# General practice funding in England: a comprehensive overview and implications for policy

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**A Resource for LMCs**

## General practice funding in England: what does the Health Foundation report mean for GPs?

The Health Foundation's 2026 report, *General practice funding in England*, examines how general practice is funded, how funding is distributed between practices, and how this translates into GP income and practice costs.

Its central conclusion is that general practice is being asked to do more, but its share of NHS resources has not kept pace with its role. At the same time, the funding system is complex and does not always reflect workload, deprivation or clinical need.

For GPs, this matters because the funding system itself contributes to considerable variation between practices. Deprivation, rurality, dispensing, practice size, QOF, PCN funding and other payment mechanisms all affect funding, meaning resources do not always follow workload or population need as closely as might be expected.

The report also highlights an important distinction between headline NHS investment and money available to practices. An increase in reported investment does not necessarily translate into an equivalent increase in funding that practices can use flexibly to meet the needs of their patients at a local level.

## General practice is being asked to do more, but its share of NHS resources has fallen

There has been significant additional investment in general practice in recent years. The 2025/26 GP contract represented an £889 million increase across the core practice contract and Network Contract DES, taking their combined value from £12.287 billion

to £13.176 billion. The 2026/27 contract added a further £485 million, taking the contract to £13.863 billion before the DDRB pay uplift. Including the 3.5% DDRB recommendation, the increase is around £601 million and the contract is worth approximately £14 billion.

Including PCN funding, the GP contract is equivalent to around **£219 per registered patient per year**. The report estimates that this is intended to cover around five to six appointments per patient each year, as well as most practice overheads and non-clinical work. This figure represents the breadth of activity that general practice funding must cover, not GP income.

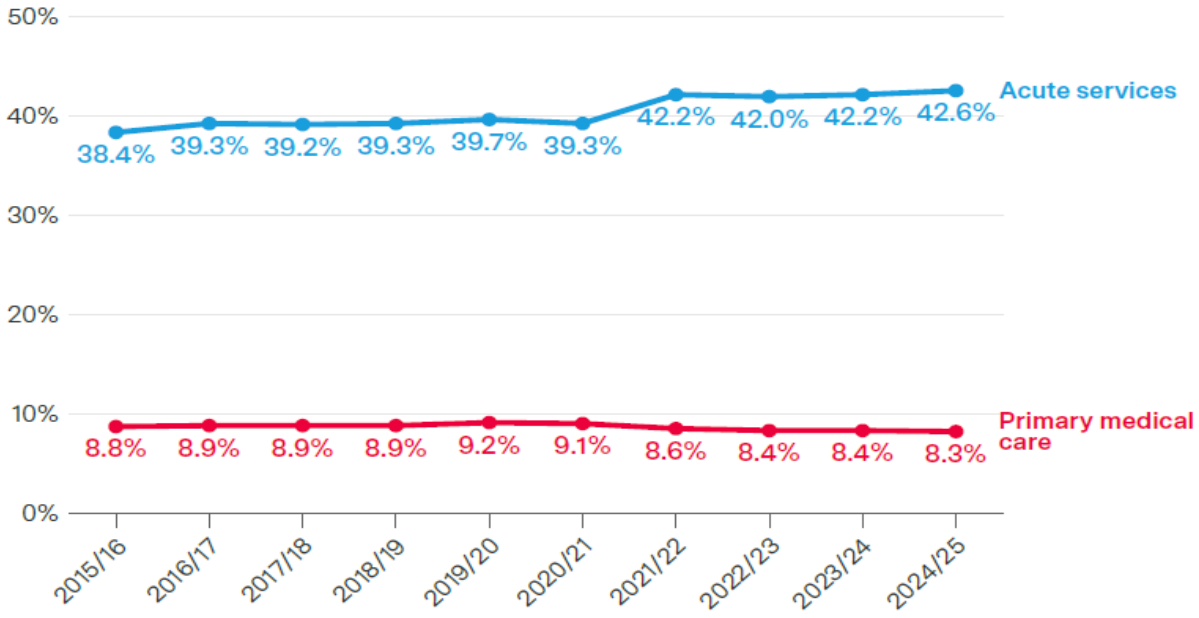
The report compares this annual per-patient resource with the cost of individual hospital episodes: approximately £203 for a consultant outpatient appointment, £272 for an ambulance episode and £280 for an emergency care episode. This illustrates how modest the annual resource attached to a whole year of general practice care is compared with individual episodes elsewhere in the NHS.

Successive governments have committed to shifting care from hospitals into the community. Yet general practice has not gained a larger share of NHS resources.

Between 2015/16 and 2024/25, general practice's share of NHS commissioning expenditure fell from **8.8% to 8.3%**, while acute and hospital services increased from **38.4% to 42.6%**.

**Figure 6: The share of the NHS commissioning budget for England spent on primary medical care reached its lowest in almost a decade in 2024/25**

Percentage of NHS commissioning spend allocated to primary medical care and acute services, from 2015/16 to 2024/25




Source: UK Parliament, written question UIN 117398, 3 Mar 2026. · Includes spend for services commissioned by NHS England and the integrated care boards (ICBs), formerly the clinical commissioning groups (CCGs), using audited figures between 2015/16 and 2024/25.

