

A Healthy Nation

Free When It Matters, Fast When You Choose, British-Trained Throughout

An independent SovereignOS™ companion paper on Restore Britain's published policies · Final · 21 November 2026

Sources: Restore Britain's official website and policy-paper PDFs, and official UK statistics, each opened and checked on 21 November 2026

'...investing in people who increase British economic vibrancy.'

— Stuart M. Williams

An independent view. This paper is the independent view of SovereignOS™, written by a Restore Britain member and supporter. It builds on Restore Britain's published policies, viewing them through a systems lens, and draws on more than 30 years of experience. It is not Restore Britain policy and it has not been endorsed by Restore Britain. Everything attributed to Restore is drawn from its official website and policy papers. Suggestions are marked as proposals; facts are sourced with numbered references [n] to the list in Section 10, and analytical judgements and estimates are labelled as such.

Executive summary

Bottom line. Britain loves the NHS, and Britain is waiting. At the end of September 2026 there were 7.4 million waits for planned hospital treatment in England, involving about 6.2 million people, and only 65.8% had been waiting less than the 18 weeks the NHS promises [1]. In parts of Britain the longest wait for a new knee has passed five years, and for a new hip it is close behind [2]. Meanwhile British-trained nurses cannot find first jobs [3], and 2.68 million people are economically inactive through long-term sickness [4]. This paper sets out a plan to fix the system, not just to fund it.

It builds on Restore Britain's principles: the NHS 'will always remain free at the point of need for citizens', emergency care stays free for all, and private health costs become tax deductible [5]. It then goes further, in nine proposals (P40–P48) numbered on from A Policy on the Policies [6]:

- **Free when it matters.** An NHS Core, free for every citizen: emergency and catastrophic care, cancer, GPs and pharmacy, long-term conditions, mental health, maternity and all children.
- **No more endless waits.** The 18-week standard becomes a legal maximum. After 126 days, the money follows the patient to any approved provider at the NHS price.
- **Fast when you choose.** Optional British Fast-Track Cover for operations, as a top-up, never a replacement, at an indicative SovereignOS™ estimate of about £30–35 a month, subject to actuarial review. Self-pay prices published for every common operation.

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- **British-trained throughout.** A first post for every British graduate, Learning & Earning routes from healthcare assistant to nurse and doctor, and overseas recruitment tapered as British supply rises. Removing people with no right to remain is Restore's fair-rules policy; it is not presented here as a source of NHS jobs.
- **Healthy at the base.** Prevention through In Them, On Them, and Around Them, linked to Rooted in British Soil; Pharmacy First; Back to Work, Back to Health; a Live Waits Dashboard; and British Medicines and Discovery, so the NHS becomes a source of national wealth as well as a cost.

What this means for you

If you are ill or injured: the NHS Core is free, for every citizen, at the point of need. Nothing in this paper charges a British patient for emergency care, cancer, a GP, a long-term condition, mental health care, having a baby or treating a child.
If you are waiting for an operation: you get a legal maximum of 18 weeks. If the NHS cannot treat you in time, you choose another approved hospital, NHS or private, and the NHS pays.
If you want to be seen faster: you can choose British Fast-Track Cover, with no insurance premium tax, at an indicative £30–35 a month (our estimate, to be checked by an actuary). You never lose your free NHS place by choosing it.
If you pay for yourself: every private hospital publishes its price for common operations, so you can compare before you book.
If you want a career in health: you can learn while you earn, from healthcare assistant to registered nurse, or have a medical or nursing degree paid for through national service, with a first post at the end.
If you are off work through ill health: fast-track physiotherapy and mental health care to help you back, paid for from the welfare savings when you return.
You will be able to see it working: every hospital's waits, live and public, on the Live Waits Dashboard.

1. Where we are

Health is devolved, so most figures here are for England, where the latest data are fullest; Scottish and Welsh figures are noted separately.

