PATIENT POLICY BRIEF · SPENDING REVIEW 2027

Risk-stratified prostate cancer screening is preventative spending

Why a programme for men at elevated risk belongs in the Treasury's new preventative DEL, and five questions for HM Treasury and the Department of Health and Social Care before the 2027 settlement closes

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Summary

At Budget 2026 the Chancellor created a new ringfenced spending category, preventative Departmental Expenditure Limit (PDEL), for introduction at Spending Review 2027, and cut the Green Book discount rate from 3.5% to 3.0%. Both changes were designed for programmes whose benefits arrive years after the money is spent. A risk-stratified prostate cancer screening programme is such a programme. This brief asks for five things before the Treasury and the Department of Health and Social Care close their SR2027 settlement:

1. **Include early detection in PDEL.** That the PDEL definition published for SR2027 explicitly includes early detection, so that screening programmes can be bid for as preventative spending rather than as ordinary day-to-day health spending.
2. **Name the review date.** A named review date for the prostate screening recommendation tied to TRANSFORM stage 1 reporting, which the trial expects before the end of 2027, rather than the default 2029 review.
3. **Set the modelling scope.** Confirmation that the three-year funded modelling programme will assess first-degree family history on its own, BRCA1, Black men, and a lower age floor for high-risk men.
4. **Explain the threshold.** An explanation of why the Screening Committee tests prostate screening at £20,000 per QALY when NICE can approve late-stage prostate cancer medicines at £35,000 per QALY, and whether the forthcoming methods guide will align the two.
5. **Open the model.** Publication of the screening model on terms equivalent to NICE's, so that the cost, duration and discount-rate assumptions challenged in the Westminster Hall debate on 26 October and in written questions since can be tested independently.

Since v3 shipped on 30 October, the Department has confirmed PDEL will be introduced at SR2027 and described it in the framing this brief uses — protecting "programmes that generate benefits over the longer term" [22]. The eligibility question remains open.

Scale of the problem against scale of the programme (England, each year)



Stage 3/4: 47% of men with a recorded stage, NHS England registrations 2022 via CRUK [18]; roughly a quarter of cases have no recorded stage. Eligible: DHSC, UIN 8696 [10].

1 Where I start from

In January 2025 I went to my GP with an abdominal swelling. I had no prostate cancer symptoms. The GP suspected a bowel problem and thought I was too young for prostate cancer; I asked for full bloods and the GP agreed. A colorectal specialist, reading the results for something else, spotted a PSA of 4,056. In February 2025, at 52, I was diagnosed with Stage 4 polymetastatic prostate cancer and started triplet therapy within a few months. Almost two years on, my PSA is 0.02. I am not cured. I will be on hormone therapy for the rest of my life. Prostate cancer runs in my close family. Nothing in the system was going to find mine. This brief sets out why a risk-stratified screening programme belongs in the preventative spending category the Chancellor announced on 28 October, and what the Department and the Treasury need to settle before Spending Review 2027.

2 The claim

Prostate cancer screening for men at elevated risk meets the structural test the Treasury has set for PDEL. The spend is modest and immediate. The savings are large, spread over fifteen to twenty-three years, and fall across more than one budget line: late-stage treatment and long-term hormone therapy sit with DHSC; lost earnings and tax sit with HMT; incapacity and carer support sit with DWP. That is the pattern PDEL was created to recognise. The Budget describes it as spending that will "help facilitate shared resource and accountability across budget holders" and "protect programmes that generate benefits over the longer term" [1], and the Department has used the same framing in a written answer confirming PDEL will be introduced at SR2027 [22].