This is particularly significant given the current policy emphasis on moving care into communities and neighbourhoods. The Health Foundation has separately identified strengthening primary care as central to the Government's three intended shifts: hospital to community, sickness to prevention, and analogue to digital.

## Why is GP funding so difficult to understand?

One of the report's key findings is that there is no single, straightforward figure for GP funding.

Depending on the dataset used, there is a distinction between:

- overall investment attributed to general practice;
- expenditure recorded by NHS commissioners;
- the value of the GP contract;
- payments actually made to practices; and
- funding that passes through PCNs, federations or other organisations.

For example, NHS England investment data showed around £252 per patient in 2022/23, while payments actually made to practices were around £169 per patient in 2024/25. These figures are not directly comparable, but they demonstrate how difficult it is to establish how much money ultimately reaches practices.

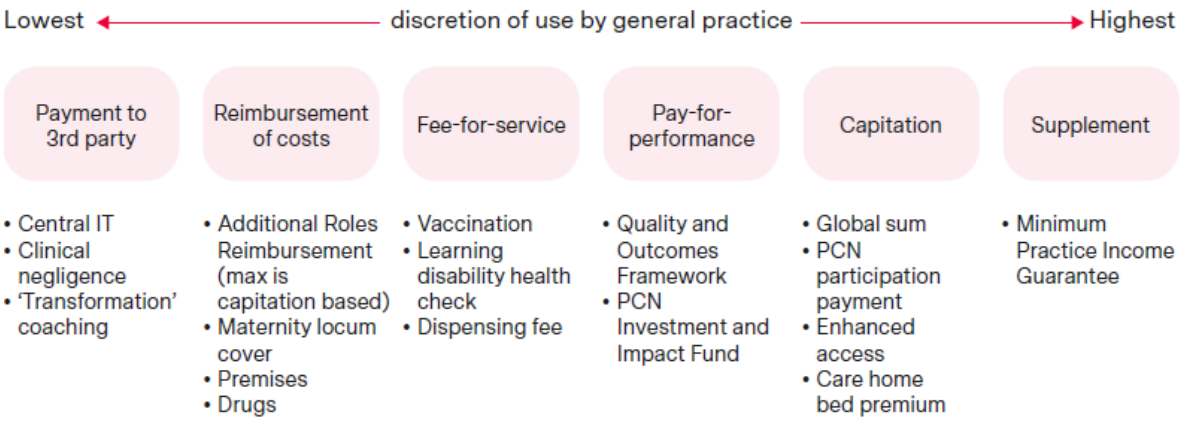
The report is particularly concerned about funding attributed to general practice that does not necessarily reach individual practices**.** PCNs are the clearest example: in 2022/23, around £1.78 billion of reported investment related to PCNs, but only around 41% appeared in practice-level payment data. Much of the remainder was routed through other organisations.

This makes it difficult to determine exactly how much additional resource has reached practices.

## How is general practice funded?

General practice is funded through multiple streams:

**Figure 2: Payment mechanisms with examples**

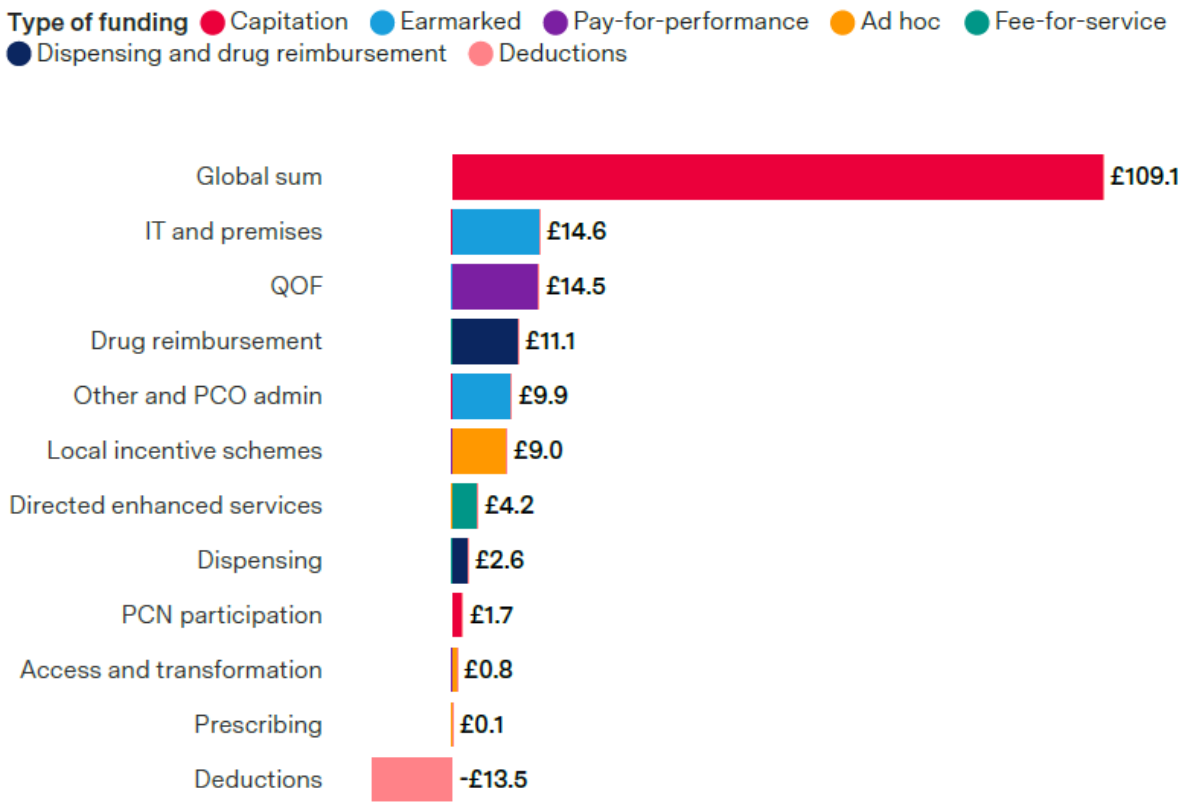



In 2024/25, around three-fifths of payments to practices came from the Global Sum, with the remainder coming from other funding streams.

This fragmentation matters because each funding stream has a different purpose and eligibility criteria. The report therefore argues that policy should not focus solely on Carr-Hill but should consider the whole funding architecture.

**Figure 7: The global sum, on average, represented 61% of payments in 2024/25, with the remainder made up from a mix of sources**

Average payments per registered patient by type of funding, 2024/25




Source: NHS England, NHS Payments to General Practice 2024/25. · Practices below 1,000 registered patients and the top 0.5% and bottom 0.5% of practices by average payment per registered patient were removed. COVID-19 and PCN payments excluded apart from PCN participation payments.

## Carr-Hill: the attempt to pay practices according to need

The Carr-Hill formula adjusts basic capitation according to characteristics of the population served. It takes account of factors including age and sex, morbidity, mortality, expected consultation rates, patient turnover, nursing and residential home patients, rurality and local staffing costs.

In principle, this means practices with populations expected to generate greater workload should receive more funding.

However, the report highlights concerns that some underlying workload data are now old. The formula is also politically difficult to change because redistribution creates winners and losers: practices that lose funding may struggle to absorb a significant reduction, particularly where they have become dependent on the existing income.

The current review of Carr-Hill is therefore significant, but the Health Foundation argues that it should form part of a much wider review of practice funding.

## Carr-Hill and deprivation

Carr-Hill provides additional capitation funding to practices serving more deprived populations. In 2024/25, the most deprived practices received approximately 8.3% more capitation funding per patient than the least deprived.

However, once all funding streams are included, **this position reverses**:

- Least deprived: approximately £171 per weighted patient
- Most deprived: approximately £155.80 per weighted patient

The least deprived practices therefore received approximately 9.8% more overall funding per weighted patient.

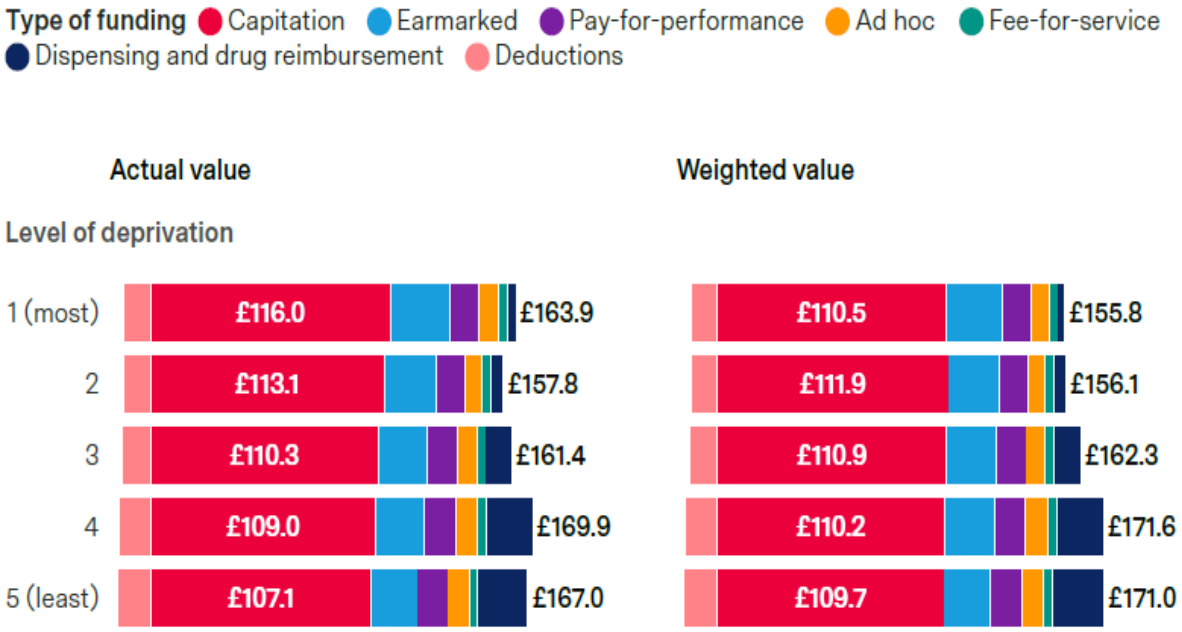
This is not because Carr-Hill deliberately favours affluent areas. Rather, other payment mechanisms can offset or outweigh its deprivation weighting. The report identifies dispensing and drug reimbursement, pay-for-performance and other payments as important contributors.