Measure	Figure	Date	Source
Waits for planned treatment (England)	7.4m pathways, about 6.2m people; median 12.2 weeks	Sep 2026	NHS England [1]
Within 18 weeks (standard: 92%)	65.8%	Sep 2026	NHS England [1]
Waiting over 52 / 78 / 104 weeks	116,353 / 2,015 / 314	Sep 2026	NHS England [1]
Longest hip / knee wait, NHS Highland	1,786 / 1,868 days (medians 104 / 90 days)	2024/25	FOI data via Inverness Courier [2]
A&E attendances; seen within 4 hours	28.0m; 74.9%	2025-26	NHS England Digital [7]
GP appointments in the month; same day	35.1m; 45.0%	Sep 2026	NHS England Digital [8]
UK healthcare spending	£345bn, 11.4% of GDP; 81% government-financed	2025	ONS [9]
NHS England total revenue resource limit (of which revenue DEL excluding depreciation)	£215.4bn (£205.2bn)	2026-27	DHSC [10]
Economically inactive through long-term sickness (UK)	2.681m	Jul–Sep 2026	ONS [4]
People with private medical cover (UK)	4.92m, about 7% of the population	2025	LaingBuisson [11]

Table 1. The NHS in figures. 'Pathways' count waits, not people: one person can be waiting for more than one treatment.

Are there really four-year waits? Not typically in England, where 314 people had waited more than two years in September 2026 [1]. But they exist elsewhere in Britain: the longest knee wait in NHS Highland in 2024/25 was 1,868 days, more than five years [2], and very long

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orthopaedic waits in Wales were rising again in 2026 [12]. The honest headline is this: waits of up to five years in parts of Britain, and more than 116,000 people in England waiting over a year.

Money alone has not fixed this. NHS England's core revenue budget (revenue spending excluding depreciation) grew from £158.5bn in 2022-23 to £205.2bn in 2026-27 [10], yet only about two thirds of those waiting have been waiting less than the 18-week standard [1]. Restore makes a similar point, arguing that the NHS's failure 'has nothing whatsoever to do with spending levels' [5]. The system needs a guarantee, a workforce, and a reason to keep people well.

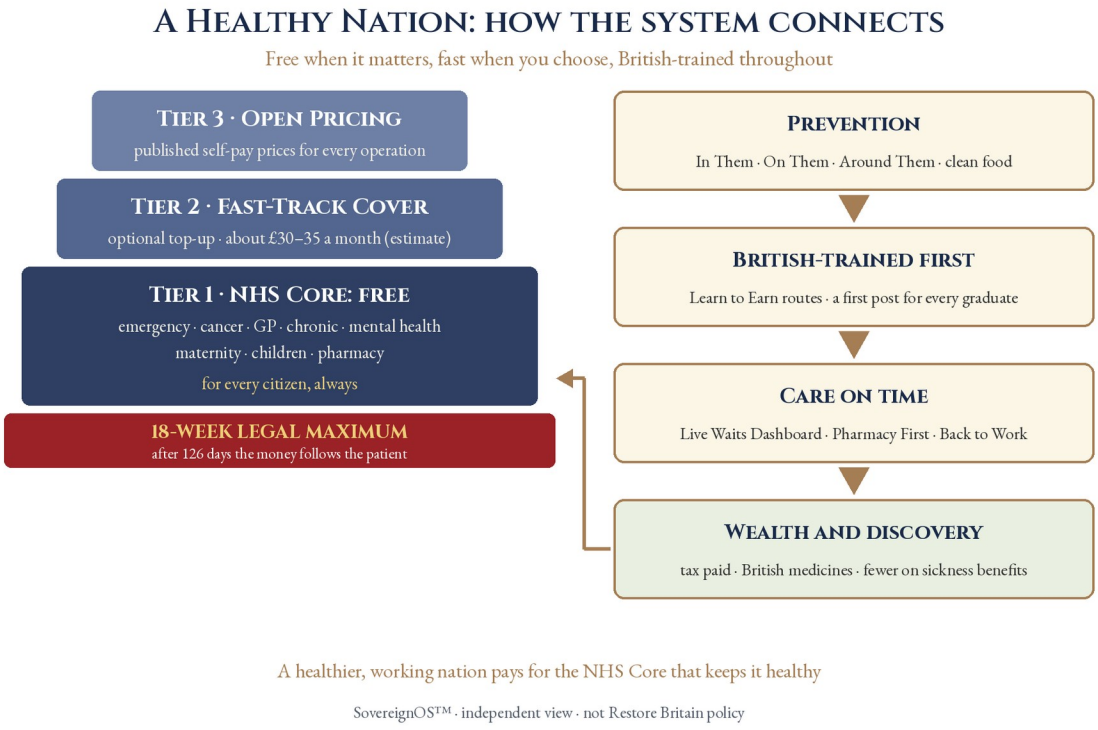


Diagram 1. A Healthy Nation as one system. The free NHS Core is the base, protected by an 18-week legal maximum, with optional Fast-Track Cover and Open Pricing above it. Prevention, a British-trained workforce and care on time produce a healthier, working nation whose taxes and discoveries fund the NHS Core.

