General practice funding in England

A comprehensive overview and implications for policy

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Contents

Figures

Table

Boxes

Key points

- General practice is the foundation of the NHS, but these foundations are under strain. Although the workforce in general practice has expanded, more people need more care and there are fewer full-time equivalent GPs per patient than a decade ago.
- The challenges facing general practice in England are complex, but funding lies at their core. For the first time, this report brings together multiple national data to provide a comprehensive overview of general practice funding in England. We analyse investment into general practice, how funding is allocated between practices and GP income.
- We find that general practice's share of the NHS budget declined from 8.8% to 8.3% between 2015/16 and 2024/25 – despite repeated policy commitments to increase it. Investment in general practice is modest relative to its role in the NHS: the 2026/27 GP contract commits £219 for a full year of general practice per patient, substantially below the average cost of a single ambulance or emergency care episode.
- Real-terms growth in total investment between 2015/16 and 2024/25 has been largely driven by primary care network funding, accounting changes and funding streams that may have indirectly benefited practices but not translated into direct payments. As a result, payments practices received per patient were lower in 2024/25 than a decade earlier.
- In 2024/25, around three-fifths of payments to GP practices came from the 'Carr-Hill' capitation formula. While the Carr-Hill formula allocates more funding to practices with patients in areas of higher socioeconomic deprivation, and to rural areas, this may not sufficiently reflect the additional health and care needs these areas face.
- The remainder of payments to general practices came from a mix of earmarked, pay-for-performance and fee-for-service payments. Dispensing and drug reimbursement payments associated with dispensing practices (15% of practices) are the main drivers of differences in total payments across practices of different characteristics. Pay-for-performance and other ad hoc payments are higher in practices in less deprived areas. When all payment streams are considered together, total funding tends to be higher in practices serving less deprived populations.
- Substantial variation exists in GP contractor (also known as GP partner) income over time, with peaks related to the 2004 GP contract and the COVID-19 vaccination programme. Marked variation also

exists between GP contractors, with higher income being associated with running a dispensing, larger or London-based practice.

- GP contractors' estimated income before tax is, on average, nearly double that of salaried GPs' employment income after accounting for pension contributions and reported working hours. A gender pay gap exists favouring male GPs, both for contractor and salaried GPs, which persists after adjusting for reported working hours.
- If the government is to shift care into the community and general practice is to play a central role in neighbourhood health services, a clear multi-year commitment is needed to increase general practice's share of NHS spending. This must be accompanied by a review of all general practice payment streams, how they are used and how these align with policy objectives.
- Policymakers and general practices must increase transparency around GP incomes, address pay gaps between GPs, and align incentives and career pathways to support a more sustainable GP workforce. If the GP partnership model is to remain central to general practice, it will need to evolve to better support GP workforce recruitment and retention.
- Our findings draw on the best available national data, but these have limitations. More transparent, timely data on general practice funding are needed to strengthen accountability and support evidence-informed policymaking. This must be coupled with evaluation of any GP funding reform and regular reviews of payment mechanisms – particularly their effects on inequalities, workforce retention and quality of care. This is necessary to ensure limited resources are used to their greatest effect across the NHS and within general practice.

Introduction

General practice is the foundation of the NHS. It acts as the first point of contact for most patients and plays a vital role in managing people's health and coordinating care. Yet general practice is under strain from rising demand for services and persistent workforce pressures.[1,2] The government's ambitions for the NHS in England involve shifting care from hospitals to the community, with an expanded role for primary care and, within this, general practice.[3,4] But there is still little clarity about how this will be funded and existing investment is skewed towards hospitals.

Debate about general practice funding is often characterised by contradictions. General practitioners (GPs) frequently call for greater investment, yet media and political narratives about high GP earnings fuel public scepticism and undermine support for that investment.[5] England has more licensed GPs than ever, but the proportion working in NHS general practice is falling and there are fewer full-time equivalent GPs per patient in the NHS than a decade ago.[6,7,8] Difficulty in getting an appointment in general practice regularly tops the list of public concerns about the NHS but there are reports of GP unemployment and private general practice expanding.[9,10,11] Meanwhile, the inverse care law persists, with more deprived areas having higher relative health needs but more patients per full-time equivalent GP and greater challenges in recruitment and retention.[12,13,14] The causes of these contradictions are complex, but funding lies at their core.

This report analyses general practice funding in England with the aim of informing decisions about how to meaningfully invest in general practice and the policy changes needed to do it. Previous studies have looked at different parts of GP funding – such as total spending or how funds are allocated. Here, for the first time, we bring together a broad range of datasets on general practice funding to provide a more comprehensive picture.

We begin by outlining how general practice is structured and funded, and the way this has changed over the past two decades. We then analyse publicly available data to understand levels of investment going into general practice, how this funding is distributed between general practices, and how this translates into estimated GP earnings and expenses. In the final section we explore the implications for policymakers if they are to deliver on objectives to shift care from hospital to the community and boost investment in general practice.

