

# PARLIAMENTARY DEBATES

HOUSE OF COMMONS  
OFFICIAL REPORT  
GENERAL COMMITTEES

## Public Bill Committee

### TERMINALLY ILL ADULTS (END OF LIFE) BILL

*Twenty-eighth Sitting*

*Tuesday 25 March 2025*

*(Morning)*

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CLAUSE 32 under consideration when the Committee adjourned till this day at Two o'clock.

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**not later than**

**Saturday 29 March 2025**

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**The Committee consisted of the following Members:**

*Chairs:* PETER DOWD, CLIVE EFFORD, SIR ROGER GALE, CAROLYN HARRIS, † ESTHER McVEY

- |   |   |
|---|---|
| † Abbott, Jack ( <i>Ipswich</i> ) (Lab/Co-op)                         | † Opher, Dr Simon ( <i>Stroud</i> ) (Lab)                                 |
| † Atkinson, Lewis ( <i>Sunderland Central</i> ) (Lab)                 | † Paul, Rebecca ( <i>Reigate</i> ) (Con)                                  |
| † Campbell, Juliet ( <i>Broxtowe</i> ) (Lab)                          | † Richards, Jake ( <i>Rother Valley</i> ) (Lab)                           |
| † Charalambous, Bambos ( <i>Southgate and Wood Green</i> ) (Lab)      | † Sackman, Sarah ( <i>Minister of State, Ministry of Justice</i> )        |
| † Francis, Daniel ( <i>Bexleyheath and Crayford</i> ) (Lab)           | † Saville Roberts, Liz ( <i>Dwyfor Meirionnydd</i> ) (PC)                 |
| † Gordon, Tom ( <i>Harrogate and Knaresborough</i> ) (LD)             | † Shah, Naz ( <i>Bradford West</i> ) (Lab)                                |
| † Green, Sarah ( <i>Chesham and Amersham</i> ) (LD)                   | † Shastri-Hurst, Dr Neil ( <i>Solihull West and Shirley</i> ) (Con)       |
| † Hopkins, Rachel ( <i>Luton South and South Bedfordshire</i> ) (Lab) | † Tidball, Dr Marie ( <i>Penistone and Stocksbridge</i> ) (Lab)           |
| † Joseph, Sojan ( <i>Ashford</i> ) (Lab)                              | † Woodcock, Sean ( <i>Banbury</i> ) (Lab)                                 |
| † Kinnock, Stephen ( <i>Minister for Care</i> )                       |   |
| † Kruger, Danny ( <i>East Wiltshire</i> ) (Con)                       | Lynn Gardner, Lucinda Maer, Jonathan Whiffing,<br><i>Committee Clerks</i> |
| † Leadbeater, Kim ( <i>Spen Valley</i> ) (Lab)                        |   |
| † Malthouse, Kit ( <i>North West Hampshire</i> ) (Con)                |   |
| † Olney, Sarah ( <i>Richmond Park</i> ) (LD)                          | † <b>attended the Committee</b>   |

## Public Bill Committee

Tuesday 25 March 2025

[ESTHER McVEY *in the Chair*]

### Terminally Ill Adults (End of Life) Bill

9.25 am

**The Chair:** Would everyone ensure that all electronic devices are turned off or switched to silent mode? Tea and coffee are not allowed in the Committee Room. I remind Members that interventions should be short, and raise points of clarification or questions; they should not be speeches in and of themselves. Members who do wish to give a speech should bob and continue to do so throughout the debate that they wish to speak in, until they are called. When Members say “you”, they are referring to the Chair. “You” should not be used to refer to each other. Debate should come through the Chair.

#### Clause 32

SECRETARY OF STATE’S POWERS TO ENSURE  
ASSISTANCE IS AVAILABLE

**Danny Kruger** (East Wiltshire) (Con): I beg to move amendment 525, in clause 32, page 19, line 26, leave out subsection (2).

**The Chair:** With this it will be convenient to discuss the following:

Amendment 537, in clause 32, page 19, line 27, after “assistance” insert  
“by a registered charity but not”.

*This amendment would limit the provision of an assisted death to charitable providers and not permit provision as part of the National Health Service.*

Amendment 528, in clause 32, page 19, line 27, at end insert—

“(2A) Regulations under subsection (1) cannot authorise a body other than a public authority from providing such assistance even if that body is to be contracted by a public authority to do so.”

Amendment 529, in clause 32, page 19, line 28, leave out subsection (3).

Amendment 530, in clause 32, page 19, line 31, at end insert—

“(5) The Secretary of State may not lay a draft statutory instrument before either House of Parliament that makes provision containing (whether alone or with other provision) regulations under subsection (1) unless they also lay before both Houses an impact assessment on such regulations.

(6) The impact assessment under subsection (5) must include an assessment of the impact of such regulations on the workforce of health professionals and on the National Health Service.”

Clause stand part.

Amendment 545, in clause 39, page 23, line 6, leave out subsections (3) to (5) and insert—

“(3) The Secretary of State may not make a statutory instrument containing (whether alone or with other provision) regulations under section 5(3A), 8(6A), 30(3), (Voluntary assisted dying services: England) or (Voluntary assisted dying services: Wales) unless a draft of the instrument has been laid before, and approved by a resolution of, each House of Parliament.

(4) Any other statutory instrument made by the Secretary of State containing regulations under this Act is subject to annulment in pursuance of a resolution of either House of Parliament.

(5) The Welsh Ministers may not make a statutory instrument containing regulations under section (Voluntary assisted dying services: Wales) unless a draft of the instrument has been laid before, and approved by a resolution of, Senedd Cymru.”

*This amendment brings together the various provisions about the procedure for regulations. It also makes regulations under clauses 5 and 8 about training, qualifications and experience, and regulations under NC36 and NC37, subject to the draft affirmative procedure.*

New clause 36—*Voluntary assisted dying services: England*—

“(1) The Secretary of State must by regulations make provision securing that arrangements are made for the provision of voluntary assisted dying services in England.

(2) In this section ‘commissioned VAD services’ means services provided by virtue of regulations under subsection (1).

(3) The Secretary of State may by regulations make other provision about voluntary assisted dying services in England (whether or not the services are commissioned VAD services).

(4) Regulations under this section may for example provide that specified references in the National Health Service Act 2006 to the health service continued under section 1(1) of that Act include references to commissioned VAD services.

(5) Regulations under this section must provide that section 1(4) of that Act (services to be provided free of charge except where charging expressly provided for) applies in relation to commissioned VAD services.

(6) Regulations under this section may make any provision that could be made by an Act of Parliament; but they may not amend this Act.

(7) In this section ‘voluntary assisted dying services’ means—

(a) services for or in connection with the provision of assistance to a person to end their own life in accordance with this Act, and

(b) any other services provided by health professionals for the purposes of any of sections 4 to 22 except section (Determination by panel of eligibility for assistance).”

*This new clause imposes a duty on the Secretary of State to make regulations securing that arrangements are made for the provision of voluntary assisted dying services in England. It also confers a power to make other provision about voluntary assisted dying services in England.*

Amendment (a) to new clause 36, after subsection (1) insert—

“(1A) Regulations under subsection (1) cannot authorise the National Health Service in England to provide voluntary assisted dying services.”

Amendment (c) to new clause 36, after subsection (1) insert—

“(1A) Regulations under subsection (1) cannot authorise a body other than a public authority to provide voluntary assisted dying services if that body is to be contracted by a public authority to do so.”

Amendment (b) to new clause 36, leave out subsections (4) and (5) and insert—

“(4) Regulations under subsection (1) may not amend, modify or repeal section 1 of the National Health Service Act 2006.”

Amendment (d) to new clause 36, leave out subsection (6).

Amendment (e) to new clause 36, after subsection (6) insert—

“(6A) The Secretary of State may not lay a draft statutory instrument before either House of Parliament that makes provision containing (whether alone or with other provision) regulations under subsection (1) unless they also lay before both Houses an impact assessment on such regulations.

- (6B) The impact assessment under subsection (6A) must include an assessment of the impact of such regulations on the workforce of health professionals and on the National Health Service.”

*New clause 37—Voluntary assisted dying services: Wales—*

“(1) The Welsh Ministers may by regulations make provision about voluntary assisted dying services in Wales, including provision securing that arrangements are made for the provision of such services.

(2) Regulations under subsection (1) may make any provision that—

- (a) could be made by an Act of Senedd Cymru, and
- (b) would be within the legislative competence of the Senedd if it were contained in such an Act.

(3) The Secretary of State may by regulations make provision about voluntary assisted dying services in Wales.

(4) Regulations under subsection (3) may make any provision that—

- (a) could be made by an Act of Parliament, and
- (b) would not be within the legislative competence of the Senedd if it were contained in an Act of the Senedd.

(5) Regulations under this section may not amend this Act.

(6) In this section ‘voluntary assisted dying services’ has the meaning given by section (Voluntary assisted dying services: England).”

*This new clause confers a power on the Welsh Ministers to make provision about voluntary assisted dying services in Wales, including provision securing that arrangements are made for the provision of such services. It also confers a power on the Secretary of State to make provision about such services, where the provision would be outside the legislative competence of Senedd Cymru.*

**Danny Kruger:** It is very good to serve under your chairmanship, Ms McVey, on what is probably our last day in Committee. I fully expect that we will reject clause 32 in due course, so although I want to move my amendment, I have no intention of pushing it or any of the other amendments in this group to a vote, but I do want to take the opportunity to address the clause and to speak to the amendment in my name.

Clause 32 was always going to be an important one, because it would have allowed the Government to provide money to fund the assistance to die; it would have allowed the Secretary of State to make financial arrangements to secure the provision of assistance under the Bill. What we might have been debating if we were sticking with this clause—I think it is still worth inviting the hon. Member for Spen Valley and people who support the Bill to speak to this point—is that the Bill will require the Government to fund the provision of assisted suicide services, but it makes no provision to fund the supply of palliative care. I think everyone in this Committee recognises the absolute imperative of a properly supported palliative care sector, and I deeply regret that although the Government are supporting a resourcing of this new service, there is no balancing commitment to provide what we have all acknowledged is the essential corollary of any assisted dying service. What is worse, in clause 32 and in new clause 36, which will replace it, we have something different.

Last Wednesday night, just as the Committee rose, the hon. Member for Spen Valley tabled amendment 538, which would remove clause 32 from the Bill. This is the clause that committed the Secretary of State to make the financial commitments—commitments that were debated in principle when the House debated the money resolution on 22 January. Once again, I regret that

important undertakings that were made by the Government and by the hon. Lady have, in the course of the debate subsequent to Second Reading and now subsequent to the money resolution, been superseded by further provisions.

Amendment 538 is consequential on two new clauses, one of which is new clause 37, which will allow Welsh Ministers to set up a system to implement the Bill in Wales. This will give very wide powers to Welsh Ministers, including the powers to make provision about the service that would be outside the legislative competence of Welsh Ministers. That is significant. Unlike clause 32 and new clause 36, which will replace it, new clause 37 does not make any reference to the health service in Wales. I think it is worth us teasing out the challenge to the devolution settlement that these new clauses represent; I am sure the right hon. Member for Dwyfor Meirionnydd will speak to that.