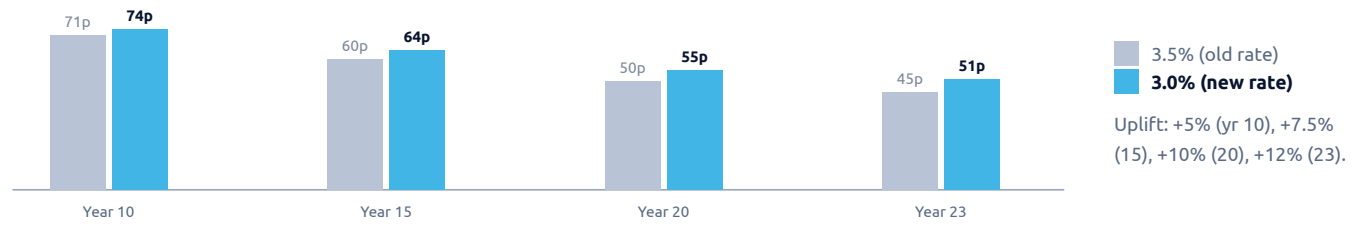
The argument here is about whether a programme should exist at the scale the evidence now supports, not about its detailed design. The Screening Committee's own model is funded for a further three years and is, in the Minister's words, able to be revisited as evidence emerges [2]. The question for SR2027 is whether that work is budgeted as prevention, with the protection PDEL offers, or left to compete with acute pressures inside the ordinary health settlement.

3 The mechanism

Budget 2026, section 3.4, introduces PDEL at the 2027 spending review. The worked example the Treasury chose is rough sleeping: £432 million invested now against an estimated fiscal cost of around £14,000 per person sleeping rough per year [1]. The logic is that a defined investment now reduces a recurring cost later, and that the recurring cost does not sit neatly inside the budget that pays for the intervention. In his Budget speech the Chancellor put it in one line: "I will ringfence prevention spending that brings down costs in the future" [3].

Two further features of the Budget matter here. First, the Green Book discount rate falls from 3.5% to 3.0% [1]. At 3.5%, a pound of benefit twenty years out is worth 50p today; at 3.0% it is worth 55p. For benefits arriving at twenty-three years, which is the follow-up period of the largest screening trials, the change raises present value by about 12%. Second, the Bailie review of NHS productivity and AI reports in early 2027, ahead of the spending review [1]. Earlier diagnosis is a productivity question as much as a clinical one: a man treated for localised disease needs a fraction of the clinic time, imaging, drugs and inpatient care of a man treated for metastatic disease for the rest of his life.

What £1 of future benefit is worth today, old rate against new Green Book rate



Discount factors $1/(1+r)^t$ computed from the rates in Budget 2026, section 3.4 [1]. Rounded to the nearest penny.

The Treasury has not yet published the eligibility rules for PDEL. The proposal from which PDEL grew, published by Demos and the Health Foundation, recommended that the category cover primary and secondary prevention, which would include early detection [4]. If the published definition is narrower than that, screening programmes fall outside PDEL before any department can bid. That is why the first ask in this brief is addressed to HM Treasury rather than to DHSC.

4 The evidence

The chronology

On 26 March 2026 the UK National Screening Committee reached its final recommendation: a targeted programme for men aged 45 to 61 with a BRCA2 variant and a relevant family history, with BRCA1 dropped from the November 2025 draft and family history added as a condition [5]. On 15 May 2026 the Cochrane systematic review of PSA-based screening was published: six randomised trials, 789,086 participants, follow-up to twenty-three years, with the conclusion that screening likely reduces prostate cancer-specific mortality (GRADE moderate) [6]. On 2 June 2026 the Government accepted the Committee's recommendation and announced a £20 million research investment including expansion of TRANSFORM [7]. In August 2026 DHSC withdrew the Prostate Cancer Risk Management Programme [8]. On 1 October 2026 the abridged Cochrane review was published in BJU International [9].

From recommendation to spending review



Default next NSC review without a named date: 2029 [14]. Sources [1] [5] [6] [7] [8] [15].

What the programme covers

DHSC estimates around 1,500 men in England will be eligible [10]. Opening the Westminster Hall debate on 26 October, the Petitions Committee's spokesman noted that the Department "acknowledges that most prostate cancer cases will therefore fall outside the programme" [11]. The Minister accepted in reply that "for many it does not go far enough" [2].