Structure of general practice

In the UK, general practice has traditionally been delivered through the independent contractor model. This means GP contractors provide NHS primary medical services via a GP contract, while working as self-employed contractors rather than being employed by the NHS.[15] This differs from hospital services, which are largely delivered by NHS trusts through an employed workforce. Box 1 sets out how general practices can be classified and contracted, including by ownership model, contract type, rurality and dispensing status.

Box 1: How general practices are classified and contracted in England

Ownership: Partnerships remain the dominant model of ownership (80%), followed by single-handed practices – operated by an individual GP contractor (11%), incorporated companies (8%) and NHS body ownership (1%).[16] Payments do not typically vary subject to ownership type, although how money is used by the organisation may vary.

Contract type: Practices are generally classified according to their principal contract type, although some provider organisations may hold multiple contracts across different practices or services.[17] There are three principal contract types:

- General Medical Services (GMS): the national standard contract negotiated between NHS England and the BMA GP committee. Around 71% of general practice contracts in 2024/25 were GMS.[18]
- Personal Medical Services (PMS): introduced in 1998, these allow local negotiation of contracts between GPs and their local commissioner (currently integrated care boards). Their use has declined over time.[19] Around 23% of general practice contracts in 2024/25 were PMS.[18]
- Alternative Provider Medical Services (APMS): APMS contracts providers which may not be GP owned and controlled – including private companies, social enterprises and NHS trusts to deliver primary medical care. They are locally commissioned and usually time limited. Around 5% of general practice contracts in 2024/25 were APMS.[18]

Box 1 (continued)

Rurality: In 2024/25, 17% (1,069) of general practices were classed as being in a rural area; the remainder were classed to be in an urban area.[18] Capitation payments to general practice take rurality into account through the global sum, based on the Carr-Hill formula (see Box 2).[20]

Dispensing: Practices may directly dispense medicines to eligible patients living more than 1 mile from a community pharmacy, subject to the practice holding the necessary dispensing approvals.[21] In 2024/25, 15% (940) of practices covering 15% (9.8 million) registered patients in England were dispensing practices. Most of these – 73% (682) – were in rural areas.[18] Dispensing practices receive additional payments through dispensing fees and reimbursement for medicines they dispense, with reimbursement levels determined by national drug tariffs.[22] As a result, they receive substantially higher drug reimbursement payments than non-dispensing practices. Non-dispensing practices also receive some dispensing and drug reimbursement payments, reflecting reimbursement for personally administered items such as vaccines, injections and contraceptive devices.