2. What Restore Britain proposes

Restore Britain has said it 'will announce more detailed plans concerning healthcare in due course' [5]. Its published position is already clear in principle, and this paper builds on it:

Source	Restore's position (its words or a close summary)
Objectives: Restore the National Health Service [13]	'Restore the NHS as a NATIONAL health service. The NHS must serve the British people as its first and only priority.' Ultra-high-skilled migrants welcome; not millions of low-skilled migrants. Free car parking for NHS staff, patients and visitors. 'Medical school caps will be demolished', and the NHS will employ British graduates over foreign staff.

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Source	Restore's position (its words or a close summary)
The Wealth of Our Nation, Healthcare (3 Aug 2026) [5]	The NHS 'will always remain free at the point of need for citizens'. Non-British nationals charged at point of use with a market-rate tariff. 'Emergency care will remain free at the point of use for those in need.' Private health costs tax deductible at the marginal rate of income tax. Restore estimates these measures will 'save/raise around £20 billion per annum with maternity benefitting in particular'. Health is exempt from its three-year budget freeze, and it would abolish insurance premium tax.
Putting Britain's Veterans First [14]	A Veterans Health Guarantee: free NHS care for qualifying veterans without prescription or dental charges, private dentistry fees covered where NHS provision is unavailable, and free eye and hearing tests.
Civil liberties and pandemic accountability [15][16]	An independent inquiry into COVID-19 vaccines, faster and larger vaccine damage payments, and a public reckoning with the handling of the pandemic.

Table 2. Restore Britain's published health position, from its own website and papers.

Restore's principles already contain the skeleton of a three-tier system: emergency care free for all, care free at the point of need for citizens, and private care made tax deductible. Abolishing insurance premium tax, currently 12% on medical insurance [17], would cut the price of every policy. We give Restore full credit for these foundations.

Where we see even greater opportunity. We think Restore should give further consideration to a legally enforceable maximum wait, with the money following the patient, because tax relief helps those who can already afford private care while 6.2 million people on NHS lists need a guarantee [1], and thus we see even greater opportunity: a promise every voter can hold the NHS to.

Where we see even greater opportunity. We think Restore should give further consideration to matching 'demolish the medical school caps' with funded training posts and first jobs, because British graduates already face 1.86 applicants per specialty training post [18] and newly qualified nurses are shut out of many entry-level jobs [3], and thus we see even greater opportunity: British-trained staff who are hired, not just trained.

Where we see even greater opportunity. We think Restore should give further consideration to publishing a costing of marginal-rate tax relief, because the Department of Health estimated that a narrower 20% relief on private medical insurance would cost £1.7bn a year [17], and a published costing would make Restore's £20bn estimate easier to defend, and thus we see even greater opportunity.

Where we see even greater opportunity. We think Restore should give further consideration to prevention, social care and life sciences inside its health plan, because obesity alone costs the NHS £11.4bn a year [19] and Britain's research base is among the strongest in the world [20], and thus we see even greater opportunity: health as a source of national wealth, not only a cost.

3. The three tiers

Stuart M. Williams proposed a three-tier system: free care for emergencies and catastrophic illness, affordable insurance for operations so that no one is left on a years-long list, and full private pay. We tested it against the numbers and against other countries. The design below keeps its strengths and closes its gaps (proposal P40).

3.1 Tier 1: the NHS Core, free for every citizen

Most people meet the NHS through care that is neither an emergency nor an operation: a GP visit, a diabetes check, a mental health appointment, a pregnancy, a child's asthma. In September 2026 alone there were 35.1 million GP appointments in England [8], and mental health spending is planned at £14.0bn in 2026-27 [21]. So the NHS Core covers all of it, free at the point of need for every citizen, as Restore promises [5]:

- **Emergency and catastrophic care,** including A&E, ambulances, intensive care, trauma, stroke, heart attack and cancer.
- **GP and pharmacy** as the front door, with Pharmacy First (P46).
- **Long-term conditions,** such as diabetes, heart failure, COPD and arthritis, and their medicines.