I want to speak briefly, but I hope clearly and powerfully, to the essential challenge. Without getting too involved in the party politics, we all talk about “our NHS”, and in a sense it is our NHS: this nation’s great domestic institution, created in the 20th century in response to the shamefully inequitable provision of healthcare that preceded 1946. Labour rightly claims the credit for having introduced the NHS under the Attlee Government and in fact the Liberals also have a good claim to it—it was a Liberal, Beveridge, who first advocated the provision of a national health service—but what is not enough recognised is that, as I am sure my hon. Friends are proud to say, it was a Conservative Health Secretary who first put before the House of Commons a plan for a national health service: Henry Willink, Health Secretary in the wartime coalition Government. Unfortunately, the public voted us out of power in 1945 and it fell to Labour to implement a slightly different plan. Nevertheless, we can all claim some parentage of this great institution, the NHS. That is why it is so significant that in the new clauses we are debating, a fundamental change to the NHS in England is proposed.

The duty on the Secretary of State under the National Health Service Act 1946, as updated in 2006, is to promote

“a comprehensive health service designed to secure improvement in the physical and mental health of the people of England...and the prevention, diagnosis and treatment of illness”—

that is, physical and mental illness. That has been the purpose of the NHS since 1946.

I find it curious that a linguistic sleight of hand is being practised in new clause 36. The new phrase, “voluntary assisted dying services” or “VAD services”, is introduced, and it is used to avoid having to spell out that section 1(1) of the NHS Act 2006 will now include references to “assistance to end” the lives of people in England and Wales—that is the language of the Bill as introduced, in the long title and in nearly every clause up to this point. The explicit language that this is about ending people’s lives is avoided in the new clause. Why? I put it to the Committee that it is a hard thing to do: to take a red pen to Bevan’s legacy, to fundamentally change the NHS from one that is

“designed to secure improvement...in the physical and mental health”

of the people of England and Wales, and dedicated to

“the prevention, diagnosis and treatment of...illness”,

and to add to that founding clause “to end” the lives of terminally ill people.

[Danny Kruger]

I will be blunter than the drafters have been. New clause 36 changes the NHS from being the national health service to the national health and assisted suicide service. That is its direct implication. Furthermore, the new clause is also designed not only to alter fundamentally the national health service, but to enable the private sector to be paid from NHS funds to end the lives of terminally ill people—and not only that, but to do so with a Henry VIII power so broad as to enable any changes in the NHS or any law to facilitate that goal.

**Dr Simon Opher** (Stroud) (Lab): Does the hon. Gentleman accept that end-of-life care is also part of the NHS? That has always been part of the NHS, and it is not promoting health but enabling a good death.

**Danny Kruger**: No, I fundamentally disagree: end-of-life care is healthcare. It addresses symptoms and conditions, and it is designed in a way that is completely compatible with the founding principle of the NHS, whereas the Bill—I appreciate the honesty of the drafters in recognising this, even if they do not quite spell it out—and its proposal of an assisted suicide service is not compatible with the founding principle of the NHS. That is why adapting that founding subsection as in the original NHS Act is required. Of course I recognise that end-of-life care is healthcare and completely compatible with what the NHS does. I wish it were more part of the NHS—that is another debate. Palliative care should have been more closely integrated into NHS provision, and it still should be.

I want to tease out a tension among the drafters and advocates of the Bill about exactly how the assisted suicide service will be facilitated and provided. We have got a bit closer to it, but some questions remain, which is regrettable when here we are on the very last day of the Committee's debate. Last month, the hon. Member for Spen Valley told the Committee:

“This is not assisted suicide by the state. The state is not involved.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 11 February 2025; c. 318.]

I am perplexed by that. I think many members of the public would not agree with that analysis of how the Bill has evolved in Committee. If involving the state in the provision of this service was not intended, then that is not the Bill we have.

In contradiction to that, and I think more accurately, the Minister for Care told us that the promoter's intent—speaking for the hon. Member for Spen Valley—is

“to ensure that the assisted dying service is available as an integral part of the NHS. Officials are working on amendments to later clauses to establish the operating model for her consideration.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 5 March 2025; c. 802.]

That is clearly what has happened, and it is where we are now. However, I am sorry to say that I do not feel that the operating model is now clear. We still do not have an impact assessment, we do not know how the Government envisage it working in practice, and important information is still lacking for the debate today. We do not know the possible impact on general practice or medical specialists, nor how it might impact money that is available for palliative care. I hope the Minister can tell us more today about how he envisages the service being implemented, especially in the light of the British Medical Association conference earlier this month, which supported the motion that

“Assisted dying is not a health activity and it must not take place in NHS or other health facilities”.

That is a principle I agree with.

On 5 March, the hon. Member for Spen Valley said: “there is no expectation that assisted dying would be set up as a private enterprise or service. It would be delivered within the provision of the NHS.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 5 March 2025; c. 799.]

That now agrees with the Minister—fine, interesting; it is to be an NHS service not to be provided privately. But the new clauses do not rule out private provision, nor any profit making by providers or remuneration of people outside the NHS. Indeed, the new clauses refer to “voluntary assisted dying services”, which suggests the hon. Member for Spen Valley is supportive of services outside those that are NHS commissioned, which will be possible under subsections (1), (3) and (7)(a). That will be in line with comments made by my right hon. Friend the Member for North West Hampshire, who made a very coherent case for private provision of assisted suicide if that is what Parliament chooses to legalise; he said that nothing should prevent someone from opting for private provision. In response, the hon. Member for Spen Valley said:

“This service, like many others, will be delivered through a range of providers”.—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 5 March 2025; c. 800.]

I remain unclear about the extent to which this is an NHS monopoly, as it were, or whether there will be private provision that is privately paid for, or private provision that is publicly paid for. I would be grateful for the hon. Member's clarification.

Lastly, on the question of profit, in an article in *The Times* that appeared to have some briefing behind it, there was a suggestion that there would be a cap on the profit of private companies providing the service, limiting them to “making a reasonable profit”. Again, there is nothing in the new clauses about limitations on providers' profits. If the hon. Member could clarify how she envisages the private provision of the service, I would be grateful.

**Sean Woodcock** (Banbury) (Lab): It is a pleasure to serve under your chairship, Ms McVey. I rise to speak to amendment (b) to new clause 36, which was tabled by my hon. Friend the Member for Shipley (Anna Dixon). The amendment states:

“Regulations under subsection (1) may not amend, modify or repeal section 1 of the National Health Service Act 2006.”

For clarity, I will read out the relevant part of section 1 of the 2006 Act:

“The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement—

(a) in the physical and mental health of the people of England, and

(b) in the prevention, diagnosis and treatment of physical and mental illness.”

Those core principles have remained the same since the National Health Service Act 1946. As the hon. Member for East Wiltshire stated, in a Britain that was devastated by war, Clement Attlee and Nye Bevan together promised a better future, one where healthcare should be available to all, regardless of wealth. It enshrined a principle that as a society we will care for the ill and we will do that together. No one's health should be left behind, especially that of the vulnerable.

The NHS stands as the greatest legacy of a Labour Government—despite the input of Opposition parties referred to by the hon. Member for East Wiltshire—and perhaps of any Government since the second world war. The establishment of the NHS lives on in section 1 of the NHS Act. It is why at the height of the pandemic NHS staff courageously put themselves on the frontline to protect us. It is their mission to secure improvement in the physical and mental health of all, free at the point of service. As we consider assisted dying, we must not lose the values at the heart of the NHS.

Section 1 of the 2006 Act has changed little from the corresponding first section of the 1946 Act. It is not just a line in legislation; it has become part of our national story and our national identity, and amendment (b) to new clause 36 is about continuing that. It seeks to preserve the legacy of Attlee and Bevan, and that of Labour Governments committed to the betterment of the people.

Twenty-five senior doctors and pharmacists from Shetland and Orkney spoke of that legacy in their written evidence:

“We note with pride the founding principles of the NHS, with the 1946 National Health Service Act stating, ‘It shall be the duty of the Minister of Health...to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness.’ We believe that Parliament must reflect the lasting ethos of our founding document.”

There are very few lines in legislation that come to represent an institution in this way. It is a testament to the ideal of those founding principles in section 1 that they guide doctors to this very day. This is the thread that runs through the 1946 Act to the 2006 Act—two Labour Governments, 60 years apart, united by this mission to improve the physical and mental health of the people. This Committee should continue the thread of those principles.

Of course, I understand that previous legislation may need to be amended to provide assisted dying services, and that may include the 2006 Act. New clause 36(4) clarifies that specified references to commission voluntary dying services may be included in that Act. I note with regret that the new clause gives us so little information elsewhere about the use of these powers, which are commonly known as Henry VIII powers or clauses. This is not a term that I was familiar with until very recently. I am sure other Members are much more familiar with it than I am, but on the off-chance that there are one or two Members who need a reminder, I will read Parliament’s own official definition of the term:

“‘Henry VIII clauses’ are clauses in a bill that enable ministers to amend or repeal provisions in an Act of Parliament using secondary legislation, which is subject to varying degrees of parliamentary scrutiny.”

Helpfully, it adds:

“The expression is a reference to King Henry VIII’s supposed preference for legislating directly by proclamation rather than through Parliament.”

I accept that it might be rather odd to talk about Henry VIII in this debate, but we should not let that distract us from the serious question of this new clause, which could result in a significant transfer of power from Members of this House to the Secretary of State, and it is not clear what that power will be used for.

The Hansard Society has noted that there is little indication about what role or nature these powers will take, saying:

“A key principle that the House of Lords Constitution Committee has applied to delegated powers is that they ‘should not be framed in such a way that gives little indication of how they should be used.’ The Delegated Powers and Regulatory Reform Committee’s guidance to Departments states that the Delegated Powers Memorandum should set out how it is proposed that a power should be exercised.”

I would be grateful if my hon. Friend the Member for Spen Valley and Ministers could provide clarity on those questions. New clause 36(1) does not specify that voluntary assisted dying be provided on the NHS, but subsection (4) allows for the National Health Service Act 2006 to be amended. What is the intention of these powers? What will the structure of the voluntary assisted dying service be? How will it be funded and who will be responsible for the provision of the services? The answer to those questions will inform which legislation needs to be amended, and that information should be in the Bill.

To be clear, as I have said, I accept that changes to previous legislation may be required. However, the provision of assisted dying should not amend the foundational principles of the national health service. It should not break with the legacy of Attlee, of Bevan and of Labour. That is why I support amendment (b) to new clause 36.

9.45 am

I also want to speak in support of amendments (c) and (d) to new clause 36, tabled by the hon. Member for Richmond Park. Amendment (c) prohibits the private provision of assisted dying, and instead places responsibility for such provision on public authorities. I have a number of practical concerns about private providers, but let me start with the question of accountability for assisted dying. Should Parliament pass this legislation, it will bring about a profound change to the role of the state. I do not think that is in dispute across the Committee; everyone is well aware of the importance of this piece of legislation. We must not make such a significant decision only to delegate to private providers; the risks are too great.