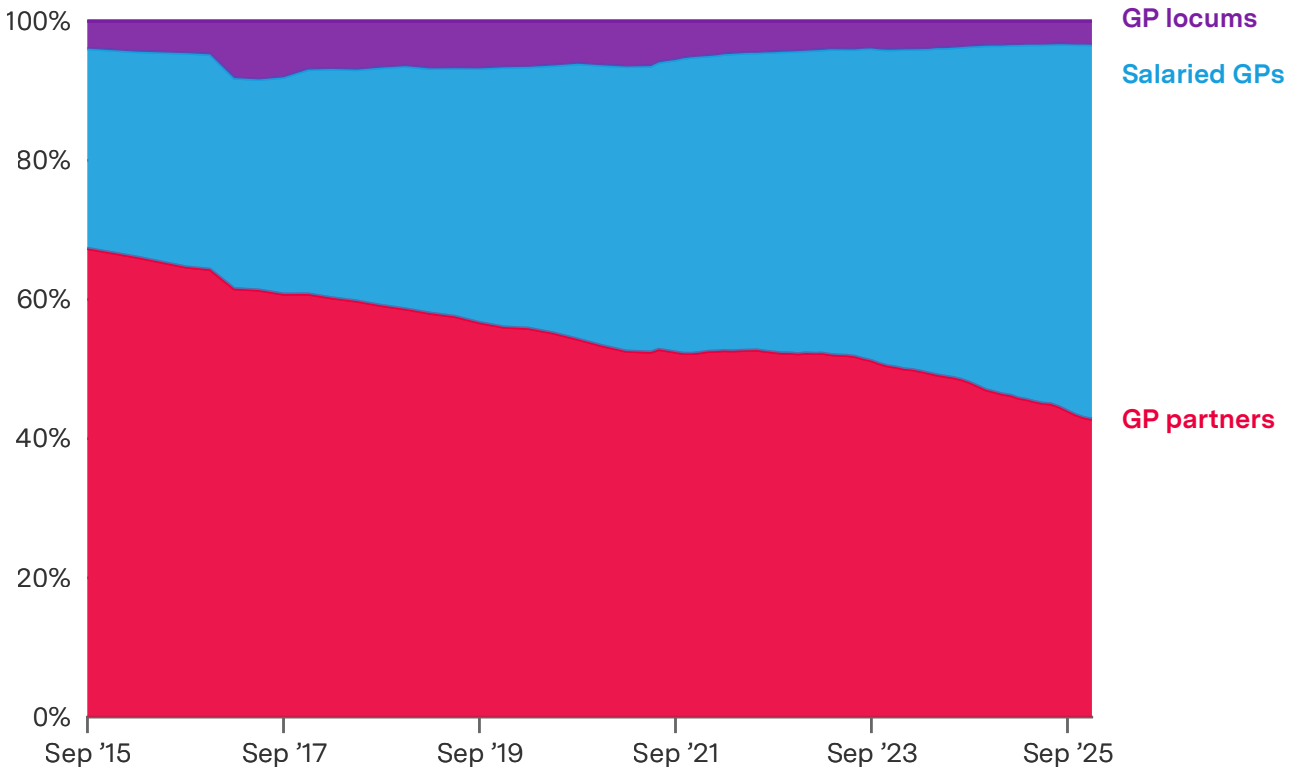
The shift from partner to salaried GPs

Traditionally, GPs have held the GP contract either as individuals or in partnership with other GPs and occasionally with nurses or practice managers.[23] Over the past decade, however, the number and proportion of GPs who are contractors (often referred to as 'partners') has fallen sharply from 24,491 (67%) in September 2015 to 17,974 (43%) in December 2025.[24]

Meanwhile, the number and proportion of salaried GPs – GPs employed by the practice but who do not hold the contract – has doubled over the same period, from 10,441 (29%) to 22,595 (54%) (Figure 1).[24] Overall, there are fewer GPs now than a decade ago after accounting for population growth, with 2,117 registered patients per full-time equivalent GP in March 2026 compared with 1,938 in September 2015[8] (see 'Limitations' section on differences between list sizes and population estimates).

Figure 1: The percentage of GPs who are partners has fallen substantially since 2015, while the percentage in salaried roles has risen

Percentage of GPs in partner, salaried or regular locum roles by headcount, Sep 2015–Dec 2025



Source: NHS England, General Practice Workforce; NHS England, Primary Care Network Workforce (from Dec 2022).
· 'Ad hoc' locums who cover short-term unplanned absences (eg brief illness) are not included due to data collection differences. 'Salaried GPs' include GP retainers.

The shift from partners to salaried GPs has been attributed to younger GPs being unwilling or unable to take on the financial risks of partnership.[25] These risks include unlimited liability and where partners own the premises – while they cannot sell the 'goodwill' of the business – there may be an expectation to buy into ownership of the premises, although owners are then paid 'notional rent' or 'borrowing cost reimbursements' for mortgage costs by NHS England.[26,27,28] However, data on the number of unfilled partnership posts do not exist and the fall in partnership numbers also reflects longer term structural changes brought about by the 2004 GP contract reform, which reduced incentives for GP contractors to take on new partners and dilute profit share.

The 2004 GP contract

The 2004 GP contract reform fundamentally altered the financial model of general practice: it removed the obligation to provide out-of-hours care, allowed more flexibility in determining the services practices provide and shifted payments away from individual GP reimbursements towards practice-level payments.[29] The new contract introduced the global-sum formula (often called 'Carr-Hill') to calculate practice-based, capitated payments based on the registered list size (see Box 2); and the Quality and Outcomes Framework (QOF), a set of pay-for-performance indicators that initially accounted for around 20–25% of practice income.[30,31] The contract also introduced the minimum practice income guarantee (MPIG) supplement, used to protect practices from losing out under new funding arrangements. This has since been phased out.[32]

The 2004 GP contract resulted in a substantial rise in GP contractor income. While this partly reflected GPs' success in achieving quality targets, its value for money was questioned by a National Audit Office (NAO) report and subsequently became an ongoing source of tension in contract negotiations between the government and the BMA GP committee.[33]

The 2004 GP contract resulted in a substantial rise in GP contractor income.

Box 2: The global sum (Carr-Hill) capitation formula

The global sum formula for working out capitated payments to general practice – an amount paid per registered patient per year – was introduced in 2004.[20] It is also referred to as the Carr-Hill formula, after Professor Roy Carr Hill, a health economist and statistician at the University of York who led the research that underpinned its design. The formula adjusts general practice funding to try to account for three factors: (1) anticipated workload, (2) anticipated additional population needs and (3) unavoidable costs. Together these aim to reimburse practices for the services they provide.

Workload: The anticipated workload aspect of the formula considers likely consultation length and need for home visits based on patients' age and sex, and the number of patients in nursing or residential care. List turnover is also adjusted for on the basis that patients in their first year of registration at a practice tend to have more and longer consultations. Data used to design this aspect of the formula used electronic health record data from 240 practices between 1996 and 2002, and GP workload surveys from 1992/93.[20]

Additional population needs: These are adjusted for using area-level measures of morbidity and premature mortality. Morbidity is adjusted for using standardised limited long-standing illness (SLLI) and premature mortality is adjusted for using standardised mortality ratio for those aged younger than 65 years (SMR<65). These are based on health survey data in England between 1998 and 2000 across 2,404 wards in England.