This has significant implications for health inequalities. A practice serving patients with greater multimorbidity, deprivation, mental health needs, safeguarding needs, unmet need and complex consultations may ultimately have less overall resource per weighted patient than a practice serving a more affluent population.

The report therefore questions whether the funding system is sufficiently aligned with actual need.

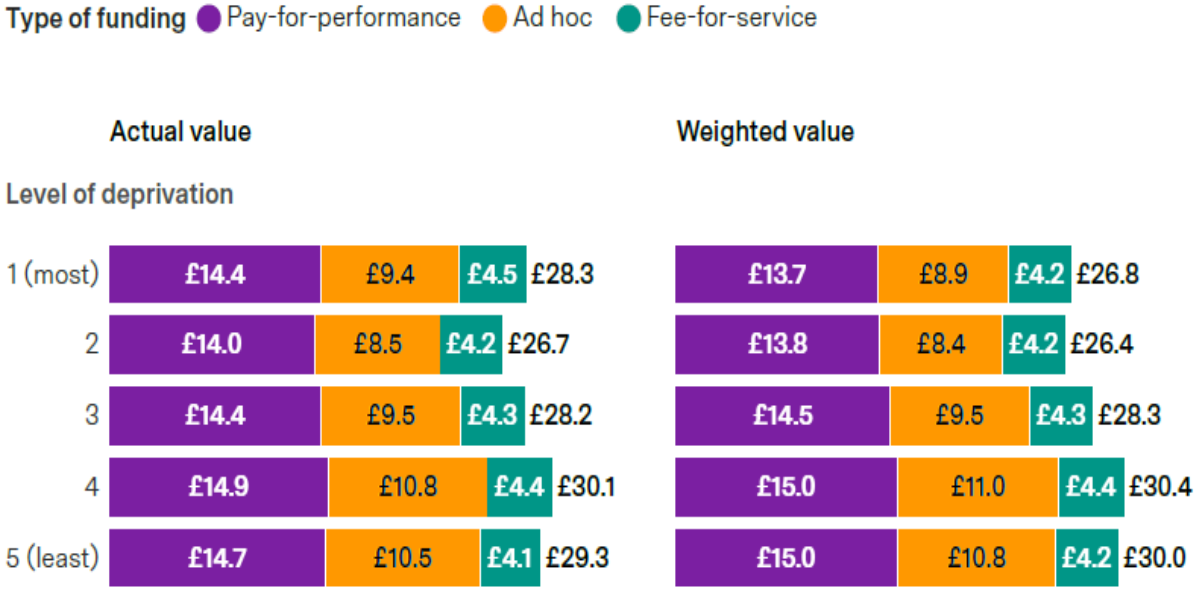
**Figure 9: Dispensing and drug reimbursement payments drive differences in GP funding that favour more affluent practices**

Average payments per registered patient by level of deprivation, 2024/25




**... zooming in, pay-for-performance and ad hoc payments tend to favour more affluent practices**

Average payments per registered patient by level of deprivation, 2024/25




Source: NHS England, NHS Payments to General Practice 2024/25. · Practices below 1,000 registered patients and the top 0.5% and bottom 0.5% of practices by average payment per registered patient were removed. COVID-19 and PCN payments excluded apart from PCN participation payments. Weighted value = total payments made to the practice divided by its weighted list size. The weighted list size is calculated using the Carr-Hill formula and is used to determine the global sum capitation payment. Deprivation is based on practices' Index of Multiple Deprivation quintiles using the LSOAs of their registered patients.

In smaller, often rural dispensing practices, dispensing income may help offset lower GP earnings.

## The structure of general practice has changed dramatically

General practices have become larger, with fewer partners running practices.

Between 2015 and 2025:

- the number of practices fell by around 19%;
- average practice list size increased by around 39%; and
- the average number of GP partners per practice fell to approximately 2.5.

The workforce has also shifted substantially away from partnership. In 2015, around 67% of GPs were partners. By 2025, this had fallen to around 43%, while salaried GPs increased from 29% to approximately 54% of the GP workforce.

## What does this mean for the partnership model?

The report recognises clear advantages to partnership, including:

- professional autonomy;
- flexibility;
- the ability to respond to local circumstances; and
- opportunities for innovation.