This is not simply a question of principle, or consistency within the Bill; it is about establishing proper accountability for assisted dying. The state must oversee and regulate the delivery of this enormous legislative and social change. It must remain visible. Public authorities like the NHS are directly accountable to Parliament and the Government; there must be that same accountability for assisted dying. Private bodies are not accountable to the state, the Government or the public in the same way as public bodies. For example, private services are subject to fewer checks and regulations than public ones, and there can be less transparency about organisational structure, recruitment and finances.

We have been assured that data collection and monitoring would safeguard the implementation of the legislation, but without uniform standards and clear ways of enforcing them across providers, the monitoring of the legislation will be limited, even with the best will in the world. The best way to establish uniform standards would be to provide assisted dying through public authorities.

There is also the risk of developing a patchwork of private providers with variable standards. Organisations may develop slightly different practices, guidelines and

reputations, which could create an uneven framework, preventing the establishment of best practice across services. I reiterate that that will place the public at risk.

**Dr Opher:** My hon. Friend is making a reasoned speech. The thing is that the way the NHS is delivered is already very complex: for example, GPs are private providers who are on a contract with the NHS. Amending the Bill to completely ban private providers will not in any way enhance it; it will create a situation in which almost no doctors can get involved. We need to keep the private aspect simply so that the NHS can control what is going on, albeit the providers can be from independent organisations.

**Sean Woodcock:** I am afraid I just do not agree. My view is that if we are going to do this, it should be done via the NHS. As somebody who stood on a Labour election platform not too long ago, that is something I stand by.

We know that geography and socioeconomic factors render access to healthcare, especially private healthcare, unequal. In oral evidence, Baroness Kishwer Falkner, head of the Equalities and Human Rights Commission, and Fazilet Hadi of Disability Rights UK both explained how the impact of the Bill on an unequal society might cause problems. Baroness Falkner said that

“from what one understands, GP provision and general access to healthcare are poorer where demographics are poorer than it is in the better performing parts of the country. One other factor to consider in terms of a postcode lottery is that people in wealthier parts of the country tend to be more highly represented in private healthcare than in public healthcare and use of the NHS. That also impacts their choices and the care they get.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 29 January 2025; c. 181, Q235.]

The system must not only be fair, but be seen to be fair. If we had such a system of private provision in place, public trust would almost certainly fall. We do not have to look far to see what happens if these matters go unaddressed. When we have a lack of oversight and accountability, it is the public who suffer. There have been too many scandals in recent history for us not to recognise that reality.

One of the big factors in the Post Office Horizon scandal was that Fujitsu, the supplier of specialist computer software, did not admit when it knew that things were going wrong. I have spent much of my working life in the public sector and I am not saying it is perfect—far from it—but the Horizon scandal is an example that teaches an important lesson. Sometimes private companies will not share information that could mean they lose a lucrative contract. They do not have the same oversight as public authorities, which are ultimately accountable to the Government, to Parliament and, through them, to the public.

We must give the public reason to trust that assisted dying services will have proper oversight; otherwise, the consequences will be felt not just in the provision of assisted dying but in healthcare more generally. Amendment (c) to new clause 36 addresses some of the risks by establishing that voluntary assisted dying services must be provided by a public authority. Furthermore, a body contracted by a public authority to provide the service must be a public authority.

A public authority is defined as:

“A body substantially publicly funded which performs statutory duties, objectives and other activities consistent with central or local governmental functions.”

It is clear that public authorities have stronger mechanisms for transparency and reporting. Requiring assisted dying provision to be through such authorities also places the responsibility firmly with the state. It allows the direct implementation of regulations and guidelines on the provision of assisted dying. Best practice is easier to establish when the regulations apply to the same types of organisations.

**Rachel Hopkins** (Luton South and South Bedfordshire) (Lab): It is a pleasure to serve under your chairship, Ms McVey. In similar circumstances, with the provision of intense personal services such as in vitro fertilisation, there are a range of providers, some in the private sector and some in the public sector—in fact, most are in the private sector even if they deliver under NHS funding or an NHS contract—but they are all subject to the same rules, inspection and regulations. Does my hon. Friend not accept that if it can work in an intense, personal and sometimes ethically complex situation like that, it could equally work here, because there is experience in that sort of environment?

**Sean Woodcock:** I accept that it could work, but my view is that it is far less likely to work and that it is more likely to be successful if it is wholly the responsibility of public authorities.

I will vote in favour of amendment (d) to new clause 36. It would remove subsection (6), which says:

“Regulations under this section may make any provision that could be made by an Act of Parliament; but they may not amend this Act.”

It strikes me as dangerous to provide in the Bill for the Secretary of State to amend primary legislation, and we should vote to remove that power. It is surely a weakening of the Bill’s safeguards. Assisted dying must remain firmly in the control of the democratically elected Parliament. I urge Members to join me in voting to remove subsection (6).

If we fail to rule out the possibility of private provision and allow the Secretary of State the power to amend primary legislation, we will fail to implement the necessary safeguards. Amendments (c) and (d) to new clause 36 would go some way to addressing that, by ensuring that the state that sanctions assisted dying is also the body that provides it. Assisted dying services need strong reporting and accountability; otherwise, we risk inequality, or the abuse of assisted dying going unchecked. The provision of assisted dying through public authorities is essential to proper accountability, reporting and best practice, so I urge the Committee to support the amendments.

**Sarah Olney** (Richmond Park) (LD): It is a pleasure to serve under your chairmanship, Ms McVey.

In Richmond Park, a Henry VIII power has traditionally meant the right of the monarch to hunt the deer in the large open space that gives my constituency its name—something that I am sorry to say he has in common with the dog of the hon. Member for East Wiltshire—

**Danny Kruger:** I didn’t know it was illegal. [*Laughter.*]

**Sarah Olney:** He paid a hefty fine, I think.

The efforts of Henry VIII’s descendants to try to enclose the park and maintain the powers for the exclusive benefit of the royal family were defeated by a popular



and somewhat genteel uprising of the residents of Richmond. I stand here today as the Member for Richmond Park to do a similar job: to assert the rights of the House of Commons and the Houses of Parliament to determine what legislation is, and not to allow it to be delegated under Henry VIII powers.

The normal approach is that legislation made by Ministers is delegated legislation, and such legislation is therefore of subsidiary character to primary legislation. However, there is a type of power, known as a Henry VIII power, that gives Ministers the power to amend even primary legislation. The glossary on Parliament's website says:

"The expression is a reference to King Henry VIII's supposed preference for legislating directly by proclamation rather than through Parliament."

We may in the course of time start to refer to them as President Trump powers—who knows?—but that is the precedent we act on.

The Hansard Society, a non-partisan organisation that is neutral on assisted dying, issued a report that was critical of the power in the Bill. It said this:

"little can be deduced about how it is thought this power will be used in practice, beyond the fact that it may, in particular, be used to enable the provision of assisted deaths through the National Health Service.

But as the DPRRC"—

the Delegated Powers and Regulatory Reform Committee—

"has previously stated, where a power provides that delegated legislation may 'in particular' include a specified matter, it implies the legislation may deal with matters beyond that specified matter. The explanatory notes shed little more light, except to clarify that the power could be used to make arrangements for the funding of any provision made by the regulations. Could the regulations thus be used to enable the provision of assistance through the private sector on behalf of the health service in England and in Wales? If the intention is that the regulations will be used only to establish an assisted dying service, either within or separately to the NHS, would they require that the service be free at the point of access to the person requesting assistance?"

A key principle that the House of Lords Constitution Committee has applied to delegated powers is that they 'should not be framed in such a way that gives little indication of how they should be used.' The DPRRC's Guidance to Departments states that the Delegated Powers Memorandum should set out how it is proposed that a power should be exercised.

In the current absence of the DPM, MPs may therefore wish to seek clarification from the sponsor of the Bill, Kim Leadbeater, about how she envisages the power being used, and similarly from Ministers how they expect to use this power if it were granted to them."

The drafter of the Bill, Dame Elizabeth Gardiner, appeared on the Hansard Society podcast and gave some further detail on this power and how it arose:

"In other areas, like, is it going to be delivered through the National Health Service or in some other way, indeed the regulation of any substances that might be involved, in the time available, we didn't have time to go into all the detail of how those regimes work and to make the provision on the face of the Bill, and so there are regulation making powers there, which enable that provision to be set out in detail, as you say, when the Government has looked at it and decided how it would implement it."

Given the time available and the constraints of the private Member's Bill process, the hon. Member for Spennymore can be forgiven for not including the detail of how assisted dying will be provided on the NHS in the Bill on its introduction, but she and the Government have now had months to think about it. Many people had hoped that clause 32 would be replaced with detailed

arrangements for the delivery of the service, to be put on the face of the Bill by way of an amendment, which the Committee could properly scrutinise.

On 5 March, the hon. Member for Spennymore repeatedly said that it would be made clear by clause 32. When the hon. Member for East Wiltshire called for clarity in the Bill as to how the service would be delivered, the hon. Member for Spennymore said: "It will be." The Minister said:

"Officials are working on amendments to later clauses to establish the operating model for her consideration."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee, 5 March 2025; c. 802.*]

This does not appear to have happened, which means Parliament will be limited to a 90-minute debate on this issue when the regulations are eventually made, and such a motion will be unamendable. Surely the issue of how the service is to be delivered is much more important than that and deserves greater scrutiny.

It is disappointing to see new clauses 36 and 37 as the replacement clauses. Ideally, instead of the new clauses we would have had a detailed set of amendments to specify exactly how assisted dying is to be delivered. We do not have that; instead, we have a Henry VIII power that provides even more power than the one in clause 32, because the new one includes a power to modify Acts of Parliament passed subsequent to this legislation.

New clause 36 provides very little guidance on how the Henry VIII power would be exercised. Will assisted dying be provided by the state? If so, would that be on the NHS or through another body? Subsection (1) one does not specify that it must be on the NHS. Subsection (4) gives the power, but not the duty, to change section 1 of the National Health Service Act 2006—a foundational piece of Labour legislation if there ever was one, as the hon. Member for Banbury said—but subsection (5) requires it to be free at the point of use.

The question of whether assisted dying should be provided as part of normal NHS services, or in a parallel service, as requested by both the BMA and the Royal College of General Practitioners, is not answered by new clause 36, although hopefully it can be fleshed out in the debate on the amendments in the name of the hon. Member for East Wiltshire. Alternatively, it would seem that the power can be used to commission private providers to deliver the service on behalf of the state. Instead of deciding between the various models, new clause 36 simply leaves it open. It therefore gives very little indication about how it should be used.

When giving the Gray's Inn reading at Gresham College last year, Lord Falconer said:

"The wider the power—because there is less material in primary legislation to define how it should be exercised—the greater the reduction in parliamentary scrutiny, but also the harder"—

it would be—

"to identify any legal basis of challenge."

He went as far as to suggest that such wide Henry VIII powers were "unconstitutional". Given his great support for the Bill, it would be interesting to hear the response of the hon. Member for Spennymore and the Minister to Lord Falconer's remarks.