The harms question

The Committee's caution rests on overdiagnosis. Its estimate is that for every 1,000 men offered screening, up to twenty could be overdiagnosed while around two lives are extended; Prostate Cancer Research's analysis of more recent MRI-led studies puts the ratio closer to three men overdiagnosed for every two lives saved [12]. The gap between those two figures is the gap between the diagnostic pathway of the early 2000s and the one the NHS runs today. On the current pathway a raised PSA leads to MRI before biopsy, and a low-risk finding leads to active surveillance rather than treatment. The Minister confirmed that the Committee modelled the current standard of care including MRI before biopsy, but did not include newer approaches whose evidence is still being established [2].

Active surveillance is not costless. It means repeat PSA tests, repeat MRIs, and the psychological weight of carrying a known cancer; it is a real burden placed on men whose disease may never have threatened them. Risk-stratified screening is designed to concentrate that burden where the probability of lethal disease is highest, not to spread it indiscriminately. The input that most needs independent scrutiny is therefore not whether overdiagnosis exists, but whether the Committee's model prices it correctly against the modern pathway's protections against overtreatment.

The model inputs

In the debate the former Prime Minister set out three assumptions in the Committee's model: treatment costs of around £27,000, where most independent estimates are higher; that only about a quarter of men receive the most advanced drugs, where audit data suggest twice as many do; and that those drugs are not received for more than

three years, where the evidence is that men receive them for longer [13]. Each of those assumptions understates the cost of late diagnosis and therefore understates the benefit of finding cancer earlier. The Minister did not respond to the three points. She did confirm that the model is funded for a further three years and that evidence from TRANSFORM "can be considered as it emerges" [2].

The discount rate

The discount rate used in the Committee's base case was put to the Department in a written question on 2 November 2026 [23]. The Department's reply pointed to its own published materials rather than naming the figure. Those materials confirm, at page 87 of the SENSS modelling report, that the base case applied a discount rate of 3.5% per annum to both costs and health benefits, in line with NICE methodology [24]. The HMT Green Book rate of 1.5% per annum on health benefits was tested only as part of a bundled sensitivity scenario (Scenario 9), which simultaneously altered the decision threshold to £15,000 per QALY — not a clean comparison. Budget 2026 has since reduced the Green Book headline rate to 3.0% [1]. A programme whose benefits accrue over fifteen to twenty-three years looks materially different at the lower rate, and the Committee's base case has not been re-run.

The review date

Without a named date, the next scheduled review falls in 2029 [14]. TRANSFORM's first-stage results are expected before the end of 2027 [15]. A review date tied to that reporting point costs nothing and removes two years from the gap between evidence and decision.

5 The equity case

The Minister told the House that "black men are twice as likely as white men to be diagnosed with prostate cancer, and that disparity rightly worries us all" [2]. Black men are not in the programme. Nor are men with a first-degree family history unless they also carry a BRCA2 variant. The programme's own equality impact assessment notes that men from less deprived areas may be able to pay privately for BRCA tests, and that "this could further entrench health inequalities" [16]. The shadow Minister put the carrier estimate at around 13,000 men, most of whom have never been tested and do not know [14]. The gap between 13,000 carriers and 1,500 eligible men is itself an equity question.

Deprivation compounds this. Men in the most deprived areas of England have an 11% higher chance of a metastatic diagnosis, a 19% lower chance of receiving a prostate cancer diagnosis at all, and 14% higher mortality; around 740 prostate cancer deaths a year are linked to deprivation [17]. A system that depends on a man knowing his risk and asking his GP will reach the informed and the affluent first. That is the structural case for risk-stratified invitation rather than reliance on request.

Family history also deserves its own line in the modelling programme. The Minister said work is under way "to refine the definition of family history and ensure that it is properly reflected in the UK National Screening Committee's model" [2]. That work should assess first-degree family history on its own, without the BRCA2 condition, together with BRCA1, Black men, and a lower age floor for men in each of those groups. Those are the four scope items in ask three.