However, partnership also brings considerable responsibility and financial risk, including:

- responsibility for practice finances;
- employing staff;
- premises liabilities;
- uncertainty over future income;
- responsibility for losses; and
- increasingly complex organisational management.

The report argues that these responsibilities have become less attractive to some GPs. It also highlights the changing economics of partnership and the difficulty of bringing

new partners into practices where existing partners may already have significant financial interests.

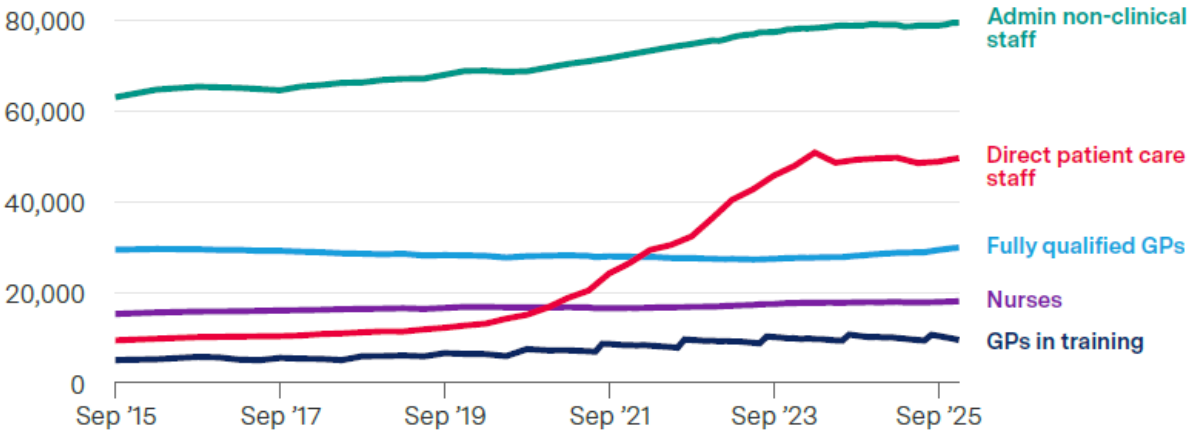
It therefore suggests that alternative models should be carefully tested, rather than assuming the independent contractor model will remain sustainable indefinitely.

## PCNs and the changing workforce

Since 2019, PCNs and the Additional Roles Reimbursement Scheme have supported a substantial expansion of multidisciplinary roles in general practice. The report estimates that the number of direct patient-care roles supported through ARRS has increased nearly five-fold.

**Figure 3: The number of other direct patient care staff increased rapidly from 2019, levelling off in 2024**

Number of full-time equivalent staff working in general practice and primary care networks, Sep 2015–Dec 2025




Source: NHS England, General Practice Workforce; NHS England, Primary Care Network Workforce (from Mar 2020) NHS England, Primary Care Workforce Quarterly Update (from Sep 2021). · 'Direct patient care staff' include roles that deliver patient care but are not a GP or nurse eg pharmacist, physiotherapist, social prescriber.

However, it questions whether this investment has generated additional capacity or has, at least in part, substituted for investment in GP capacity. The report therefore argues that this should be evaluated more carefully.

## Patients per GP have increased

Despite growth in the wider primary care workforce, the number of patients per FTE GP has increased:

**1,938 patients per FTE GP in 2015 → 2,117 in 2026.**

Simply counting the number of GPs employed therefore does not show how much GP capacity is available to patients. FTE numbers are particularly important because many GPs work part-time.

GPs now make up only around a quarter of general practice staff, with the remainder comprising a broad range of clinical, administrative and support roles.