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- **Mental health,** from talking therapies to crisis care.
- **Maternity and every child under 18.**

This is the bulk of NHS spending. In the latest published cost split (England, 2022/23), unplanned (non-elective) inpatient care cost more than £22bn plus £4.5bn of short stays, against about £7bn for planned inpatient care and £6.7bn for day cases [22]. Emergency and unplanned care cost roughly twice as much as planned operations. That is why the Core must stay public and free.

3.2 Tier 2: British Fast-Track Cover, optional and on top

Tier 2 does not replace free NHS operations. Every citizen keeps a free NHS place and the 18-week legal maximum. Fast-Track Cover is for people who want to be treated sooner, or to choose their surgeon and date. It would be a single, regulated national product, priced on community rating in broad age bands, with no insurance premium tax (Restore's policy), eligible for employer salary sacrifice and for tax relief under Restore's principle, with the cost published. It could not use NHS emergency capacity.

What would it cost? (indicative SovereignOS™ estimate, subject to actuarial review.) No official figure exists for the full cost of NHS operations, so we built one from published numbers. Planned inpatient care (about £7.0bn) and day cases (£6.7bn) cost about £13.7bn in England in 2022/23 [22]. NHS England's core revenue budget grew by a factor of about 1.29 between 2022-23 and 2026-27 (£158.5bn to £205.2bn) [10]; assuming operations grew in line gives about £18bn. Spread over England's 58.8 million people [23], that is about £300 per person a year, or £25 a month. Adding 20% to 40% for administration, margin and a prudent buffer gives **roughly £30–35 a month (£360–420 a year) per person, if everyone is in one pooled national product.** This is our own estimate, not an official or actuarial figure, and it covers procedures only; consultations, diagnostics and follow-up stay with the NHS. Abolishing insurance premium tax would take about £3–4 a month off a £35 premium.

For comparison, the average private medical insurance premium was £1,582 per subscriber in 2025, and £2,608 for individually bought policies, whose holders tend to be older [11]. Self-paying for a hip replacement costs £13,199 to £17,280 depending on the provider [24].

The risk is adverse selection: if only older people join, the price rises towards today's individual premiums. Australia solves this with incentives to join young. A 1% to 1.5% Medicare levy surcharge applies to higher earners without hospital cover [25], and Lifetime Health Cover adds 2% to the premium for each year a person delays joining after 30, up to 70% [26]. 45.8% of Australians hold hospital cover [27]. We propose the same: join before 31 to avoid a loading.

3.3 Tier 3: Open Pricing

Full private pay already exists in Britain. Tier 3 means transparent, published prices, not American-style billing. Every private hospital would publish package prices for common operations, and what they exclude, building on the work of PHIN [28].

Operation (self-pay)	Price range by provider (Oct 2026) [24]	Average package price by city [28]
Hip replacement	£13,199 – £17,280	£13,847 – £17,540
Knee replacement	£13,799 – £17,082	£14,341 – £18,236
Cataract surgery (one eye)	£2,065 – £4,060	£2,522 – £3,417
Hernia repair	£3,449 – £5,190	–
MRI scan	£350 – £590	–

Table 3. What common operations cost to self-pay in the UK. Prices vary by provider and city and change often; they are a guide, not quotes.

3.4 What other countries teach us

Country	How it works	Key figure	Lesson
Australia	Free public hospitals plus optional private hospital cover	45.8% hold hospital cover (June 2026) [27]; levy surcharge 1–1.5% [25]	The closest model: a top-up beside free care, with incentives to join young

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Country	How it works	Key figure	Lesson
Denmark	Tax-funded, with a waiting-time right	After 30 days, treatment at an approved private hospital at public expense [29]	A guarantee, not a premium, is the strongest promise
Sweden	Tax-funded care guarantee	Treatment within 90 days of a decision to treat [30]	Guarantees work when someone pays when they are missed
Singapore	MediSave accounts, MediShield Life catastrophic cover	MediSave 8–10.5% of wages by age (2026) [31]	Personal health accounts build ownership
Netherlands	Compulsory, regulated basic insurance	Average premium about €1,884 a year; €385 excess (2026) [32]	Universal and regulated works; children covered free
Ireland	Public system with optional private insurance	About 46% insured (Q2 2026) [33]	Keep private capacity separate from emergency beds
United States	Mixed employer, private and public	18.4% of GDP on health (2025 projection) [34]; 26.7m uninsured all year (2025) [35]	Not a model. Open Pricing must never mean US pricing

Table 4. International comparison. Figures as published by each country's official bodies; currencies not converted.