While the Carr-Hill formula does not directly adjust for the socioeconomic deprivation by using the Index of Multiple Deprivation (IMD), the SLLI and SMR<65 do seek to capture illness and premature death, which may be associated with socioeconomic deprivation and therefore additional needs.[20,34]

Box 2 (continued)

Unavoidable costs: The final adjustment for rurality and staff 'market forces' seeks to reflect unavoidable costs that practices will incur associated with geographical variation.[20] The NHS's staff market forces factor (MFF) is calculated using salary data from the private sector.[35] This means that in a location where private sector salaries are higher, corresponding practice payments will also be. While the adjustment only applies to non-general practitioner staff expenses, it is at odds with evidence that it is generally harder to recruit and retain general practice staff in more socioeconomically deprived areas.[12,14] The formula also increases funding for rural practices recognising that they face higher per patient costs (eg smaller list sizes, travel time and fewer economies of scale). In addition, there is an off-formula London adjustment that aimed to mitigate the potentially destabilising effects of the 2004 formula on practices in London when introduced.[20]

Reform attempts: In 2007 a review of the Carr-Hill formula, led by NHS Employers, recommended weighting using the health domain of the IMD and removing adjustments for SMR<65, SLLI and nursing/residential homes.[20] The review also recommended the introduction of an adjustment for the cost of recruitment and retention and an adjustment for 'unavoidable smallness' to take account of the lost economies of scale effects on isolated rural practices that unavoidably have smaller list sizes. For reasons that are unclear, this proposal was not adopted.

In 2016 the Carr-Hill formula was revisited and a new formula was recommended by the Advisory Committee on Resource Allocation (ACRA) with revised age–sex weightings, IMD weighting and an updated workload measure using general practice electronic health records from the Clinical Practice Research Datalink (CPRD).[36,37] This was adopted for primary medical care allocations to clinical commissioning groups (CCGs) and, in 2019, for some PCN allocations. However, it was not adopted for the principal capitation (global sum) payment to general practice. Again, the reasons for this are unclear but likely relate to concerns about destabilising practice incomes if not accompanied by significant additional funding.[38]

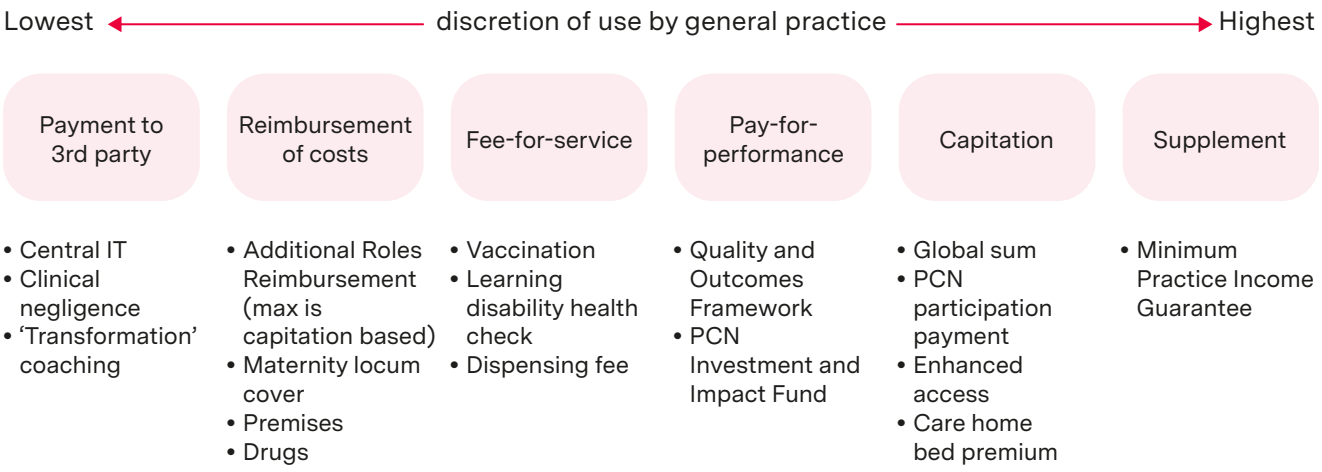
A further review of the Carr-Hill formula was announced in October 2025 with the aim of delivering a 'fairer distribution of funding and address health inequalities'.[39] Findings are expected to be published soon.

Payment mechanisms

England uses a 'blended' funding model, meaning a range of payment mechanisms are used to fund general practice, with the global sum contributing the greatest proportion to practice payments. Different blends of payment mechanisms offer trade-offs between central control and local autonomy, with implications for the ability of policymakers to drive specific activity versus enabling GPs the flexibility to respond to local needs.[40,41]

Payment mechanisms differ in both the activities required to receive funding and the degree of discretion practices have over how that funding is used. As a result, they vary in the extent to which commissioners retain control or delegate decision making to practices. At one end of the spectrum, payments made directly to third parties or as cost reimbursements (eg for IT or premises) offer practices little or no flexibility. Fee-for-service and pay-for-performance payments sit between these extremes, requiring defined activities or outcomes while allowing some discretion over how funds are used. At the other end, capitated payments, such as the global sum, and supplements, such as MPIG, give practices the greatest flexibility to determine how resources are deployed at practice level (Figure 2).