6 The fiscal case

The cost pool

Around 58,000 men in England are diagnosed with prostate cancer each year and around 10,000 die of it [16]. Of those whose stage is recorded at diagnosis, 47% are diagnosed at Stage 3 or Stage 4, which is at least 19,000 men a year on the recorded data; roughly a quarter of cases have no recorded stage, and if they follow the same pattern the figure is around 27,000 [18]. The National Prostate Cancer Audit puts the share diagnosed with metastatic disease at 12% [19]. At the Committee's own treatment-cost assumption of £27,000, the annual treatment cost of the late-stage cohort is between £500 million and £730 million. That figure uses the assumption the former Prime

Minister described as too low, and it excludes hormone therapy beyond three years, lost earnings, tax forgone and welfare costs. Analysis commissioned by Prostate Cancer Research, cited in the debate, found that treating a man diagnosed at Stage 4 costs roughly ten times as much as treating a man diagnosed at Stage 1 [20].

The programme cost

Prostate Cancer Research's costing of a targeted programme for Black men aged 45 to 69 and men aged 45 to 69 with a family history, around 1.3 million men across the UK, is £25 million a year, which it puts at 0.01% of the annual NHS budget [21]. The England pro-rata share, at roughly 84% of the UK population, is around £21 million a year — set against the £500 million to £730 million late-stage cost pool estimated for England above.

Annual cost pool against annual programme cost



Cost pool: men × £27,000, the NSC model's own assumption, described in the debate as too low [13] [18]. Programme: PCR, Oct 2025 [21]; England share pro-rata at roughly 84% of the UK population.

What this brief does not claim

It does not claim how many late-stage diagnoses a programme would prevent. That is the output of the model, and the model is the thing in dispute. What it does claim is that the cost pool is at least twenty times the programme cost on the Committee's own assumptions, that the benefits run for fifteen to twenty-three years, and that they land in DHSC, HMT and DWP budgets. Those are the three characteristics the Treasury has said PDEL is for.

The appraisal rate

At the old 3.5% discount rate a benefit arriving in year fifteen is worth 60p in the pound today; at 3.0% it is worth 64p. In year twenty-three the figures are 45p and 51p. For a programme whose benefits arrive late, the Budget's change to the Green Book is worth between 7% and 12% of present value before any other assumption moves. The case for screening is stronger under the Treasury's new rules than it was under the rules the Committee's model was built against. Running the model again at the new rate is, so far, not committed.

The threshold

The Committee tested screening against £20,000 per QALY. Since April 2026 NICE has been able to approve medicines for advanced prostate cancer at up to £35,000 per QALY [20] [14]. The same cancer is valued at one rate for prevention and a higher rate for late-stage treatment. The Minister did not address the point in her reply. The Treasury has a direct interest in the answer, because the £35,000 line is where the late-stage cost pool is spent.

7 Four nations, four budgets

The National Screening Committee advises all four UK health departments. Any English screening programme change triggers Barnett consequentials for Scotland, Wales and Northern Ireland, and parallel engagement with the Scottish Government, Welsh Government and Northern Ireland Department of Health. A PDEL-classified programme in England is, in practice, the lever that moves the question across the Union.

The devolved administrations are not currently meeting their own cancer waiting-time standards. In the quarter ending 30 June 2026, 73.6% of Scottish patients started treatment within 62 days of urgent referral against a target of 95% [25]. In May 2026, 57.1% of Welsh pathways started first definitive treatment within 62 days of first being suspected of cancer against a target of 75% [26]. Both targets have been missed for successive quarters. A preventative programme that reduces late presentations reduces exactly the load that is currently overwhelming devolved acute pathways.

8 The asks

For HM Treasury, ahead of the PDEL definition

1. **Include early detection in PDEL.** Publish the eligibility rules for preventative DEL in time for SR2027 bids, and state that secondary prevention, including risk-stratified screening programmes, is within scope. The Demos and Health Foundation proposal on which PDEL is based recommended exactly that [4]. The Department's description of PDEL in its 10 November 2026 written answer — protecting "programmes that generate benefits over the longer term" [22] — supports that reading.