## Practice expenditure has risen substantially

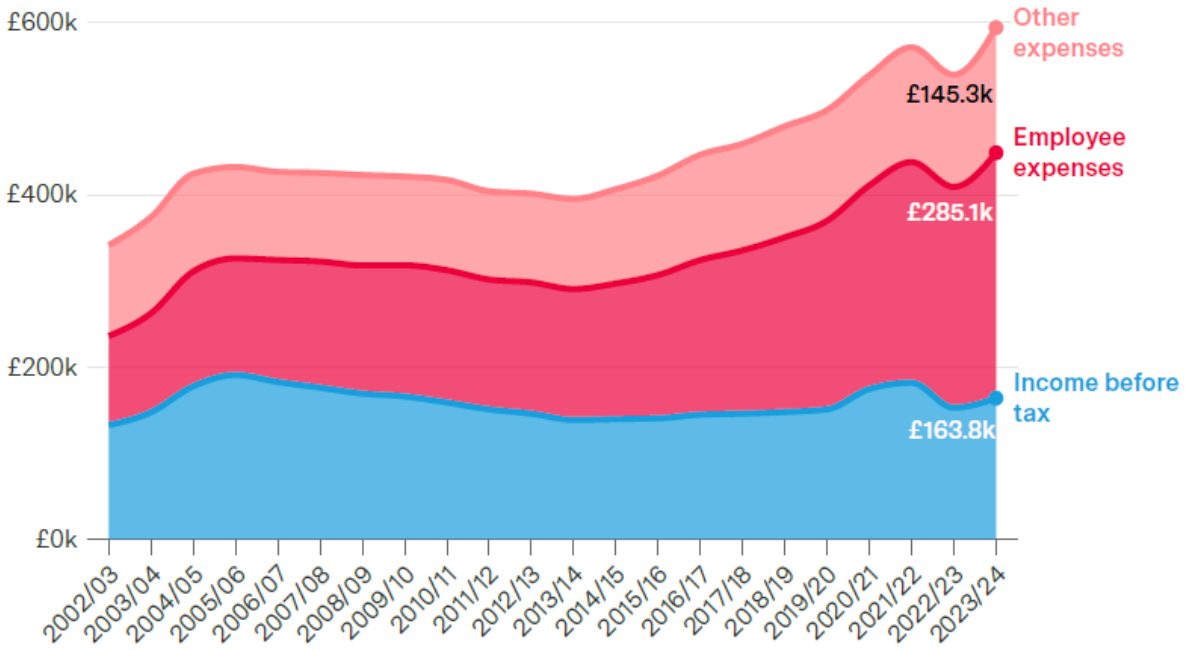
Practice expenses have increased considerably. The ratio of practice expenses to contractor earnings rose from around 1.3:1 in 2005/06 to 2.3:1 in 2023/24.

Employee costs increased from around 50% of practice expenditure in 2002/03 to 66% in 2023/24, reflecting the growth in salaried GPs and other practice staff.

For partners, therefore, higher practice turnover does not necessarily mean higher personal income. A significant proportion may be required to meet staff salaries and employer pension contributions; premises and indemnity costs; IT and equipment; training and utilities; and other overheads.

**Figure 17: GP contractor expenses have risen markedly since 2013/14, largely driven by growing employee expenses**

Estimated GP contractor expenses and income before tax, from 2002/03 to 2023/24 (2024/25 prices)




Source: NHS England, GP Earnings and Expenses Estimates, 2002/03–2023/24; ONS, CPIH deflator (2024/25 prices). · Estimates are based on HMRC Self-Assessment data and include NHS and private GP-related income for full- and part-time contractor GPs, excluding locum-only GPs. Figures show expenses and income before tax, adjusted for inflation. NHS England adjusts estimates to exclude employer pension contributions from contractor GP income values. No expenses breakdown was published for 2005/06, so values were estimated using the average of 2004/05 and 2006/07.

## What about GP pay?

GP contractor income is substantially higher than salaried GP income. In 2023/24, mean contractor income was approximately £163,751 before tax.

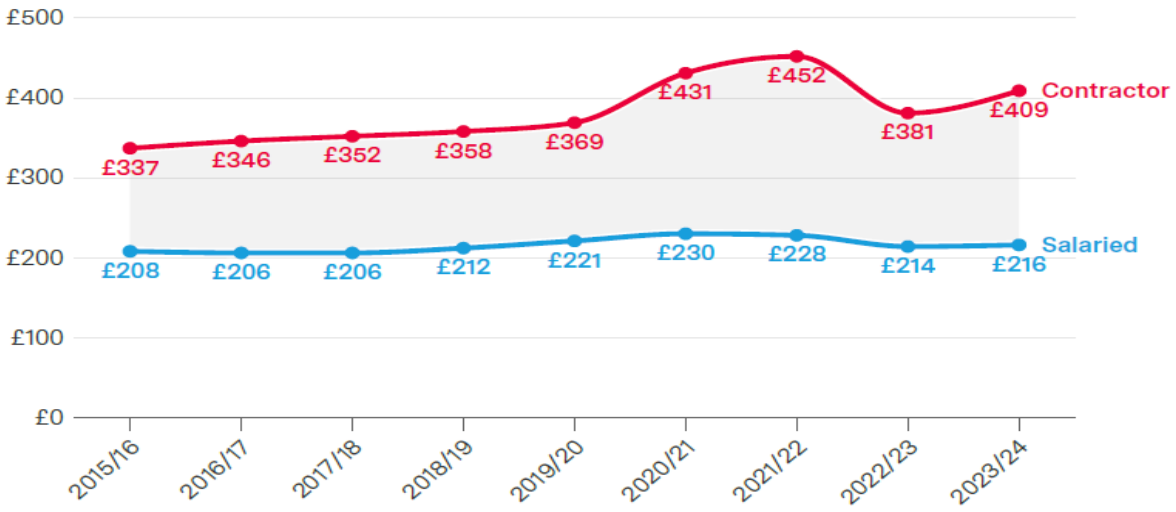
However, the report stresses that contractor income should not be treated as equivalent to a salary. It reflects business risk and responsibility for staff, practice liabilities, premises, capital investment and fluctuations in income. Partners are also not NHS employees.

Practice income and individual GP earnings are therefore not the same thing: a GP partner receives the surplus from running a healthcare business contracted by the NHS.