Figure 2: Payment mechanisms with examples



Earnings, expenses and income

After covering operating expenses – such as staff salaries and premises (but not the cost of investigations or drugs, which are largely paid for separately) – GP contractors retain any surplus as income. As a result, if practice-related expenses rise but earnings do not, contractors must find efficiencies, generate additional funded activity or employ salaried GPs at a lower cost or other roles instead of taking on new GP partners to prevent the dilution of income.

Opportunities for economies of scale, financial pressures and policy changes that encourage practices to work at large scale have contributed to a substantial number of practice mergers and closures over the past decade.[42,43] Between September 2015 and December 2025, the number of practices fell by 19% (from 7,623 to 6,174), while the average list size rose by 39% (from 7,465 to 10,349 patients).[24] As a result, practices have become fewer in number but larger in size.[44] A smaller total number of GP contractors are now carrying increased responsibility, alongside potential for higher individual income. In 2024/25, mean total payment per practice was £1.8m, the median was £1.5m and in December 2025, there were on average 2.5 GP partners per practice.[18,24]

Primary care networks

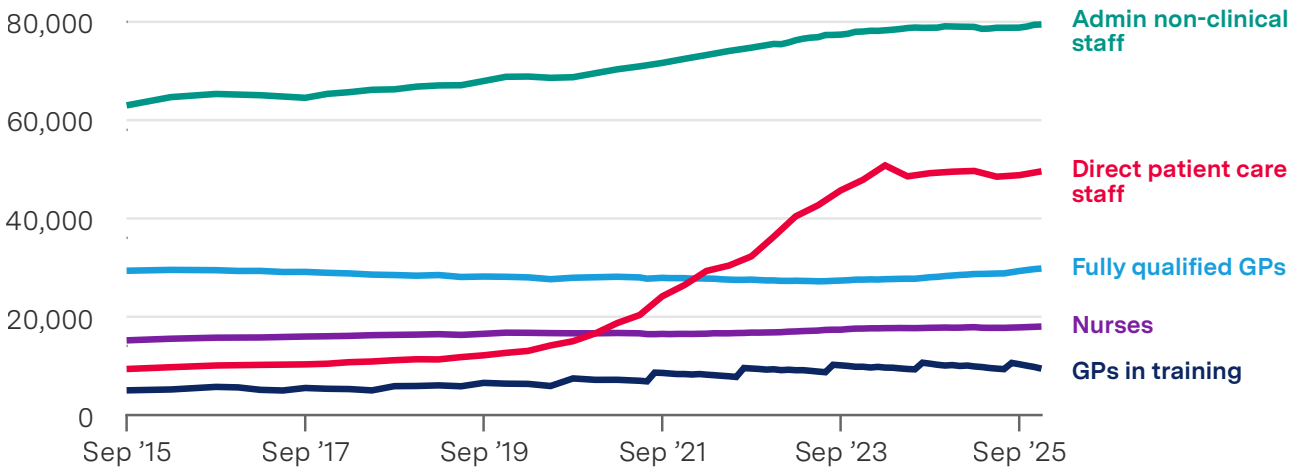
Over the past decade, policymakers have encouraged general practices to work together at greater scale, leading to the emergence of GP federations.[42,43] Federations typically bring together multiple practices to provide services collectively and support workforce development, and in many areas enabled the development of primary care networks. In 2019, a new primary care network (PCN) direct enhanced service (DES) – an optional addition to the main GP contract – was introduced for practices to come together in groups, covering around 50,000 patients, on average, to provide additional services to their local population. Nearly all practices in England signed up to the PCN DES, with substantial variation in the composition and characteristics of the PCNs formed.[45,46] The PCN DES provided funding for general practice through a range of mechanisms, although the majority came through the Additional Roles Reimbursement Scheme (ARRS), which enabled PCNs to recruit pharmacists, physiotherapists, social prescribers and other direct patient care (DPC) roles to work in practices across the PCN.[47]

From October 2024, the programme allowed the recruitment of GPs within 2 years of qualification and nurses, and was extended to all GPs in the 2026/27 GP contract.[48] Since 2019, the proportion of DPC roles in general practice has increased nearly five-fold (Figure 3) and the average number of appointments per patient has increased.[8] However, the proportion of appointments delivered by GPs has fallen, and the job market for GPs has become difficult as practices lack the incentive to use their own income to employ more GPs – and may also lack the physical space to do so.[8,10] The rapid growth of other direct patient care role staff between 2019 and 2024 through ARRS has meant that by December 2025 GPs represented only 16% of the total full-time equivalent NHS general practice workforce, including administrative roles, in England.[8,24,49]

The 2026/27 GP contract has allowed practices to access PCN money at practice level to provide more sessions using salaried GPs.[48] Although concerns about the sustainability of this funding have been raised by GPs, the government has said it is committed to continuing to fund the reimbursement model.[50] Reimbursement rates for ARRS roles are specified in the PCN DES and, for comparable occupations, are based on the NHS's national pay and grading framework, Agenda for Change.[51] In contrast, pay for non-ARRS employees is not linked to this framework and is determined at practice level.