For the Department of Health and Social Care, ahead of the Treasury bilaterals

2. **Name the review date.** Commit to a UK NSC review of the prostate screening recommendation at TRANSFORM stage 1 reporting, expected before the end of 2027, rather than the 2029 default [14] [15].
3. **Set the modelling scope.** Confirm that the three-year funded modelling programme will assess first-degree family history alone, BRCA1 carriers, Black men, and a lower age floor for men in each high-risk group, and publish a dated workplan by January 2027 [2] [13].
4. **Explain the threshold.** State why screening is appraised at £20,000 per QALY when late-stage prostate cancer medicines are approved at up to £35,000, and whether the Committee's forthcoming methods guide will align them [14] [20].
5. **Open the model.** Publish the Screening Committee's model on terms equivalent to NICE's technology appraisal process, so the £27,000 treatment-cost assumption, the quarter-of-men assumption, the three-year duration assumption and the 3.5% discount rate on health benefits can be tested by independent health economists [13] [24].

> **A note on PSA access.** The Minister told the House on 26 October that "a man who requests a PSA test from a GP will have that test if he is given the information and the choice is there", and undertook to write to the Member for Hinckley and Bosworth if that is not correct [2]. As of 10 November 2026 that letter has not been received. This brief takes the Minister at her word pending the letter. If the letter qualifies that position, restoring the explicit informed-choice framework that PCRMP provided becomes a sixth ask.

9 Where this ends

I am one of them. I was 52, I had no prostate cancer symptoms, and I had to ask. The men who come after me should not have to. The Treasury has built a category of spending for programmes that cost a little now and save a great deal later. The Department has a model that it has funded for three more years and a trial that reports next year. The evidence has moved. The pathway has moved. The only thing that has not moved is the decision. Spending Review 2027 is the place to move it.

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References

[1] HM Treasury, *Budget 2026*, 28 October 2026, sections 3.3 (Bailie review) and 3.4 (Prevention: PDEL, rough sleeping example, Green Book discount rate). gov.uk/government/publications/budget-2026-document/budget-2026-html

[2] Dame Diana Johnson, Minister for Public Health and Patient Safety, HC Deb 26 October 2026, vol 792, cc24WH–26WH.

[3] John Healey, Budget speech, 28 October 2026, as reported by Local Government Chronicle, "New 'prevention' category at next spending review", 28 October 2026.

[4] Demos and the Health Foundation, *Revenue, capital, prevention: a new public spending framework for the future*, October 2023, and Demos, *The preventative shift*, follow-up paper recommending PDEL focus on primary and secondary prevention.

[5] UK National Screening Committee, final recommendation on prostate cancer screening, March 2026; minutes of the March 2026 meeting published 28 May 2026. House of Commons Library, *Prostate cancer screening*, CBP-12230, 20 October 2026.

[6] Franco JV et al., Prostate-specific antigen (PSA) test for prostate cancer screening, *Cochrane Database of Systematic Reviews*, 15 May 2026. DOI 10.1002/14651858.CD004720.pub4.

[7] DHSC, Written Ministerial Statement on prostate cancer screening, HCWS80, 2 June 2026 (as cited in CBP-12230).

[8] Prostate Cancer Research, "New guidance raises concerns on access to PSA testing", August 2026; Ben Obese-Jecty MP, HC Deb 26 October 2026, vol 792, c11WH.

[9] Franco JV et al., abridged Cochrane review, *BJU International*, 1 October 2026. DOI 10.1111/bju.70455.

[10] DHSC written answer, UIN 8696, 16 June 2026.

[11] John Lamont MP, HC Deb 26 October 2026, vol 792, c2WH.

[12] John Lamont MP, HC Deb 26 October 2026, vol 792, c4WH.

[13] Rishi Sunak MP, HC Deb 26 October 2026, vol 792, c7WH.

[14] Gregory Stafford MP (Shadow Minister), HC Deb 26 October 2026, vol 792, cc21WH–22WH.

[15] John Lamont MP, HC Deb 26 October 2026, vol 792, c3WH.