Nevertheless, after accounting for pension contributions and reported working hours, the report estimates that contractor income is nearly twice salaried GP employment income.

**Figure 15: The difference between contractor and salaried GP income per session has increased over time**

Estimated mean income per session before tax for GP contractors and salaried GPs, from 2015/2016 to 2023/24 (2024/25 prices)




Source: NHS England, GP Earnings and Expenses Estimates, 2015/16–2023/24; NHS England, General Practice Workforce (FTE annual averages); ONS, CPIH deflator (2024/25 prices). · Estimates are based on HMRC Self-Assessment data and include NHS and private GP-related income. Figures show income after expenses and before tax, adjusted for inflation and average reported FTE hours. Salaried GP figures exclude self-employment income. NHS England adjusts estimates for pension contributions to ensure comparability between contractor and salaried GPs. Reported FTE hours may underestimate actual working hours and therefore overestimate income per session.

## Income varies significantly between practices

GP contractor income varies according to where and how a practice operates.

In 2023/24, mean contractor income was approximately:

- **£176,443** in rural dispensing practices;
- **£166,640** in urban dispensing practices;
- **£162,306** in urban non-dispensing practices; and
- **£153,536** in rural non-dispensing practices.

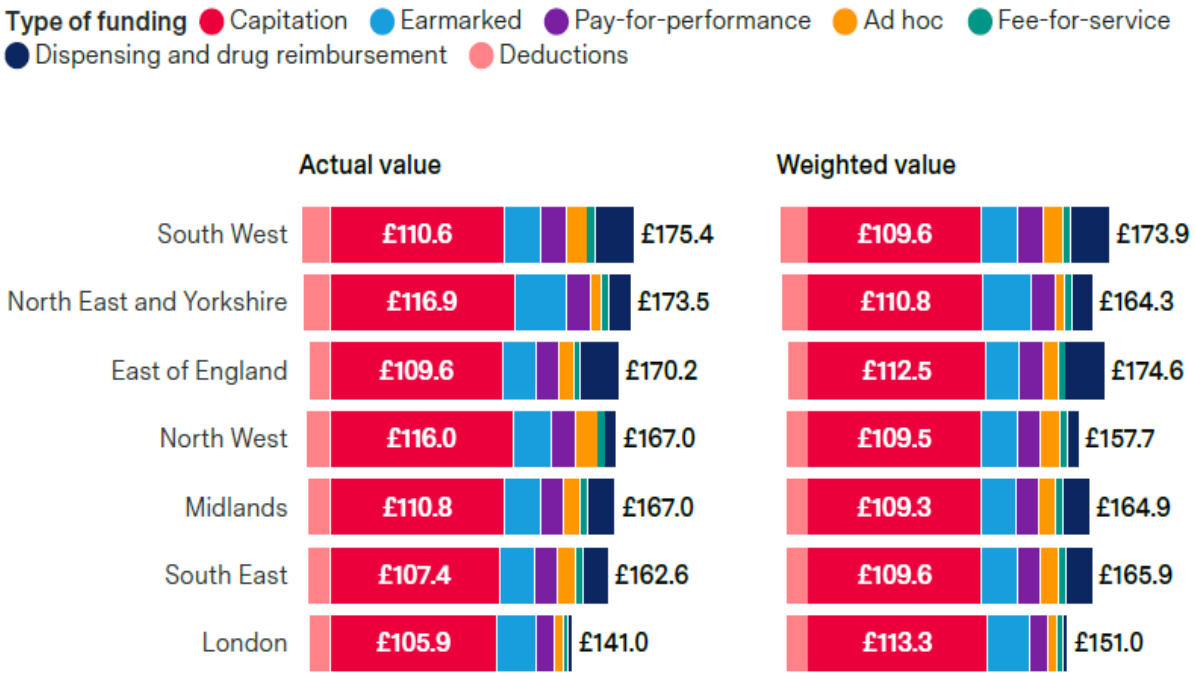
There were also substantial regional differences. Average contractor income was approximately **£190,063 in London**, compared with **£147,861 in the North East and Yorkshire** — a difference of around 29%.

Larger practices generally have higher contractor incomes despite lower payments per patient, suggesting that economies of scale may be important.

London is particularly notable: practices tend to receive relatively low funding per patient, yet London GP contractors have the highest average incomes. Funding alone therefore cannot explain the variation. Practice size, staffing structures, economies of scale, non-NHS income and other factors are likely to contribute, although the available data cannot establish precisely which factors explain the differences.

**Figure 13: Payments per patient vary markedly by region**

Average payments per registered patient by NHS England region, 2024/25




Source: NHS England, NHS Payments to General Practice 2024/25. · Practices below 1,000 registered patients and the top 0.5% and bottom 0.5% of practices by average payment per registered patient were removed. COVID-19 and PCN payments excluded apart from PCN participation payments. Weighted value = total payments made to the practice divided by its weighted list size. The weighted list size is calculated using the Carr-Hill formula and is used to determine the global sum capitation payment.