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.

Collective action

Despite additional funding through the PCN DES, GP contractors perceive financial pressures to have intensified over recent years.[52,53] Rising staff costs, higher practice expenses and ongoing workload pressures heightened tensions between the BMA and government after the COVID-19 pandemic. In 2024, GPs in England voted for collective action, including the threat of undated contract resignation letters.[54]

The Labour government has increased investment in general practice. The 2025/26 GP contract provided an additional £889m for core practice and PCN funding, equivalent to a reported 4.8% real-terms uplift, alongside a further £80m to encourage GPs to seek specialist input before, or instead of referring to secondary care, by using 'advice-and-guidance'.[55] Following the government's acceptance of the Doctors' and Dentists' Review Body (DDRB) recommendations, additional in-year funding was provided to support pay uplifts. The 2026/27 contract initially announced a £485m increase in funding, equivalent to a 1.4% real-terms uplift and bringing the estimated contract value to £13.9bn.[56] This figure was later increased following acceptance of the DDRB recommendations, taking the total increase to £601m (2.2% real-terms growth).[57]

Despite this, collective action is underway following GPs voting to reject the 2026/27 contract, due to requirements to respond to potentially unlimited online consultations alongside new rules that might affect GPs' ability to refer to secondary care.[58] The BMA has indicated it will consult with members to draw up a strategy to withdraw from the existing NHS GP contract to provide privately funded GP services like NHS dentists.[59] These proposals are concerning given the risk of potentially depleting the NHS GP workforce and creating a two-tier system. A clear, transparent understanding of GP funding is therefore needed to inform decisions by government and GPs on how they respond to financial pressures.

Trends in general practice funding

How much money is invested in general practice?

Key findings

- Successive governments have pledged to increase the share of NHS funding allocated to general practice. Yet between 2015/16 and 2024/25, general practice's share of the NHS budget declined.
- Overall real-terms growth in general practice investment has been largely driven by the primary care network funding, accounting changes and funding streams that have not translated into direct payments to practices. As a result, practices have less discretion over how to spend additional investment and payments received by practices were lower in 2024/25 than a decade earlier, after accounting for population growth.
- The annual funding allocated to general practice per patient is modest when compared with the cost of individual episodes of hospital care.
- Fragmented data sources, reporting gaps and delays in publication make it difficult to track trends in general practice funding and hold governments accountable for funding commitments.

In this section, we analyse how much is spent on general practice in England and how this has changed over time. We also look at the share of NHS spending going towards general practice and compare this to hospital spending. See Box 3 for details on the data and methods.

Box 3: Data on general practice funding methods

We use data from five sources of general practice funding available at the time of analysis:

1. NHS England's '*Investment* in General Practice' publications available from 2010/11 to 2022/23.[60,61,62,63,64] All PCN and COVID-19 related investment is included, but drug reimbursement funding is excluded here on the basis this is a reimbursement rather than a direct investment in general practice. Most recently published values are used where there is overlap in the years of publication.
2. UK Parliamentary Question response on NHS England expenditure on total integrated care board (ICB) and direct *commissioning* annual spend for 'primary medical care', from 2015/16 to 2024/25.[65]
3. NHS England annual report and accounts available 2013/14 to 2024/25 for 'GP primary care services' labelled as *NHS Accounts*.[66,67,68,69,70,71,72,73]
4. The publicly reported *GP contract value* by NHS England (including known in-year uplifts, eg following DDRB pay recommendations), available 2024/25 to 2026/27.[74]
5. NHS England's annual 'NHS *Payments* to General Practice' available from 2013/14 to 2024/25.[75] COVID-19 related payments are included. Drug reimbursements are excluded. Figures are before deductions for pensions and levies are applied. Payments include PCN participation funding from 2019/20. We report values with any other PCN-related payment data reported in the dataset using a dotted line up to 2022/23 – after which only PCN participation funding is included in the original dataset.

We present total funding and calculate per patient funding, using the average number of patients registered with an NHS general practice in England in each year, using figures reported in NHS England 'Patients Registered at a General Practice' data[76] (see Limitations section). We apply GDP deflator values from 2024/25 (2025/26 values were not available at the time of analysis). We use the GDP deflator as this is typically used to analyse public spending or investment over time.

Box 3 (continued)

Differences between *Investment* and *Payment* datasets

We group the various funding streams reported in *Investment* and *Payment* datasets (see Table S1 in *Supplementary material*) to make the two data sources comparable (Figure 5).