[16] DHSC, *Equality impact assessment: introduction of a targeted prostate cancer screening programme*, 2 June 2026 (c.58,000 diagnoses and c.10,000 deaths a year in England; private BRCA testing and health inequalities).

[17] Helen Maguire MP, HC Deb 26 October 2026, vol 792, c19WH, citing England data on deprivation and prostate cancer outcomes.

[18] Cancer Research UK, prostate cancer statistics: 53% (around 21,600) of cases with a known stage diagnosed at stage I or II, England, 2022. The recorded late-stage count of c.19,000 is 47% of the same staged cases; c.27,000 applies that proportion to all c.58,000 annual cases, including those with no recorded stage.

[19] National Prostate Cancer Audit, *State of the Nation Report 2025*.

[20] Ian Sollom MP, HC Deb 26 October 2026, vol 792, c18WH, citing analysis commissioned by Prostate Cancer Research.

[21] Prostate Cancer Research, "Life-saving targeted prostate cancer screening would cost just 0.01% of annual NHS budget, reveals new report", 14 October 2025 (£25 million a year; Black men and men with a family history aged 45–69, c.1.3 million men).

[22] DHSC written answer to UIN 40118, tabled by Toby Perkins MP on 2 November 2026, answered 10 November 2026.

[23] UIN 40120, tabled by Toby Perkins MP on 2 November 2026, answered 9 November 2026.

[24] SENSS, *SENSS Prostate Cancer Modelling Report*, v4 Final, April 2026, p. 87 (base-case discount rate) and p. 96 (Scenario 9 Green Book sensitivity). Published by the UK National Screening Committee. view-health-screening-recommendations.service.gov.uk/document/2b9ef9db-3622-44c3-91ea-a77320d67770/download

[25] Public Health Scotland, *Cancer waiting times — 1 April to 30 June 2026*, published 29 September 2026 (73.6% of patients started treatment within 62 days of urgent referral against the 95% target; 94.8% within 31 days of decision to treat against the 95% target).

[26] Welsh Government, *NHS activity and performance summary: May and June 2026*, published 23 July 2026 (57.1% of pathways started first definitive treatment within 62 days of first being suspected of cancer in May 2026 against the 75% target).

Changelog from v3 (29 October 2026) to v4 (10 November 2026)

This update ships because two written parliamentary questions tabled on 2 November by the Member for Chesterfield have been answered and open new material. v4 keeps v3's spine and adds, by section:

- **Summary** — one dated note referencing UIN 40118.
- **Section 2 (The claim)** — cross-reference to the Department's PDEL framing in UIN 40118.
- **Section 4 (The evidence) — new paragraph "The discount rate"** — records the UIN 40120 question and answer, sources the base-case 3.5% from the SENSS modelling report at p. 87, and notes that the Green Book 1.5% rate was tested only as a bundled sensitivity (Scenario 9).
- **Section 4 (The evidence) — active surveillance** — paragraph rewritten to acknowledge the real burden of active surveillance before arguing that risk-stratified screening is designed to concentrate that burden where it is most warranted.
- **Section 6 (The fiscal case) — programme cost** — adds the England pro-rata share (~£21m) of the UK £25m PCR programme so geographic denominators align.
- **Section 6 (The appraisal rate)** — one line added recording that the Committee's base case has not yet been re-run at the new Green Book rate.
- **New Section 7 "Four nations, four budgets"** — introduces the devolved-nations frame (NSC advises all four nations; Barnett; parallel engagement) and anchors it with current Scotland (PHS Q2 2026, 73.6% v 95%) and Wales (May 2026, 57.1% v 75%) cancer waiting-time performance.
- **Section 8 (The asks) — Ask 5 extended** — "and the 3.5% discount rate on health benefits" added to the list of assumptions that need independent scrutiny.
- **Section 8 (The asks) — PSA access note** — notes that the Minister's letter to the Member for Hinckley and Bosworth had not been received by 10 November 2026.
- **References** — [22] UIN 40118; [23] UIN 40120; [24] SENSS modelling report with page citation; [25] PHS Q2 2026 cancer waiting times; [26] Welsh Government May 2026 performance.