10 am

Despite paragraph 44.25 of the parliamentary business and legislation committee's "Guide to Making Legislation" requiring an impact assessment of the Bill prior to

Second Reading, we do not have that. We did not even get an impact assessment at the beginning of Committee stage. The justification given was that the Bill could change, and I accept that it has changed significantly given the removal of the High Court safeguard, which in my view has made it weaker. However, in other respects the Bill has not changed very much at all. The role of the doctors is the same as before. There has been no change on the issue of how assisted dying will be delivered by the state. New clause 36 does not provide us with any more clarity than clause 32 did. If there was insufficient detail to do an impact assessment based on clause 32, why is there now sufficient detail to do one in respect of new clause 36?

I fear that the impact assessment might not be terribly useful. I hope the Minister can give us a detailed impact assessment under all three models—delivery by the NHS, delivery by a new assisted dying agency, and delivery through third-party contractors—but until a clear decision is made on those models, I accept that the impact assessment cannot be as detailed. That is the problem: by failing to make a decision we are kicking the can down the road.

If we do not decide today, the decision will have to be made by Parliament in a 90-minute debate on a motion that cannot be amended. My amendment (e) to new clause 36 would require that an impact assessment be published prior to such a debate, and that it explains the impact on the healthcare and NHS workforce. We have a limited number of healthcare professionals. There are huge NHS waiting lists and we have all experienced difficulties in getting a GP appointment. A doctor having to book out a whole day to stay with a patient while they ingest a lethal substance is a doctor who cannot be with other patients.

Whether assisted dying is provided on the NHS, as part of another agency or by private providers, the issue is the same: it is a doctor who would not be seeing other patients. That is a trade-off that will need to be made. I would have hoped Ministers might have been open about the trade-offs on Second Reading, or even now; my amendment would ensure that, at least before voting on a particular model following only 90 minutes of debate, the House could see them clearly. I fear this would be too little too late, but it is still better than nothing, so I hope my amendment will be supported.

I will say more about the situation in Wales when we come to my amendment 535 to clause 42, but I fear that new clause 37 does not address the devolution issue. First, it completely fails to do the analysis of which matters are devolved and which matters are reserved. On 5 March, the Minister said to the right hon. Member for Dwyfor Meirionnydd that that should be done on a clause-by-clause basis. New clause 37 simply kicks the can down the road again by giving a wide Henry VIII power to Welsh Ministers in respect of what is devolved, and a wide Henry VIII power to the Secretary of State in respect of what is reserved, but it totally fails to identify which is which.

Let us suppose that, following a vote in the Senedd, Welsh Ministers do not wish to implement assisted dying in Wales, but the Secretary of State decides to use his powers on reserved matters to enable it to the extent that he can. What will the effect of that be? Would it not create legal uncertainty? There is a real risk that if the Senedd does not want assisted dying in Wales, we could

end up with a position where it is decriminalised, unregulated and not commissioned in Wales. That would not be a sustainable solution, and the Welsh Government may feel they have no real choice in the matter. The better solution is to have, as Professor Emyr Lewis suggested, different commencement provisions for England and Wales. I do not want to pre-empt the debate, but that is why I do not feel that new clause 37 is an adequate solution.

My amendment (c) to new clause 36 would specify that if a public authority contracts for the provision of voluntary assisted dying, it must be with another public authority. It would place a block on outsourcing this incredibly sensitive service to private providers. There are two basic principles. First, provision should be by public sector organisations because they are subject to greater oversight and scrutiny and are more likely to be held to account. This is not about distrusting private enterprise: it is about recognising that the stakes demand the highest level of public oversight. We have only to look to the findings of the Paterson inquiry to understand the risk of failures in oversight. Spire Healthcare lacked robust governance, and Paterson operated with little scrutiny, exploiting laxer regulations in private settings while patients assumed that NHS-level standards applied, unaware of the accountability gap.

The second principle is equally critical: NHS funding must not be diverted to external organisations that profit from, or are sustained by, the business of ending lives. Every pound spent on healthcare is a pound fought for by taxpayers, by clinicians and by patients. To direct that money into the coffers of private providers, whose incentives might lean towards efficiency over compassion, risks betraying the NHS's founding ethos. We cannot allow a system where the end of life becomes a revenue stream and where the decision to die is shaped, however subtly, by a balance sheet rather than a patient's free will.

**Daniel Francis** (Bexleyheath and Crayford) (Lab): My hon. Friend the Member for Luton South and South Bedfordshire referred to IVF. My wife and I have been through IVF, and what exists is exactly what the hon. Member for Richmond Park described. There is an annual show at Olympia where it has been commercialised and it is put to people, "Why not go down this route? Why not go down that route?" Does the hon. Member agree that that is really not a route we want to go down?

**Sarah Olney:** I am grateful to the hon. Gentleman for that point, because it provides a comparison. We are talking about there potentially being a market for end-of-life services. I do not think that is the way we should be going.

**Dr Opher:** I thank the hon. Lady for her impassioned speech, but we are rather getting off the point. The division between private and NHS provision is spurious in a process that will be delivered by doctors who are working under a code of practice. They will be rewarded in their pay which, as we have said, will be stipulated by the BMA in contracted arrangements with the Government and will be proportionate. The doctors will do the work and get the money for that. That is no different from IVF or anything else. If we accept that the NHS will be the commissioning body and will ensure standards in

that way—sorry, I am going on a bit, Ms McVey; I shall now finish—the division between an NHS provider and a private one is spurious.

**Sarah Olney:** The issue is who is commissioning the service. The issue is not the doctors or how they are recompensed for the work that they do, but who is doing the recompensing and what their incentives are. If the process is part of an NHS-provided service where it is agreed that it is a compassionate end of life choice, and where it is properly regulated within the wider NHS service and connects with other NHS services, that is one thing.

If the person commissioning that doctor has any kind of incentive around making a profit—and any profit-making organisation will be incentivised to increase the amount of profits that it makes—then, however carefully regulated, there will be subtle influence, pressure, coercion or persuasion that assisted dying is an option that patients should choose, or possibly not-so-subtle influence, to take the example from the hon. Member for Bexleyheath and Crayford. Under other circumstances, in an NHS model, that may not have been a solution they would have been persuaded to choose. It is that issue of persuasion and of incentives that really troubles me.

**Kit Malthouse** (North West Hampshire) (Con): I am not clear: is the hon. Lady suggesting that doctors who operate in the private sector are less ethical than doctors who operate in the public sector?

**Sarah Olney:** I think I said very clearly to the hon. Member for Stroud that it is not about the doctors. It is about the people who are commissioning them. I absolutely do not believe that about doctors operating in the private sector, who in my experience are often the same doctors as the ones in the NHS. It is about who is commissioning them and who is asking them to carry out this work, and whether those commissioners are motivated by a profit incentive as opposed to the incentive in the NHS to provide the best possible care.

**Danny Kruger:** I entirely agree with the hon. Lady. We are all equally ethical and unethical—the point is that we respond to incentives, and incentives have their effect. Does she agree that there is a further concern? If we had a tariff system, which we probably would, that would by definition create a market, if there was the opportunity for private provision, to earn tariffs—to make more money the more assisted deaths one provides. Furthermore, to the point made by the hon. Member for Stroud that this is all perfectly fine and normal, what about the opportunity to top up the public provision—the tariff one gets from the NHS—with one's own money, therefore definitely creating the opportunity for some sort of upmarket arrangement through the additional fees and services that might be provided? As the hon. Member for Bexleyheath and Crayford said, we could see expos dedicated to providing the most luxury or glamorous forms of assisted death through private providers with NHS funding.

**Sarah Olney:** That is not a prospect I particularly want to reflect on, but it is worth noting that the particular risk in assisted dying services is that, as we heard in oral evidence from the chief medical officer, it is really hard to define, first, whether an illness is going to be terminal and, secondly, that somebody has only

six months to live. There is an element of subjective judgment in assessing who is going to be eligible for assisted dying. Aligning subjective judgment to a profit incentive could create a serious ethical minefield.

I want to state absolutely clearly for the record that I am not questioning the ethics of doctors or the ethical standards of doctors or of any of the bodies that represent them in any way at all. My question is merely about introducing a profit incentive to this issue. As I said, this process could be contrasted with something like the provision of abortion services. Abortion services are clearly available only to pregnant women. The fact that the qualification, as it were, for this service is on a rather more subjective basis creates a risk.

Without this amendment, I am concerned that the Bill commodifies the end-of-life process and pushes what should be a sensitive, careful process towards being a transactional one. It also increases the risk that everything becomes focused on facilitating ending the patient's life rather than supporting the holistic ethos of the NHS in addressing all the patient's needs. Without the amendment, I worry that the Bill opens a door to the commodification of death, as the hon. Member for East Wiltshire has so graphically anticipated. What should be a careful, compassionate process could slide into something more transactional: a service that is marketed, packaged and sold.

We need look only to the parallel of care homes to see that danger writ large. In England, social care has been quietly overtaken by for-profit providers. Today, 75% of adult care homes, and over 80% of children's homes, are run for profit—not by design or explicit policy, but by the slow creep of market forces. The Economics Observatory, drawing on studies such as Patwardhan et al. 2022, Barron and West 2017 and Bach-Mortensen et al. 2022, reveals a stark truth: for-profit care, particularly where private equity is involved, consistently delivers worse outcomes.

Similarly, a 2019 *BMJ* study found that private providers running NHS-funded services had higher rates of complications in procedures such as hip replacements compared with NHS trusts. The focus on cost efficiency can lead to skimping on follow-up care or using less experienced staff. Why does that happen? Profit-seeking behaviour drives cuts to staff, to resources and to time. Now, if we transpose that to assisted dying, let us imagine the pressures on a private provider to trim costs and the pressures on the quality of assessments. How thoroughly are mental health conditions, or the risk that something else might be going on, explored? How great is the depth of attention to medical records? Is what is relevant to the doctor influenced by the ticking clock? Will they tick a box rather than a safeguard?

**Kim Leadbeater** (Spen Valley) (Lab): The hon. Lady said that she is not questioning the ethical judgment and practice of doctors, but the comments she is making suggest otherwise.

**Sarah Olney:** Again, I am talking about the companies that are running the service. I am not questioning the ethics of the doctors involved. I am merely suggesting that the people who are commissioning the doctors to carry out the service will have their own priorities that are not directly related to the safety or welfare of patients.

**Kit Malthouse:** I am sorry if I have failed to understand what the hon. Lady is saying, but under the Bill as it stands, every single stage is supervised by a doctor, even the final moments. I fail to see how the motivations that she seems to be applying to the private sector, malign or otherwise, might affect the conduct of the doctors, given that she accepts that doctors are equally ethical in the private and public sectors, unless she thinks that those motivations are pressuring doctors to behave unethically.

10.15 am

**Sarah Olney:** It clearly remains to be seen, but that may be an outcome as we do not yet know what model we are proposing for the delivery of assisted dying. Perhaps doctors will feel pressured to deliver an outcome because that is how the model has been set up. If we have a model that incentivises profits, particularly if we do not have a similar service within the NHS itself, it is quite possible that that will happen. It will not necessarily affect the care that doctors give to patients at the end of life, but the point is that we do not know.

We cannot fully explore that matter in Committee, because we do not have the full clarity of exactly how the process will be delivered, so we cannot examine the proposed model and identify its potential risks and pitfalls. That continues to be a real concern. Perhaps doctors will feel that pressure; perhaps the service will be precisely designed to encourage them to, for example, diagnose someone with having fewer than six months to live even when it is a slightly more subjective judgment and a different doctor operating in a different system may come to a different view.