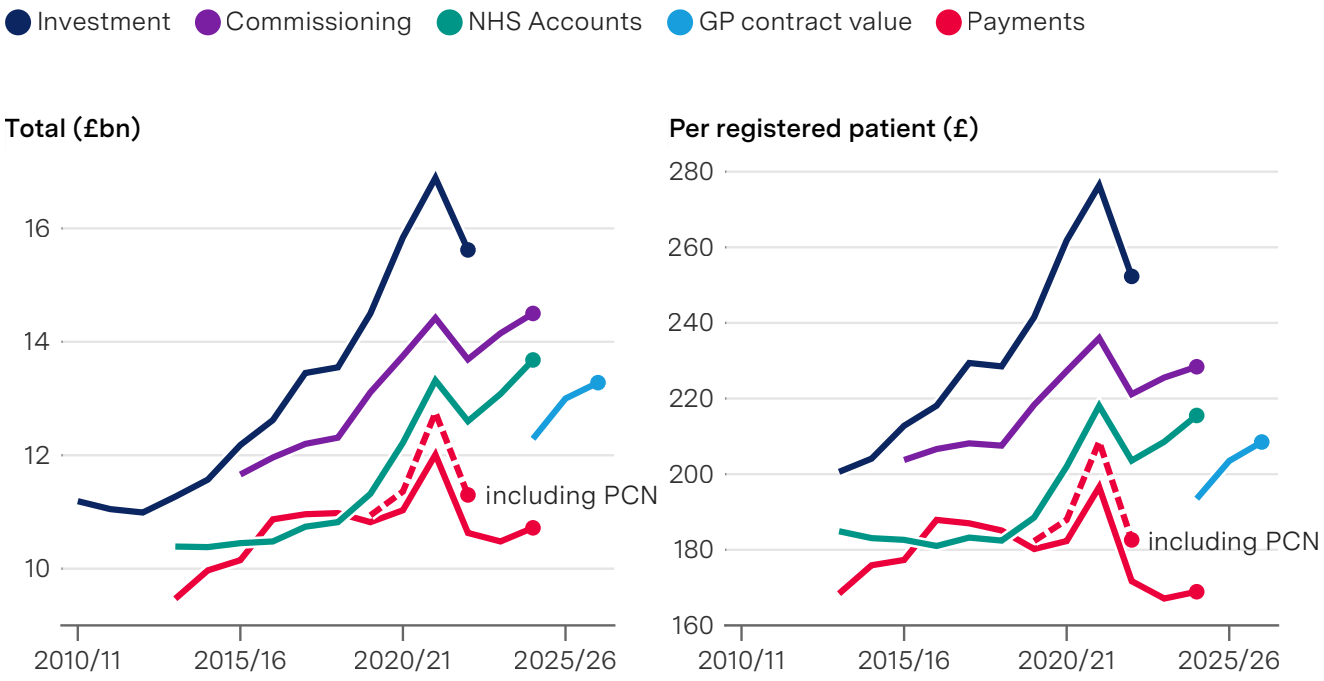
General practice funding as a proportion of NHS spend

We use Parliamentary Question *commissioning* data and *NHS England annual report and accounts* to calculate general practice funding as a proportion of NHS spend, as these are the only sources that provide a denominator 'total' spend value to allow this calculation. Both sit between *Investment* and *Payment* values (Figure 6).

General practice funding by data source over time

Understanding how much money is invested in general practice and how this has changed over time is surprisingly difficult. Estimates differ depending on the data and methods used. Figure 4 shows the total and per patient spend on general practice over time from five different data sources, adjusting for inflation.

Figure 4: Different data sources tell different stories about general practice funding
Total NHS spend on general practice by data source, from 2010/11 to 2026/27 (2024/25 prices)



Source: **Investment:** NHS England, Investment in General Practice 2010/11 to 2022/23 (inc COVID-19, exc drug reimbursements); **Commissioning:** UK Parliament, written question UIN 117398, 3 Mar 2026 – Primary Medical Care category; **NHS Accounts:** NHS England, Annual Report and Accounts 2013/14 to 2024/25; **GP contract value:** NHS England, GP contract value including known in-year uplifts; **Payments:** NHS England, Payments to General Practice 2013/14 to 2024/25 with Primary Care Network (PCN) payments 2019/20 to 2022/23 (inc COVID-19, exc drug reimbursements), dotted line includes PCN funding captured in payments, solid line includes PCN participation payments only; **Per registered patient:** NHS England, Patients Registered at a General Practice using quarterly averages for FY 2013/14 to 2025/26, and March 2026 for 2026/27; **Real terms conversion rates:** HTM, GDP deflators at market prices Dec 2025 for FY 24/25. · 2013/14 Payments to General Practice classed as experimental statistics and exclude prescribing and dispensing payments.

NHS England's *Investment in general practice* data (which report total spend categorised as investment into general practice by NHS England and all other sources of government investment) show that overall investment rose between 2012/13 and 2021/22, before falling in 2022/23 as spending on COVID-19 vaccinations fell. Investment in the most recent year of available data, 2022/23, totalled £252 per patient (£15.6bn in total) in 2024/25 prices.