Tier 2 is not a toll. It is a choice for those who want it, beside a free NHS that is legally bound to treat everyone within 18 weeks. That answers the 'privatising the NHS' line before it is spoken: nothing a British patient gets free today becomes a paid service under this paper.

4. No more endless waits

The NHS constitution already sets an 18-week standard from referral to treatment, with a 92% target [1]. It has not been met for years. P41 turns it into a legal maximum: if the NHS cannot treat a patient within 126 days, the patient may choose any approved provider, NHS or independent, and the NHS pays at the national tariff. Denmark has run a 30-day version for years [29]; Sweden guarantees 90 days [30].

Paying at NHS prices means the guarantee does not pay private providers more than the NHS would have spent. It does mean more treatment, and so more spending, while the backlog clears; this cost has not been estimated and should be (Section 9). The guarantee would start with the longest waiters and widen as capacity grows.

P44, the Live Waits Dashboard, makes the guarantee visible. Every hospital's current waits for every common operation, its outcomes and its spending would be published live on the national dashboard proposed in A Policy on the Policies (P31) [6]. Patients choose; hospitals compete on time and results; voters see whether the promise is kept.

Where we see even greater opportunity. We think Restore should give further consideration to its own principle of decentralised decisions and rewards for value [5] as the engine of the guarantee, because money that follows the patient rewards the hospitals that treat people fastest, and thus we see even greater opportunity.

5. British-trained first

Britain trains excellent doctors and nurses and then struggles to employ them. At the same time it has relied heavily on staff recruited from overseas. The figures:

Measure	Figure	Source
NHS staff with non-British nationality (England, June 2025)	About 325,000 of 1.5m (21%); 36% of doctors, 30% of nurses	House of Commons Library [36]
Licensed doctors who qualified abroad	138,405, 42% of the total	GMC [37]
Specialty training applications, 2026	39,387 applicants for 10,682 posts; 1.86 per post for the UK priority group	NHS England [18]
Medical Training (Prioritisation) Act 2026	Priority applicants filled 98% of posts (72% in 2025)	NHS England [38]
Medical school places (England)	7,571 fundable places (7,115 home), unchanged for 2026-27	Office for Students [39]

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Measure	Figure	Source
New nurses joining the register educated abroad	26.4% in 2025-26 (49.4% in 2023-24); UK-educated joiners down 4.9% to 30,581	NMC [40]
Entry-level nursing jobs	33% of Band 5 adverts required experience; only 26% were full-time, permanent and open to new graduates (Jul 2026)	RCN [3]
Health and Care Worker visas	34,143 in the year to June 2026 (down 45%); care-worker visas down 99% since 2023	Home Office [41]
Doctors leaving UK practice	4,880 doctors who qualified abroad left in 2024 (up 26%)	GMC [37]

Table 5. The health workforce. Overseas NHS staff are lawful workers: visa holders, settled residents or British citizens.

What the evidence supports. The blockage for British-trained staff is real, and its causes are the number of training posts, funded entry-level jobs and past reliance on overseas recruitment. The 2026 prioritisation law shows the lever works: 98% of specialty posts went to priority applicants [38]. Overseas recruitment is already falling sharply [41], and the GMC reports that only 8% of 2025 PLAB licensees found NHS work within six months [42].

What it does not support. There is no published evidence that people with no right to remain hold NHS posts in any material number; NHS employers check the right to work. Removing people with no right to remain is Restore Britain's policy and is right as a matter of fair rules, but this paper does not present it as a source of NHS jobs. Where enforcement does connect is in the wider labour market: sponsor-licence revocations doubled to 1,948 in the year to June 2025, with adult social care among the sectors of highest abuse [43]. Fair rules protect wages and keep the system honest.

P42, the British-Trained First Compact, sets training and first-post numbers to the nation's need, extends prioritisation from doctors to nursing, midwifery and allied health first posts, and tapers overseas recruitment as British supply rises. It changes nothing for any lawful worker already here, who will be treated fairly. Our wording: 'We will train enough doctors, nurses and carers at home, give every British graduate a first post, and taper overseas recruitment as British supply rises.'

