to be passed, further work during the implementation period would need to be done to maximise access for all those wishing to use this service in England and Wales.

Mental health

The bill is drafted so as not to exclude people with mental health conditions from accessing voluntary assisted dying services where they are otherwise eligible to do so.

Additionally, the bill is drafted so that mental illness alone is not considered to be a ‘terminal illness’ for the purposes of the bill. However, having a mental illness would not exclude a person from accessing assisted dying if they are otherwise eligible (clause 2(3)).

Having a mental health condition does not mean someone does not have capacity. However, capacity can be impacted permanently (for example due to a stroke or a learning disability) or in the short term (for example due to mental illness) - see reference 43. As provided for in clause 3, references to capacity in the bill are to be read in accordance with the MCA. Under the MCA, a person is assumed to have capacity unless it is established that they lack capacity. The scheme for assessing capacity is contained in sections 1 to 3 of the MCA. Section 2(1) provides a definition of what it means to lack capacity for the purposes of the MCA. This is a legal test rather than a medical one and sets out that: 'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain'. Section 3(1) sets out that a person is unable to make a decision if they are unable to:

- (a) understand the information relevant to the decision
- (b) retain that information
- (c) use or weigh that information as part of the process of making the decision
- (d) communicate their decision

Each case will be fact-specific and the relevant information may need to be tailored to the specific situation.

As per the paragraph on 'Capacity' under 'Disability', there are a number of safeguards throughout the bill designed to ensure that a person's capacity to determine whether to choose to end their own life in accordance with the bill is properly assessed. An individual's capacity, rather than the existence of a mental health condition alone, is therefore relevant to whether they are eligible to access assisted dying.

Census data has shown an increased risk of suicide among low survival cancer patients, patients with chronic ischemic heart conditions, and patients diagnosed with chronic obstructive pulmonary disease, all of which are conditions likely to be terminal (see reference 39). The bill provides that only people with a life expectancy of 6 months or less would be eligible to legally request assistance to end their own lives as set out in clause 1. We have no evidence of how many patients with those conditions and a life expectancy of 6 months or less may want or not want to request assisted dying.

Evidence also suggests that a large proportion of LGBTQ+ individuals experience mental ill-health and/or suicidal ideation (see reference 33). There are safeguards throughout the bill to ensure that an individual's capacity is assessed (with regards to the decision to legally request assistance to end their own life) - see paragraph 'Capacity' under 'Disability' in this publication for details on the relevant safeguards. We have no data on how many eligible terminally ill LGBTQ+ people would want to request assisted dying.

A large proportion of the disabled population (34% of 16.1 million in 2022 to 2023, see reference 19), also report a mental health disability, and there is significant comorbidity between learning disabilities or autism and mental ill-health. Certain parts of this publication’s section on ‘Disability’ may apply to people with mental illness.

See information under ‘Disability’ in this publication for further safeguards relating to access to independent advisors for which those with mental disorders qualify.

Other people with mental illness may have capacity as defined in the MCA but may not be able to express a clear, settled and informed wish to end their own life (clause 1) due to their mental illness (for example those with bipolar disorder (https://www.nhs.uk/mental-health/conditions/bipolar-disorder/)).

This bill does not discriminate against people with mental illness and is providing equal access to assisted dying subject to the person having mental capacity.

Engagement and involvement

This is a private member’s bill, and government has taken a neutral stance on this bill. The sponsor, not the government, has been responsible for engagement and involvement of stakeholders. It is not appropriate for government to comment on this engagement and involvement.

Summary of analysis

Government is neutral on this bill and on the substantive issue of assisted dying. Notwithstanding, the government has a duty to the statute book and has offered technical support to the sponsor to help ensure the legislation, if passed, is technically and legally workable. This EQIA is based on the bill’s text as it stands at the end of committee stage in the House of Commons.

Monitoring and evaluation

The bill makes provision in clause 45 for the commissioner to monitor the operation of the bill and submit an annual report. This report must include information about persons with protected characteristics, and the commissioner is to consult the CMO as well as representative organisations of persons with protected characteristics (clause 45(3)). In clause 46 the bill also sets out a mandatory review 5 to 6 years after passing of the bill. The Registrar General must at least once a year prepare and lay before Parliament a report with statistical analysis of deaths (clause 35(3)).

Government would ensure monitoring and evaluation are appropriately implemented if it is Parliament's will that this bill becomes law. Further details on monitoring and evaluation can be found in the impact assessment accompanying this bill.

Conclusion

Government is neutral on this bill, however, has offered technical support on workability. If it is the will of Parliament that this bill becomes law, government will ensure that it is implemented in such a way that attempts to mitigate unlawful discrimination, harassment and victimisation and manage any equality issues that may arise.

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