**Kit Malthouse:** That is an extraordinary claim to make against doctors.

**Tom Gordon** (Harrogate and Knaresborough) (LD): I am just trying to wrap my head around the argument. We already know that integrated care boards and other commissioning bodies have incentives given to them when they commission services, so it would be in their interests to diagnose or produce a demand for a service in a particular area. There is already an analogous situation within the NHS; I do not see how that is any different.

**Sarah Olney:** I thank my hon. Friend for his intervention, but those incentives are not about creating profits that make money for individuals. They are about directing the way that resources are allocated to ensure that a broader range of health outcomes are achieved. When I talk about a profit incentive, it is an entirely different kind of incentive from the one he has just raised.

**Danny Kruger:** This is a very important debate, and my concern is that there is a naive assumption that the innate goodness of doctors will render them impervious to all the incentives in the system. As the hon. Lady suggests, if it were possible, as I think it is under the Bill, for a profit-making organisation—a company—to set itself up to provide an assisted suicide conveyer belt as a pathway through this process, and to earn money publicly or privately according to the volume of the provision it enables, we are setting up incentives that would corrupt the doctors who would be required to sign it off.

I regret that my right hon. Friend the Member for North West Hampshire has such an optimistic view of human nature that he thinks that no doctor would respond to the incentives in the way that is clearly enabled through the Bill. There are other medical professionals—ethical doctors—who do respond to incentives, such as those in the cosmetic surgery industry.

**Dr Opher:** Will the hon. Member give way?

**Danny Kruger:** I would, but actually I am making an intervention. It may appear that I am making a speech, so I will soon sit down, but I would be interested in the hon. Gentleman's response to the suggestion that even he—the paragon of virtue that he is—might not be entirely resistant to the economic incentives in the system. That is why we have an NHS that explicitly tries to exclude profit making from the provision of healthcare.

**Sarah Olney:** I thank the hon. Member for his intervention, but I do not associate myself with his use of the word “corrupt”; I am absolutely not implying that in any way, and I want to be very clear about that. However, there is a grave risk—even for the most ethical person, if they are offered money to carry out an action that they are inclined to carry out anyway as part of their professional practice—that those incentives drive behaviour that leads to worse outcomes for patients, specifically in relation to assisted dying.

**Dr Opher:** There may be an incentive to review a patient for assisted dying, but there is absolutely no incentive in the Bill to approve assisted dying. The idea that doctors would approve assisted dying for financial reasons is completely spurious.

**Sarah Olney:** As I say, we do not have a model before us that we can fully scrutinise or test for risks, and we will not have the opportunity to propose amendments to address those risks—nor will we at any stage. There is a serious risk about all the different parts of the system, not just the doctors, being incentivised by private profit. My amendment would comprehensively remove that, so it would not be a risk. Given that we cannot fully and properly scrutinise the proposed model, my amendment is the best we can do.

**Dr Opher:** I really want to point out that there is no incentive to agree to assisted dying, only to assess for it. There is no reason for people to be corrupted into agreeing, because it would not mean they would get any more money.

**Sarah Olney:** We do not have the model to scrutinise, and we do not know within that whether the first or second co-ordinating doctor will be paid for their services in carrying out those initial assessments. To say that there is no incentive for making the final decision ignores the fact that people might be incentivised for making those initial decisions, where the professional judgment is required and may differ between doctors. That is why there is a risk.

**Kim Leadbeater:** Clause 40(4) is very clear that medical practitioners can receive only “reasonable remuneration” for the provision of services, so it is clear that they cannot make money from the provision of assisted dying. Is the hon. Lady saying that where there is a private provider or one commissioned by the NHS—the model that I

have set out in the Bill—there is a financial incentive for doctors to do more hip or knee operations, or other things? That is a question about the model of public and private healthcare as it stands, not about assisted dying.

**Sarah Olney:** On the hon. Member's comment about clause 40, "reasonable" is a fairly elastic term. We will find in time that the word "reasonable" will come to have its own accepted definition, but it does not preclude a profit margin.

**Kim Leadbeater:** I would argue that it does.

**Sarah Olney:** But the Bill does not say that. It does not say that the payment to the doctor should not include any consideration of profit. Regarding hip operations, someone would have one only if they needed it. My point is that assisted dying is one of a range of options at the end of life being presented here. The concern is that people motivated by profit would be incentivised to push for assisted dying at the expense of other options for the patient that do not attract the same level of reward. That is the issue. It is not a binary decision in the way that most treatments are.

**Danny Kruger:** In response to the hon. Member for Spen Valley, the scenario that she mentions is exactly the problem in many healthcare systems around the world, particularly in America, where doctors are incentivised to deliver volumes of treatments and procedures that are often not strictly necessary. We do have a problem even in our own system with the over-prescription of certain medical treatments, particularly pharmaceuticals, so incentives do apply. Doctors are subject to them, and we do our best to regulate them out of the system. One of the great advantages of the NHS compared with other healthcare systems is that we manage to prevent the over-provision of services in response to economic incentives. That is a founding principle of the NHS that we are overriding with this process.

**Sarah Olney:** I will conclude my remarks by observing that the only reason that we are looking at contracting out assisted dying services to a private provider is that the country is simply not ready for assisted dying. We know how overstretched and under-resourced our NHS is, and we are looking at cutting corners in the Bill, in our policymaking, in our scrutiny of this legislation, and in how this legislation and the service is delivered.

**Naz Shah (Bradford West) (Lab):** It is interesting to follow the hon. Member for Richmond Park, because I rise to speak to amendment 537, tabled by my hon. Friend the Member for Shipley. The amendment goes further than the hon. Member for Richmond Park would as far as local authorities are concerned.

The amendment also concerns both the national health service and the provision of healthcare by charities. My hon. Friend the Member for Shipley knows both fields extremely well. She was the director of quality and strategy and chief analyst at the Department of Health, and then had a senior role at the Centre for Ageing Better. Her amendment would mean that assisted dying services could be provided only by charitable organisations and not by the national health service.

I strongly support the general principle that if we do have assisted dying, it should be free at the point of use. If this House decides that people do indeed have the right to an assisted death under the conditions that this Bill sets out, then it should not be something limited to those who can afford private healthcare. There are, however, strong objections among general practitioners to providing assisted dying as part of their services, and I do not think we should plan to have private firms work under contract from the NHS to provide assisted dying either.

The Royal College of General Practitioners said in its written evidence that

"any assisted dying service should be seen as a standalone specialised service that healthcare professionals may opt to provide with additional training and should not be deemed core GP work."

The royal college's advice, which is founded on the views of its members, means that we should give very strong consideration to putting assisted dying outside the normal workings of the NHS. If we do that, it seems that there are a few options. One is for the Secretary of State to invite private firms to tender for contracts and administer assisted dying services. As I have said, there are very strong reasons why we should not plan to have private firms work under contract to the NHS to provide assisted dying; for me, that it is one of the worst possible options.

Another option is for the NHS to fund a specialised assisted dying service that would be separate from its other functions. That could potentially be feasible, but it could also represent a significant cost for the NHS, because we still have not had the impact assessment from the Government and we have no idea how significant that cost may be.

There is also the worry that if assisted dying becomes available on the NHS, some people will become too frightened to access palliative care, as was outlined to the Committee by Dr Jamilla Hussain. I will read a brief part of her written evidence to the Committee. After talking to the patients in ethnic minority and other disadvantaged groups, she said:

"Overwhelmingly, racialised communities expressed deep concerns that they would be more likely to be pushed towards AD through systemic biases and societal attitudes about whose lives are valued... While safeguards were acknowledged, many remained sceptical that they would be applied fairly and equitably, fearing that vulnerable individuals, particularly those who lack strong advocates or English proficiency, might be at greater risk of being guided towards AD rather than offered appropriate care options."

I want to share something with the Committee. We often get taxis to and from work and home; I got into a cab yesterday, and the chap who was driving was called Dave. His 84-year-old aunt died on Friday. When we were discussing this option, he told me really clearly that she has opted for a cremation, which would cost less money, just because she internalised that idea of burden and she did not want a cost for those that she left behind. She had not seen a doctor for 40 years. That brought home the idea of internalised coercion, internalised pressure and mistrust, because he also talked about what happened during covid. We had an interesting conversation. I told him that it was interesting that he had said that, and today I am talking about it. That is the reality: it is about how people perceive healthcare provision, the potential inequalities, and what the barriers are to access—all the preconceived ideas that we have about the provision of healthcare.

[Naz Shah]

That brings me to a potential third way, which is what amendment 537 is about: charities. Charities are one way of addressing the concerns I and the hon. Member for Richmond Park have outlined about the risk with private companies and the risk of loss of confidence and access to the NHS, as well as the concerns outlined by the Royal College of General Practitioners. They could well be mitigated by ensuring that the lead responsibility for administering assisted dying is given to charities rather than the NHS.

10.30 am

There is a strong argument that if we have assisted dying services, they should be administered by those primarily motivated by public service. I am not suggesting that doctors are not motivated by public service, but I have made it plain that that is unlikely to happen if we turn assisted dying contracts over to Capita, Serco or G4S. Most people who work in our NHS are absolutely motivated by public service, including doctors, as are most people who work in the charitable sector, but that is not to say that either NHS workers or charity workers are faultless. What happens if members of the public or the press begin to say that there are problems with an assisted dying service? In that case, who is more likely to investigate problems and put forward solutions: people motivated by public service or multinational firms potentially motivated by profit?

That speaks to the debate we have just had, in which my hon. Friend the Member for Stroud talked about NHS commissioned services. When we commission specialised services in the NHS, and when we commission charities, they are not for profit. That is different from commissioning a profit-making service. I would certainly not agree that the doctors would be corrupted in any way, but with private healthcare providers, there are profits to be made, and those profits influence how things work in those companies.

Hon. Members could argue that, if the assisted dying service was turned over to the charitable sector, it would become underfunded in comparison with other NHS services. However, that argument does not wash because, if the Bill passes, I hope it goes without saying that it would be a state-funded service, fully funded through the taxpayer. I look forward to hearing what the Minister has to say on that because, in the absence of an impact assessment and clarity on what model is being proposed, I have not been able to unpick this in its entirety as I would have liked. We should therefore support amendment 537, tabled by my hon. Friend the Member for Shipley.

**Rebecca Paul (Reigate) (Con):** It is a pleasure to serve under your chairmanship, Ms McVey. I rise to speak on clause stand part and new clause 36, and in support of amendment 525 and amendment (a) to new clause 36, tabled by my hon. Friend the Member for East Wiltshire. This is a really important debate. The NHS is the greatest achievement of any Labour Government, and maybe even of any Government.

**Danny Kruger:** Steady on!

**Rebecca Paul:** It transformed the quality of life of British citizens at a time of mass unemployment and widespread slums, ensuring free healthcare, in the words

of Beveridge, from cradle to grave. The provision of healthcare free at the point of delivery was life-changing and life-prolonging. Although it is far from perfect, we have seen time and time again that as a country we can be very proud of the NHS.