Salaried GPs now represent more than half of the GP workforce. Their incomes are lower than contractor incomes but more predictable, with less variation between practices and regions.

The report questions whether nationally recommended pay increases are always passed on in full. Practices may receive additional funding for pay but still face difficult decisions about how much can be passed to employees after accounting for wider cost increases.

The report recommends greater transparency around how GP pay awards translate into actual salaries.

GP remuneration and career opportunities also need to remain competitive with other medical careers, particularly hospital consultant posts, if the NHS is to recruit and retain enough GPs.

## There is a gender pay gap

The report identifies a gender pay gap among both GP contractors and salaried GPs, which remains after adjusting for reported working hours.

GP income therefore needs to be considered in the context of:

- gender;
- career stage;
- partnership status;
- working pattern; and
- employment model.

This is particularly relevant as the profession becomes more diverse and portfolio and part-time careers become more common.

## Policy implications

If government genuinely wants to shift care from hospitals into the community, the report argues that general practice needs **more stable funding, a fairer and simpler funding system, and workforce reform**.

It identifies five priorities:

### 1. Set clear investment targets

General practice's share of NHS spending fell from 8.8% in 2015/16 to 8.3% in 2024/25, despite repeated commitments to increase it.

The report recommends a clear, multi-year commitment to increasing general practice's share of NHS spending, potentially through a minimum investment standard requiring its share to rise year on year.

Funding should support workforce recruitment and retention, digital infrastructure and estates. Longer-term GP contracts could reduce uncertainty and encourage practices to invest and employ staff. The report also calls for greater transparency and consistency in measuring and reporting funding reaching general practice.

### 2. Review all funding streams

The issue is not simply the Carr-Hill formula: all funding mechanisms need to be reviewed.

Pay-for-performance and ad hoc payments can favour less deprived practices, while dispensing and drug reimbursement are major drivers of funding differences.

Reform should be gradual, transparent and subject to iterative evaluation. Changes should avoid sudden losses for practices, even if some practices gain more than others.

### 3. Balance new contracts with core general practice

New initiatives and earmarked funding should not come at the expense of the core funding practices need to provide everyday care.

Policymakers also need to decide where additional investment should flow to (individual practices, PCNs and other community-based organisations, or larger integrated providers) and consider the advantages and disadvantages of each approach.

### 4. Close pay gaps

The report highlights substantial differences between contractor and salaried GP income, alongside a gender pay gap. These have implications for fairness, recruitment and retention.

It recommends greater transparency around GP earnings and employment arrangements, stronger mechanisms to ensure salaried GPs receive agreed pay uplifts, and better understanding of why income varies between practice types.

The report also highlights international comparisons: salaried GPs in the UK earn below the OECD average relative to national average wages, while GP contractors earn well above it. Recent public polling found that more than half of the public supports NHS GP income being on a par with NHS hospital consultants.

### 5. Test modifications or alternatives to the partnership model

Falling numbers of GP partners, practice closures and changing preferences among younger GPs raise questions about the sustainability of the traditional partnership model.

The report states that "modifications or alternatives to the partnership model … could be explored and carefully evaluated."

However, wholesale restructuring could create "distraction, additional costs and unintended consequences", so reform should be collaborative and evidence based.

Recent polling found that more than half of the public supports general practices being run as NHS organisations, where no individual makes a profit or is liable for debts and losses, compared with only 6% supporting the current partnership model of unlimited liability and uncapped profits.

The report cautions, however, that the overall cost of a fully salaried model could be higher than the current model and that it may not achieve the desired effects on recruitment, retention or quality of care.

## Conclusion

The report's central message is clear: **general practice is being asked to do more without receiving a sufficiently large or flexible share of NHS resources**.

It describes general practice as "central to the NHS's ability to function" but argues that its funding "has not kept pace with the role policymakers expect it to play."

The problem is not simply the overall level of funding. The complexity of the payment system can create inequities and incentives that do not necessarily support quality or efficient resource allocation. Workforce issues (including differences between contractor and salaried GP pay and gender pay differences) also threaten long-term sustainability.

The report therefore concludes that incremental increases will not be enough. If government is serious about shifting care from hospitals to the community, it needs:

- a clear, multi-year increase in general practice investment;
- reform of how funding is allocated and used;
- action on inequalities and inefficiencies between funding streams;
- greater transparency around GP earnings; and
- incentives aligned with patient need and workforce sustainability.

## GPC Executive Team Comment

"The findings from The Health Foundation's 2026 report reinforce what we have known for some time: General Practice is being asked to do more while its share of NHS resources has not kept pace.

The priority for the government should be more recurrent, flexible funding for frontline practices, not the redistribution of an inadequate funding envelope. Investment in PCNs should supplement GP capacity, and care moved from hospitals into the community must be accompanied by the necessary funding and workforce.

The decline in GP partners should also not be assumed to mean that the partnership model has failed. Before pursuing alternatives, government should properly fund, support and de-risk this model that continues to offer considerable value to the communities they serve."