5.1 Learning & Earning health routes (P43)

Learning & Earning, the SovereignOS™ design note for the Build Britain Service (P26), already includes care apprenticeships and a university route for nursing, medicine and allied health [44]. Under Route U, each year of national service earns a year of tuition credit (£9,790 a year at the 2026/27 cap), and medicine, nursing, engineering and teaching places can carry an extra year of credit. The credit converts to a loan for anyone who emigrates within five years of graduating [44]. P43 applies this to health:

- **Healthcare assistant to registered nurse.** Paid apprenticeships from Band 2 to registered nurse, with a guaranteed first post.
- **Service-funded medical and nursing degrees,** with a five-year NHS tie-in, in line with the existing five-year rule.
- **Medical school places raised** above today's 7,571 [39] only together with the training posts to match, so no graduate is left without a route.

The return is large. Learning & Earning estimates that a 40-year NHS hospital career pays about £2.5m in income tax and National Insurance (its estimate) [44]. Every British-trained clinician who stays is an investment in British economic vibrancy. As Build Britain Service rules already state, no route in the programme may be used to delay or stop any removal.

6. Prevention and the base: In Them, On Them, and Around Them

The cheapest operation is the one that is never needed. Obesity alone costs the NHS an estimated £11.4bn a year [19]. Rooted in British Soil set out In Them, On Them, and Around Them: what is in our children (food and water), what is on them (the fields and parks they play on) and what is around them (the air they breathe) [45]. P45, Prevention Starts on the Plate, brings it into health policy:

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- **In them.** Clean, labelled British food in schools and hospitals, linked to P38 Clean Food and Clean Childhoods [45]. In 2024, 2.07% of tested UK food samples had a pesticide residue above the legal limit, and 51.26% had none of those tested for [46]: British food is well regulated, and the aim is to make that visible.
- **On them.** Safe places to play and move: school fields, parks and sport as a health service.
- **Around them.** Clean air around schools and homes.
- **Grandparents.** The Grandparent Renaissance in Rooted in British Soil gives grandparents a role in food and children's health [45]. They can also be volunteers in the health system, such as in hospital discharge and community care.

6.1 Pharmacy First, Pharmacy Local (P46)

The local chemist is the cheapest front door to the NHS Core, yet about 1,500 pharmacies have closed since 2017 and some 9.9 million people have lost their local pharmacy [47]. P46 offers a stable contract that keeps local pharmacies open and widens what they can treat, taking pressure off GPs.

6.2 Back to Work, Back to Health (P48)

2.68 million people are economically inactive through long-term sickness [4]. Many are waiting for musculoskeletal or mental health treatment. P48 fast-tracks that care for people who want to return to work, paid for from the welfare savings when they do. It links to the Build Britain Service's strand for people leaving welfare [44].

7. British Medicines and Discovery

Britain is one of the world's great places for medical discovery. UK Biobank holds genetic and health data on 500,000 volunteers [20]. But investment has been volatile: in September 2025 MSD scrapped a planned £1bn London research centre and AstraZeneca paused a £200m Cambridge investment, part of nearly £2bn of paused investment that year [48]. The government has since cut the VPAG medicines rebate from 22.9% to 14.5% for 2026 [49], and NICE's cost-effectiveness threshold rose to £25,000–£35,000 per quality-adjusted life year from April 2026 [50].

P47, British Medicines and Discovery, would:

- **Fix the price rules for a decade,** so firms can plan investment in British laboratories and factories.
- **Make trials fast,** with NHS patients able to join trials close to home.
- **Open British data safely,** building on UK Biobank, with consent and privacy protected.
- **Own a share of the upside,** through stakes in British discovery held by the British Sovereign Wealth Fund (P27) and financed by Build Britain Bonds (P28) [6].

Where we see even greater opportunity. We think Restore should give further consideration to life sciences as part of its economic philosophy, because a stable medicines market brings investment, skilled jobs and new treatments to Britain at once, and thus we see even greater opportunity: the NHS as a source of national wealth.

8. Proposals P40–P48

Numbered on from A Policy on the Policies (P1–P34) and Rooted in British Soil (P35–P39). Each is a PROPOSAL, not Restore Britain policy, and none has been costed in detail.