The National Health Service Act 1946 came into effect on 5 July 1948, as a direct consequence of the Beveridge report. Section 1 of the Act states:

“It shall be the duty of the Minister of Health...to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness”.

It was set up to help people to get better and live healthy lives, and to give hope in situations where otherwise there would be despair. It was lifesaving and life-changing. New clause 36 turns all that on its head. Subsection (4) states that:

“Regulations under this section may for example provide that specified references in the National Health Service Act 2006 to the health service continued under section 1(1) of that Act include references to commissioned VAD services.”

If this new clause passes, the founding principles of the NHS will be monumentally changed to include helping eligible people to commit suicide. That is what it does.

I want to be really clear that it is entirely possible to support assisted dying—to want to ensure that a small group of people, whom palliative care cannot help, have that assisted dying option—but not to support this new clause, which forces provision of the service through the same channels as normal healthcare. Assisted dying is not a medical treatment or a healthcare service and accordingly there should be a degree of separation.

We should be incredibly cautious about incorporating the service into the NHS. It will forever change the relationship between doctor and patient, breed mistrust and fear, discourage vulnerable groups from seeking the healthcare they need and fundamentally violate the Hippocratic oath. Dr Catherine Day, a senior partner of a large GP practice in Coventry, states:

“Trust lies at the heart of the doctor patient relationship. I believe this trust will be shattered if patients consider that their GP...may think that they should end their life and stop being a drain on our NHS.”

Siwan Seaman, a palliative care consultant said:

“How could a terminally ill patient trust a doctor if they know that the doctor was prescribing medication to the patient in the next bed in a bay or cubicle with the intention of ending their life. Letting these assessments take place alongside other NHS services will irreversibly impact on patients’ trust in healthcare professionals and negatively impact our therapeutic relationship with patients as doctors.”

**Kim Leadbeater:** If the hon. Lady is saying that she would not want to see assisted dying services within the NHS, then where does she think they would sit? Would she support my hon. Friend the Member for Shipley’s suggestion that this should be done by the voluntary sector and charities, or would she suggest the private sector?

**Rebecca Paul:** It is important that there is a degree of separation, but I would say to the hon. Lady that it would have made more sense for her to put forward a proposal that we could evaluate, assess, and identify the upsides and downsides of. It would be much easier for me to then come up with suggestions. It does not make sense to ask me, “What is the solution and how would

you do this?”, and for me to lay out the many different ways that this could be done, without having first laid a proposal in front of me.

**Kim Leadbeater:** There is a clause that I have laid before the hon. Lady—that is what we are discussing. I will come on to that in my comments. Since she is clear that she does not think this sits within the NHS, she must have given consideration to where she thinks it should sit, if it were to come into effect.

**Rebecca Paul:** I will come on to some of that, and it goes back to my belief that there should be a degree of separation. I think it should be separate from normal healthcare services and there are multiple ways that we could do that. I regret that we are not specifically debating the various different options, with a proposal in front of us detailing exactly how it would work. I am assuming, from the new clause put forward, that the proposal is for this to go through the NHS as healthcare; that is the only assumption I can make based on what is in front of me in this Bill, because there is no other detail to give me any other impression.

Sarah Davies, a consultant respiratory physician in north Wales, argues for a separate service so that ordinary NHS care is not associated with assisted dying. She said:

“It is already my experience that patients and their families are anxious about limiting treatment when they are dying. Many people believe that symptom control medication, such as those delivered in a syringe-driver to aid symptom control amount to hastening or bringing on death. This perception can hinder the patient’s acceptance of medications which can afford significant alleviation of distressing symptoms.”

I have raised my concerns about providing an assisted dying service alongside and in conjunction with day-to-day healthcare many times over the last few weeks. I think it is a massive mistake both for patients and healthcare staff. It blurs the lines of what a treatment is, increases the risk of bad decisions and, as we heard so powerfully from Dr Jamilla Hussain, it will discourage some of the most vulnerable groups from seeking essential healthcare. We have received so much evidence and it is really important that we take it on board, so I will be quoting some in my speech.

Dr Green of the BMA said:

“It should be set up through a separate service with a degree of separation. We believe that is important for patients, because it would reassure patients who may be anxious about the service that it would not just be part of their normal care... It would reassure doctors, because doctors who did not want to have any part would not feel that it was part of their normal job, whereas the doctors who wanted to go ahead would be assured of having support, emotional support and proper training.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 45, Q32.]

In oral evidence, Professor Preston argued for a separate system and pointed to the Swiss example. She said:

“In covid, we did research in care homes, and there was real concern about ‘do not resuscitate’ orders and emergency care plans that were blanketed across the care homes. Care home staff were traumatised by that, so there are real issues. We know that there are real issues day to day in how people are treated within the NHS. I think it is unconscious—I do not think people are intending it—but we know that people are treated differently and that different things are done. That is partly why we think a

system outside that would protect them, because then you are not within the healthcare team that is treating you and giving you advice about such things”.

She went on to talk about the Swiss system, also being adopted in Germany and Austria, which seeks to “protect these people by keeping it one step removed” from normal healthcare. She said:

“Most hospitals in Switzerland will not allow assisted dying to occur, because they do not want a lack of trust in their patient group.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 30 January 2025; c. 246, Q317.]

I therefore support amendment 525, tabled by my hon. Friend the Member for East Wiltshire, which would amend clause 32 in order not to allow the provision of the assisted dying service to be done through the health service. That would ensure that much-needed degree of separation. In light of what the Bill’s promoter has said, I recognise that there are different ways to do that; I am very open to those different ways, but I need to see that degree of separation from normal healthcare. I also support new amendment (a) to new clause 36, also tabled by my hon. Friend, which does the same thing.

Let me come to the other amendments in this group. Amendments 537 and 528, tabled by the hon. Members for Shipley and for Richmond Park respectively, are important to debate—we have had some good debate on them this morning—as they raise the different ways of delivering an assisted dying service. I have been listening closely to the points made. Amendment 537 would limit the provision of an assisted death to charities rather than to the NHS, and conversely, amendment 528 would limit provision to public authorities only.

I do not have the answer on the best way to do this, and that is why I regret that a royal commission has not been set up to properly investigate and evaluate all the options and recommend the best way forward. Instead, we are here without all the relevant information and expertise available to us, trying to land on the best way to do it. That is not the way to make such an important decision. I can tell the Committee, however, that—like many others, including my hon. Friend the Member for East Wiltshire—I have huge reservations about delivering such a service through the NHS alongside normal healthcare.

I agree with much of the evidence that has already been cited: there should be a degree of separation. The BMA said that assisted dying could be part of the NHS, but should be outside existing care pathways and separate in some way:

“Our view is that assisted dying should not be part of the standard role of doctors or integrated into existing care pathways—it is not something that a doctor can just add to their usual role... The separate service could take the form of a professional network of specially trained doctors from across the country who have chosen to participate, who come together to receive specialised training, guidance, and both practical and emotional support. They would then provide the service within their own locality—for example, in the patient’s usual hospital, or their home. Or it could be a combination of some specialist centres and an outreach facility.”

In its written evidence, the Royal College of General Practitioners also proposed a separate service:

“The establishment of a separate service which covered every stage of the process would ensure healthcare professionals of multiple disciplines (including GPs) who wanted to do so could still opt in to provide assisted dying, but this would be arranged through a different pathway.”

[Rebecca Paul]

I agree with both bodies that the service should be separated out in some way. It is now apparent that my hon. Friend the Member for Runnymede and Weybridge (Dr Spencer), whose amendments would have created an assisted dying agency, was on the right track. I regret that the Committee did not explore his ideas in any real detail during our proceedings.

We received important written evidence from Robert Twycross, a pioneer of palliative care who sadly died in October, but had given his friend Ariel Dempsey permission to submit it. Dr Dempsey writes:

“Twycross recommends a de-medicalized model in which AD is a separate service, delivered outside of healthcare practice. He argues for a standalone Department for Assisted Dying, separate from the NHS. He writes, ‘Data indicate that the primary reason for a persistent desire for AD is to relieve distress over a perceived loss of autonomy and to experience a sense of personal control over the circumstances of their dying. These are not medical reasons. Thus, for patients fulfilling the legal criteria, a separate AD service should be established. Indeed, this would be the best way to prevent a corrosive effect on medical practice generally.’ ‘Given the widespread disquiet felt by doctors, a law with minimal medical involvement would be the most equitable.’ He suggests, ‘One way to achieve this would be for [AD] to be delegated to a stand-alone Department for Assisted Dying, completely separate from the NHS and with its own budget. Victoria almost achieves this with its combination of Care Navigators, mandatory training for participating doctors, and a separate Voluntary Assisted Dying Statewide Pharmacy Service.’

Twycross emphasizes that hospice and palliative care must be a ‘sanctuary’ for patients – ‘an assisted dying free zone. Even in the absence of AD, some people decline referral to palliative care despite unrelieved pain and/or other distressing symptoms because they fear they will be “drugged to death”... This unfounded fear will most likely be enhanced if AD is legalized, particularly if palliative care is involved’ and result in an overall increase in suffering.”

10.45 am

Dr Sarah Davies says:

“Specialist assisted-dying centres would be better placed to talk with the patient about the process and the potential complications. It would also be more likely that a specialist centre can procure the medications required.”

She goes on to make the important point that in rural areas it would be difficult for the co-ordinating doctor to find a second doctor. She says:

“In a large city like London, this could readily be circumvented. In rural areas then this aspect of the bill is impractical and unworkable. This is another reason why I think specialist private assisted-dying centres should be considered.”

I am also concerned about the imbalance in resources and the message sent out by including a fully funded assisted dying service within the NHS. In written evidence, Dr Amanda Harlow says:

“The NHS is at breaking point. There are 16% less GPs in the UK than in countries with similar economies... Patients find it difficult to access both GPs and hospitals. Are patients who have requested Assisted Dying going to have priority over those who want to live?”

Claire McLachlan, a retired clinical nurse specialist, says:

“The NHS was set up to support people ‘from the cradle to the grave’ yet while our maternity care (rightly) receives 100% Government funding, Palliative Care receives just 30% government funding. But if this Bill becomes law in the future, we could have assisted dying that is 100% funded.”

What message does it send out when palliative and end-of-life care is not fully funded and is not provided ubiquitously? Why are we as a society happy to rely on charity shops selling second-hand clothes to fund it, while assisted dying will be fully funded by the NHS?

Professor Nancy Preston, who also gave written evidence co-written with another professor at Lancaster, Suzanne Ost, said:

“Our concern is the real risk that placing AD within the NHS will communicate the wrong symbolic message when the majority of palliative care is provided through charities.”

**Dr Opher:** Briefly, the hon. Lady says that only 30% of palliative care is funded by the NHS, but that is quite spurious, because everyone who gives palliative care—all doctor time, palliative care consultants, palliative care departments, all GP services, all district nurses—gives it under the NHS. What she must be talking about is social care, which is obviously very different from medical NHS care.

**Rebecca Paul:** I thank the hon. Member for his intervention. I was quoting written evidence, so I just quoted it, of course, as written.