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#	Proposal	What it does	Builds on
P40	Three-Tier Health Guarantee	Tier 1 NHS Core free for every citizen (emergency, catastrophic, cancer, GP, pharmacy, chronic, mental health, maternity, children); Tier 2 British Fast-Track Cover (optional, pooled, community-rated, no IPT, salary sacrifice, join-young incentive); Tier 3 Open Pricing. A personal health account is a longer-term option	Restore's free-at-need, emergency and tax-deductibility principles
P41	No More Endless Waits	18 weeks (126 days) as a legal maximum; then the money follows the patient to any approved provider at NHS tariff	Restore's decentralisation and value principles
P42	British-Trained First Compact	Training and first posts set to need; prioritisation extended to nursing and allied health; overseas recruitment tapered as British supply rises; fair treatment for lawful staff	Restore's 'NHS will employ them' objective; fair-rules policy
P43	Learn to Earn Health Routes	Healthcare assistant to nurse apprenticeships; service-funded medical and nursing places with a five-year tie-in	P26 Build Britain Service; P24; five-year rule
P44	Live Waits Dashboard	Live waits, outcomes and spending for every hospital, public	P31 national dashboard
P45	Prevention Starts on the Plate	In Them, On Them, and Around Them for health; clean food in schools and hospitals; grandparent volunteers	P38 Clean Food and Clean Childhoods; P37
P46	Pharmacy First, Pharmacy Local	A stable contract to keep local pharmacies open and widen what they treat	Tier 1 front door (P40)
P47	British Medicines and Discovery	Stable pricing, fast trials, safe data access, and national stakes in discovery	P27 Sovereign Wealth Fund; P28 Build Britain Bonds
P48	Back to Work, Back to Health	Fast-track musculoskeletal and mental health care for people who want to work, paid from welfare savings	P26 welfare strand; Restore's work-for-benefits policy

Table 6. The nine proposals. All are SovereignOS™ suggestions.

9. Fiscal effect and answers to the attack lines

Item	Direction	Status
Tier 2 premiums (P40)	Paid by those who choose it; reduces NHS demand at the margin	Indicative £30–35 a month (SovereignOS™ estimate, subject to actuarial review)
Tax relief on Tier 2 (Restore principle)	Cost to the Exchequer	Not costed. DHSC estimated 20% relief on all PMI at £1.7bn a year [17]; marginal-rate relief would cost more unless capped
IPT abolition on health cover (Restore)	Cost to the Exchequer	Not costed here
18-week guarantee (P41)	Extra treatment while the backlog clears, paid at NHS tariff	Not costed
Non-citizen tariff and tax relief (Restore)	Savings and revenue	Restore estimates about £20bn a year [5]; not independently checked
Back to Work (P48)	Pays back through tax and lower benefits	Not costed
Training and first posts (P42, P43)	Up-front cost; long-run return	About £2.5m tax per hospital career (Learning & Earning estimate) [44]

Table 7. Honest fiscal summary. Most items need a full costing before publication.

Attack line	Answer
'Privatising the NHS'	Nothing free today becomes paid. The NHS Core is free for every citizen, and the 18-week guarantee covers everyone. Fast-Track Cover is a choice
'Two-tier health'	The guarantee lifts the floor for everyone. The models are Australia and Denmark, not the US
'Only the rich will buy cover'	A single pooled product at an indicative £30–35 a month, salary sacrifice and no IPT; compare £13,199 or more to self-pay a hip [24]
'Staff will leave for private work'	The same British-trained workforce serves both; service-funded places carry a five-year tie-in
'Blaming migrants'	Lawful staff are treated fairly. Removals are about fair rules, not NHS jobs

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10. Sources and caveats

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- The British Fast-Track Cover premium of about £30–35 a month is an indicative SovereignOS™ estimate, subject to actuarial review. It is built from 2022/23 National Cost Collection data scaled by growth in NHS England's core revenue budget, assumes a single community-rated national pool, and covers procedures only. An age-rated or voluntary-only product would cost older buyers much more.
- Health is devolved: waiting, workforce and budget figures are for England unless stated. The NHS Highland figures are FOI data reported by a newspaper, and the Welsh long-wait trend is from a health board committee paper.
- The emergency versus elective cost split is the latest published (2022/23). Self-pay prices change often; international figures are in local currency.
- Restore's £20bn a year is Restore's own estimate. The £1.7bn DHSC estimate of 20% relief on private medical insurance was reported by The Guardian and is not a costing of Restore's marginal-rate relief. The £2.5m career tax figure is an estimate from Learning & Earning.
- There is no published evidence that people with no right to remain hold NHS posts in material numbers; this paper therefore makes no claim that removals create NHS vacancies.
- Proposals P40–P48 and the fiscal and attack-line notes are SovereignOS™ suggestions and analytical judgements, not sourced statistics or Restore Britain policy. None has been costed in detail.

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