We should be ashamed if what I have set out is where we end up as a result of this Bill. How would it in any way recognise patient autonomy and give them a real choice? Clearly, it would not. We will end up with patients taking an assisted death because there is no alternative to dying well. If as much effort was put into improving palliative care as has been put into legalising assisted dying, a much greater number of people would be given the dignified, comfortable deaths they rightly deserve. It is a travesty that we find ourselves considering the introduction of assisted dying while hospices are on their knees and patients face a postcode lottery when it comes to receiving adequate end-of-life care. Accordingly, I will vote against new clause 36.

**Lewis Atkinson (Sunderland Central) (Lab):** It is a pleasure to serve under you this this morning, Ms McVey.

I rise in support of new clause 36, which sets out an entirely workable, appropriate and safe set of provisions for the Secretary of State to ensure that these services are provided across England, as well as appropriate powers for Wales, although I am far from being an expert on those matters.

The new clause would convey powers to the Secretary of State to commission services free at the point of use, in a way that is entirely analogous to the commissioning of other health services that are provided, as we know, by a range of providers.

I came to this place having been an NHS manager for nearly 20 years, and I feel that the debate has sometimes slightly confused elements of commissioning, provision and the way in which the NHS commissions and manages services. My hon. Friend the Member for Banbury said that the state must oversee and regulate the service, and I entirely agree. Commissioning powers sitting with the Secretary of State will ensure that that is the case. The hon. Member for Richmond Park said that the issue is who is commissioning. Again, we are clear that the only person doing any commissioning will be the Secretary of State, potentially delegating this to NHS structures at the time.



The NHS and the Secretary of State are not unused to commissioning highly specialised, sensitive services in this way. Indeed, I would be amazed if the Minister and my hon. Friend the Member for Spen Valley do not confirm that the Government were involved in the drafting of this new clause to ensure that it is equivalent to the other powers that the Secretary of State has.

This will clearly be a specialist service. It is a new service. At high levels of NHS England and equivalent bodies, there is significant expertise and practice in commissioning specialised services. The importance of the commencement period, which I hope we will discuss later today, is that engagement around the exact service specification will be drawn up in just the same way that it would be for a new cancer treatment or a treatment for a rare disease. It is right that the time will be taken to engage on that.

Fundamentally, services have to be commissioned. Some suggest that this will be a free-for-all, that anyone can provide this service and that anyone can be paid for it, but that idea is nonsense. There is no obligation for the Secretary of State to reimburse anyone who decides they want to provide this service. The service must be explicitly commissioned.

**Naz Shah:** My hon. Friend says that this will be explicitly commissioned. I completely agree with everything he has said, but this will be a newly designed service by definition, so will that not leave the door open for new providers, such as Serco or G4S, to come in, design a new service and bring in the expertise to deliver it?

**Lewis Atkinson:** No, it will not, in the same way that G4S does not suddenly appear and provide treatment through a new cancer service that the Secretary of State decides to commission under specialist powers.

I am afraid that some opponents of the Bill are trying to scaremonger about potential provision as a way of altering the way people voted on Second Reading. A number of amendments clearly deal with whether potential providers should be public sector, voluntary or, indeed, private organisations. I emphasise that the overwhelming majority of GP services in this country are private contractors. It is inconsistent for Members to argue that we should maximise continuity of care and have the best safeguards around coercion and capacity by having someone who has known the individual for a long time, while also arguing that the Secretary of State should not be permitted to commission that individual's GP to play any role. I challenge opponents on that matter.

**Danny Kruger:** As ever, the hon. Gentleman is speaking very coherently in support of the Bill and the principles behind it. I think he does regard assisted suicide as another form of healthcare that, as he says, should therefore be completely consistent with the normal duties of every medical professional. I would genuinely like him to help me to understand this. Does he envisage the service being provided by bespoke clinics in the NHS? Would established professionals set themselves up with the purpose of delivering it, or would it genuinely just be something that any general practitioner would provide as part of their services? Does he imagine that there will be specialists in the NHS whose sole job, or most of whose job, would be to provide this service?

**Lewis Atkinson:** I hope to help the hon. Gentleman with the points I am about to make.

What I would say to begin with is that we have talked throughout this Committee about using an opt-in model. There is this idea that everyone will be doing this, but we have rightly set out requirements for specialised training and so on. There will clearly be individual doctors in the NHS, and so on, who decide that they want to provide these services, and specialisms and appropriate regulation will accordingly be developed as part of that.

The other thing I would highlight is that the current drafting explicitly requires a range of provision. The second doctor must be independent. Indeed, clause 8(6)(d) requires that they must not be

“a partner or colleague in the same practice or clinical team as the coordinating doctor”,

so although some are suggesting, perhaps in a positive sense, that there should be one, entirely separate organisation that does all this, that would not meet those requirements. There are those who are trying to instil a fear of one large organisation being set up to take someone from start to finish, but that is not possible under the Bill as drafted.

**Sarah Olney:** I am reflecting on the earlier intervention on me by the hon. Member for Stroud about how the only payment under assisted dying would be made at the very end, so therefore there would no possibility of a doctor making an assessment at an earlier stage in the process being influenced. Now the hon. Member for Sunderland Central is saying—this is obviously implied by the drafting—that the different bits of the approval process would need to be delivered separately. Whether that involved a payment from the NHS or a private provider, the doctor making those assessments will clearly be paid at different stages in the process.

Does the hon. Gentleman agree that this points to the fundamental problem we have in this Committee, which is that we do not have a proposed model that we can properly scrutinise? All of us are just talking about potential suppositions about how things might work. We are effectively talking about a range of straw men.

**Lewis Atkinson:** No, I do not agree with the hon. Member, and I will tell her why. The reality is that the shape of the health provider landscape is different in different parts of the country. For example, in Wolverhampton, there has been a significant amount of vertical integration, such that in many cases GP services are part of the NHS provider trust. Therefore, those amendments that would prohibit any public body from participating would explicitly prohibit GPs in Wolverhampton from that provision. Elsewhere, some hospices—a small number—are provided directly by the NHS. Given the history of the hospice sector in the UK, there is clearly a strong voluntary and charitable element of that provision, which is entirely right, but that varies in different parts of the country.

To return to the point made by the hon. Member for East Wiltshire, there are some hospices and end-of-life providers who have made it known that, if this law passes, they may wish to explore whether they will provide such services. Equally, others will not. This goes back to the conscience debate that we had last week. There will be no obligation, so a hospice in one part of

[*Lewis Atkinson*]

the country may well say, “Yes, we wish to provide this service as an option to our patients,” whereas a hospice in another part of the country might say, “We do not.” We need to get past this metropolitan mindset, whereby all the providers are within easy travelling distance from each other.

**Kit Malthouse:** The hon. Gentleman is making a strong point. Surely what should be at the heart of the organisation’s disposition is consideration of the condition and circumstances of the patient. Whether on the cancer ward, in the hospice or at home, the health service adapts, and has adapted with all sorts of treatments, to dealing with the different circumstances of the patient that it encounters. We must have a system that is flexible enough to allow it to do so for this.

11 am

**Lewis Atkinson:** The right hon. Gentleman is entirely right. These powers need to provide for that patient-centric nature, in a service that is explicitly commissioned by the Secretary of State, which will vary in different parts of the country, and not just in the provision landscape. The services provided in rural North Northumberland will, by their nature, probably be different from those provided in London, and that is entirely appropriate.

**Danny Kruger:** And yet the irony of this measure is that it is not specific to the patient. Genuine healthcare treats the symptoms and condition of the individual patient. This proposed treatment has nothing to do with the individual symptoms or the condition of the patient; it just kills them. It is totally unrelated to the condition, which is why it is not healthcare.

The hon. Gentleman suggested earlier that the Bill somehow ensures that the provision and the pathway are deliberately fragmented because the second doctor needs to be independent of the first. Does he agree that, with that single exception, it would be perfectly possible for an independent provider to set up to provide for the whole pathway of assisted death, with the single requirement that the co-ordinating doctor, who would manage the whole process from beginning to end, must get a second opinion from outside their organisation to sign the paperwork for the second assessment? With that single exception, the whole process could be managed by an independent, profit-making provider—commissioned by the NHS or otherwise—entirely on its own.

**Lewis Atkinson:** The hon. Gentleman is providing a masterclass in scaremongering. I know he needs Labour votes to switch before Third Reading, but this service must be explicitly commissioned by the Secretary of State, and it is inconceivable that they would commission that in the way that the hon. Gentleman describes. The co-ordinating doctor is of course one person, and they would be involved in the first assessment and the provision of assistance. Whether that is a doctor employed by the NHS or somebody else, it can only be one individual, but there are the other safeguards we have talked about, such as the panel, which the hon. Gentleman has spoken against. It is absolutely appropriate that the Secretary of State has the powers and the duty to commission the service, and that they will do so from range of providers, reflecting the differences.

On the other point that some hon. Members have made about regulation, I remind the Committee that any provider will be regulated not only under this Act, but by the Care Quality Commission, in entirely uniform manner. I am therefore confused by the points made by opponents of the Bill. Some have said there should be no provision of this by the NHS or any public body, some say there should be no provision by charities—including, presumably, local hospices, should they make that decision—while others say there should be no provision by local GP practices to provide continuity of care.

Perhaps those different points reflect different ideologies within the Committee that are deeper than this issue, but they perhaps also reflect the fact that opponents of the Bill simply do not want this service to be provided at all.

**Sarah Olney:** Will the hon. Member give way?

**Lewis Atkinson:** No, I am going to finish this point.

The hon. Member for East Wiltshire did a good job of reading a Bevan quotation before—although I do not advise him to seek Labour party selection with such gravitas in his voice. However, I think he is the heir not to Bevan, but to Bernard Braine, the Member for South East Essex, who said in the 1967 debate on the David Steel abortion Bill:

“The idea has been spread around that it will be available on the National Health Service.”

In reference to the waiting lists, Braine went on to ask:

“Are our consultant gynaecologists going to make that list longer by making beds available to those who want abortions?”—[*Official Report*, 13 July 1967; Vol. 750, c. 1382.]

That is the tradition of objection that the hon. Member for East Wiltshire is in. Just because he does not wish to have the option for himself, he does not believe that there should be free-at-the-point-of-use provision on the NHS for anyone else.

I will take Bevan back to this side of the Committee Room. He said:

“The essence of a satisfactory health service is that the rich and the poor are treated alike, that poverty is not a disability and that wealth is not advantaged”.

At the moment, at the end of life, wealth clearly is advantaged. Those who are wealthy and are able to go to Switzerland do have choice at the end of life. Dignity and independence and autonomy should not be based on ability to pay. That is why we need to pass this Bill; that is why the powers to commission in new clause 36 are entirely appropriate and necessary; that is why I support it.

**The Chair:** I call Liz Saville Roberts.

**Liz Saville Roberts** (Dwyfor Meirionnydd) (PC): Diolch yn fawr—thank you very much, Ms McVey. I rise to speak to clause 32 stand part and to new clauses 36 and 37.

It is gratifying that everybody on the Committee has taken so seriously the need to recognise where the powers lie in relation to the Senedd in Wales and Welsh Ministers, and Westminster and the Secretary of State. The evidence we heard from Professor Emyr Lewis is that clause 32 would contravene the Sewel convention by giving the UK Government powers of regulation to provide an assisted dying service in the NHS in Wales.

I am very appreciative of the way in which we have discussed the matter. This is, of course, a private Member's Bill; by the nature of the subject it is discussing, it is unprecedented since devolution in 1999. As we talk about constitutional matters and the Sewel convention, it is important to remember what we are doing as a Bill Committee: we are trying to make sure that we tease out the questions about the environment in which all these services will be provided, and that we are giving people who are at the most vulnerable time in their life the appropriate protection and the appropriate autonomy. That is what we should always be balancing.

New clause 36, which relates to England, and new clause 37 certainly appear—I use the word with as much generosity as I can—to clarify the responsibilities as between Welsh Ministers and Secretaries of State. My amendments would go through the Bill clause by clause and would then insert a definition into clause 40, rather than making a broad statement as the new clauses do.

Although we have debated the content of new clause 36, I believe strongly that it is not for us in Westminster to specify how Welsh Ministers may make provision for those areas over which they have responsibility. It is appropriate that we have a debate, because that raises awareness of the potential for a legislative consent motion or motions. It is appropriate to have that discussion; it is also appropriate to be aware that there may be a discussion about the commencement date and the implications, which we will address in the debate on a later amendment.

I am looking particularly at Wales, and new clause 37 would do what my amendments were attempting: it would give us future-proofing. The powers that have been granted to the Senedd in Wales are considerably different, and lesser in their extent, than those that have been granted to Scotland and to Northern Ireland. That may well change in future, and new clause 37 would allow for that.

I put it on the record that I await further discussions between Welsh Ministers and the hon. Member for Spen Valley, although I understand that some have already taken place. It is already on the record that UK Ministers, the Secretary of State, the hon. Member for Chesham and Amersham and I will have further discussions as we move ahead. There will be opportunities on Report to do what the Committee is trying to achieve, which is to future-proof the legislation and ensure that it works as effectively as possible.

I welcome the changes that the new clauses would make. Clause 32, as it stands, does not recognise the constitutional arrangements of the United Kingdom, and it is important that we do that.

**Kim Leadbeater:** I thank the right hon. Lady for her constructive and collegiate approach to the Committee, particularly on devolution. I have contacted the Welsh Government and am keen to speak to them when Committee proceedings have finished. They have said that they are happy to do that. I am keen to continue to work with the right hon. Lady and other colleagues on devolution to ensure that we get the Bill right for the people of England and Wales.

**Liz Saville Roberts:** I appreciate the hon. Lady's comments. I think there is a lesson to be learned. I understand that the legislation is unprecedented in coming through the private Member's Bill route. After this, we will have to

think about how we deal with such legislation because we are feeling our way. I appreciate the opportunity to work with the co-operation of colleagues on something for which there is no road map, but I fear, although I also appreciate, that we are making the road map as we go.

**Daniel Francis:** It is a pleasure to serve under your chairship, Ms McVey. I genuinely did not intend to speak today, but the debate, particularly the speech by the hon. Member for Richmond Park and the intervention from my hon. Friend the Member for Luton South and South Bedfordshire, has brought me to my feet.

It was 13 or 14 years ago that my wife and I embarked on the IVF road. It never worked—our children came naturally in the end—but I know the pain and despair of that process. Although I do not call into question the efficacy of any doctor, some companies, looking to their profit margins, will always prey on people.

We have had discussions today about the regulations to be made under new clause 36, but we need some clarity on Report. I referred to the annual fertility show at the Kensington Olympia; I have checked, and it is still held. I visited it about 13 years ago. Frankly, it is complete marketisation. People who are already on their knees and really depressed are left feeling that companies are simply trying to make a profit out of them. People can already book their tickets for the event in May and navigate a path through it: there are expert-led seminars, real stories, whereby people connect with others who have been through the process, wellbeing workshops and more than 70 exhibitors. Of course, they are all paying a fee to be there, and they all aim to have made a profit by the end.

Our first set of IVF treatment was free on the NHS. We paid £7,000 for our second, which was again through the NHS. We went through several visits to NHS and private providers to assess whether we were willing to pay a top-up for a slightly better service. I really did not intend to speak this morning, but I wonder whether, in the final part of the process that we are considering, there would be the sort of upsetting process that has taken root in the fertility industry in this country. We need more clarity on that by Report.

**Naz Shah:** I stopped myself intervening on my hon. Friend the Member for Sunderland Central; I had lots of questions, and he has confused me even more. He referred to the provision in clause 8(6)(d) about the doctors being different. If I am right, healthcare providers such as Aspire or Ramsay Health Care could be commissioned to deliver the services. If so, does that mean, as the hon. Member for East Wiltshire suggested, that we will need two separate doctors or providers because the co-ordinating doctor and the second doctor cannot be linked? That confuses me even further. After what we have heard this morning, it strikes me that we do not have any proposed model and the measure has not been thought through. It speaks to the idea that this is not right. We are spending hours and hours going through hypotheticals and possibilities—this could happen, that could happen—but there is nothing actually before us.

11.15 am

**Danny Kruger:** The hon. Lady is absolutely right. I am not sure that anything in the Bill would preclude a private provider—"Virgin Health" or some such

[*Danny Kruger*]

organisation—from providing the whole pathway of the assisted death, including employing, albeit in separate clinics or separate practices, the two doctors who would provide the two assessments. The provider would comply with the Bill, but the doctors might be part of the same organisation even if they work in different practices.

**Naz Shah:** I thank the hon. Member for his intervention. I have observed two things this morning. First, the reality has really hit home. Are we going to look at the amendment regarding local authorities providing the service? Are we excluding private providers? Are we excluding big firms? A new service has to be designed. Will it be two organisations or one? How will the Bill be delivered? We do not even have that before us, and that concerns me deeply.

**Kim Leadbeater:** As my hon. Friend the Member for Sunderland Central said, it is common practice in healthcare and in the NHS for services to be commissioned in a range of ways. We would not put such a level of detail in the Bill, but it would be normal practice for the Secretary of State to do that commissioning work. My hon. Friend the Member for Bradford West has her own experience of that, I imagine.

**Naz Shah:** Absolutely. As a former commissioner, I am very familiar with commissioning; I commissioned millions of pounds' worth of services across Bradford when I was in the NHS. The difference is that that was under Government Bills that had pre-consultation, impact assessments and a model that was debated. None of that has happened with this Bill. I agree that in an ideal world the process set out in new clauses 36 and 37 would be the right one, but without an impact assessment and a consultation, I am afraid that I have been left really disheartened.

I am disheartened about something else, too. I thank all Committee members, regardless of the points that they have or have not made, for the way in which the debate has been conducted, both before and during our sittings. On a few occasions, hon. Members have questioned other Members' reasons for tabling amendments—but to suggest, as has been suggested today, that we are scaremongering, when we are actually going through the detail, is something else.

I am afraid. This is not me scaremongering; this is me being afraid for women who are anorexic. This is a gendered Bill. There are amendments that I support because I want to strengthen the Bill. I genuinely do not think that the Bill, as it stands, has that strength. I feel disheartened that we are talking about what is going to happen on Third Reading and potential votes, when we should be concentrating on the amendments on the selection list.

I oppose the new clauses tabled by my hon. Friend the Member for Spen Valley, which would replace clause 32. As my hon. Friend explained, new clause 36 outlines the powers that the Secretary of State for Health would have over voluntary assisted dying services in England. New clause 37 does the same for Wales, but makes changes that are necessary because health is a devolved power. I will concentrate on new clause 36, as I represent a constituency in England.

Put very simply, if new clause 36 is agreed to, it will give the Secretary of State three sorts of power. First, it will give the Health Secretary powers under subsection (4) to, effectively, change the National Health Service Act 2006. Secondly, it will give the Health Secretary powers to set out regulations about how any service, whether public or private, carries out assisted dying services. Thirdly, the Health Secretary will have powers under subsection (1) to commission assisted dying services. As I understand it, the wording means that assisted dying services could be provided directly by the NHS or by private firms working on contract for the NHS. I will discuss those powers in the order in which I mentioned them.

Subsection (4) of new clause 36 says that the Health Secretary may pass regulations that

“may for example provide that specified references in the National Health Service Act 2006 to the health service continued under section 1(1) of that Act include references to commissioned VAD services.”

To make it clear how the new clause works, I will quote from the subsection of the National Health Service Act 2006 that it would affect. It states:

“The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement—

(a) in the physical and mental health of the people of England, and

(b) in the prevention, diagnosis and treatment of physical and mental illness.”

That Act is an adaptation of the original National Health Service Act 1946, section 1(1) of which states:

“It shall be the duty of the Minister of Health...to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness”.

The 1946 and 2006 Acts both give the Health Secretary a very clear set of duties that I think we can all support. Those duties have been the basis of how the NHS has been run for the nearly eight decades for which it has existed.

My hon. Friend's Bill would give the Secretary of State powers to change the duties set out in section 1(1) of the 2006 Act. I ask my hon. Friend and both Ministers why the Bill needs to give the Secretary of State those powers. The only reason I can think of is that someone who was part of the drafting process has pointed out that the Health Secretary's current duties might be incompatible with assisted dying.

The Health Secretary has duties to secure improvement in the people's physical and mental health and in the prevention, diagnosis and treatment of physical and mental illness. Someone could bring a legal challenge on the basis that assisted dying does not fit with that duty, and that challenge might well succeed. I think that, to prevent that happening, my hon. Friend has proposed subsection (1) of new clause 36. If there is any other reason why she has suggested that we should give those powers to the Secretary of State, it is important that the Committee understands and hears it.

What is proposed underlines just how major a change the Bill would make. Since the NHS started operations in 1948, we have had a clear understanding of what it is there for. The 2006 Act is little different from the 1946 Act in that respect. For nearly 80 years, we have had an NHS that is there to improve health and to

improve the prevention, diagnosis and treatment of illnesses. The fact that we may have to change that shows us that we are taking a very big step indeed. To make such a fundamental change to the NHS, we should have had the best possible evidence and proper consultation, not three days of witness hearings and then hundreds of pieces of written evidence, often published after we had finished discussing the topics to which they relate. That is nowhere near good enough.

The next set of powers that I want to talk about is mentioned in subsection (3) of new clause 36, which says that the Health Secretary

“may by regulations make other provision about voluntary assisted dying services in England (whether or not the services are commissioned VAD services).”

I absolutely accept that if we have assisted dying services in England, the Health Secretary should ensure that they are properly regulated. That will have to include privately provided services as well as those offered on the NHS. However, I must ask: why does the Bill say that the Secretary of State “may” pass such regulations? The best interpretation I can think of is that a future

Health Secretary might decide that private firms should provide assisted dying services directly to paying customers rather than via outsourced NHS contracts. In that case, the Health Secretary would need to provide regulations for those private sector services.

If that interpretation is correct, surely we could have tighter wording. For example, the new clause could say that if the Secretary of State decides to allow private firms to provide assisted dying to paying customers, the Secretary of State must make regulations to govern that. I would welcome clarification on the point, because I know that my hon. Friend the Member for Spen Valley previously accepted an amendment—I think it was amendment 477—

**The Chair:** Order.

11.25 am

*The Chair adjourned the Committee without Question put (Standing Order No. 88).*

*Adjourned till this day at Two o'clock.*