Meanwhile, *Commissioning* data (which cover the money spent on services commissioned by NHS England and ICBs by category, with primary medical care reported here) and *NHS England's annual report and accounts* data (which report on general practice expenditure out of total NHS operating expenses) show that per patient spend on general practice increased in 2019/20, coinciding with the introduction of PCN-related funding, and peaked in 2021/22, coinciding with the COVID-19 vaccination programme, falling thereafter. Per patient spend, based on registered patients, in 2024/25 remained below 2021/22 figures for both sources.

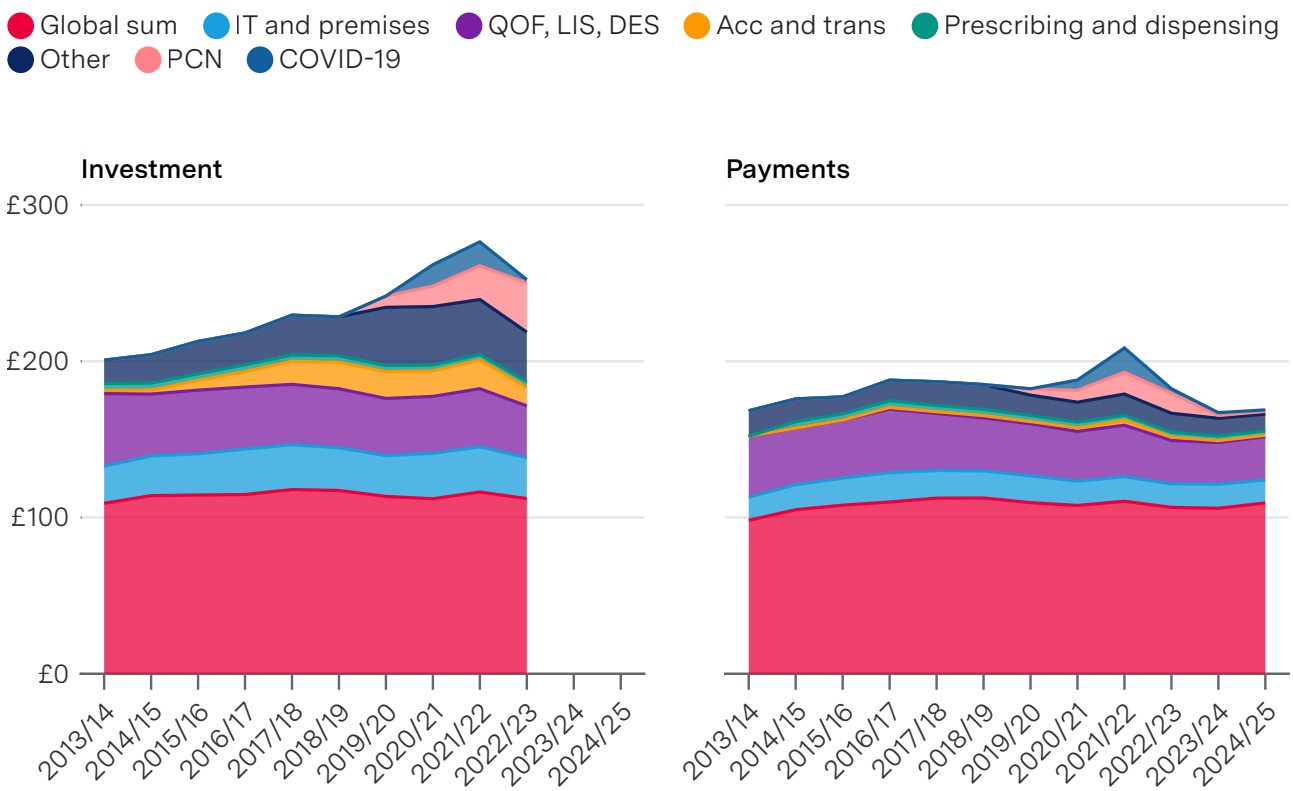
The *GP Contract Value* data, publicly reported between 2024/25 and 2026/27 (reporting the total financial commitment between the government and general practice, including PCN funding and known in-year uplifts) have risen in real terms in the 3-year period from £194 to £209 per patient (using 2024/25 prices). This figure sits between figures from *NHS England's annual report and accounts* and *Payments* made to general practice in 2024/25.

By contrast, despite a peak in 2021/22, NHS England's Payments to general practice (reflecting the money practices directly receive) were lower in real terms in 2024/25 at £169 per patient than a decade earlier. *Payment* figures include PCN participation payments, but other PCN-related funding is only partially captured in payment data and stopped being reported by NHS England after 2022/23 (dotted red line).

Differences between reported investment and payments received by practices

Overall, real-terms growth in investment in general practice between 2013/14 and 2022/23 has been largely driven by accounting changes and funding streams that did not translate into direct payments to practices (Figure 5). This explains the large gap between overall investment figures and the payments that general practices receive seen in Figure 4.

Figure 5: Various funding streams drive differences between reported investment and payments to general practice; PCN funding was offset by reductions in other fundings streams in 2021/22
NHS 'investment' in vs 'payments' to general practice by spending category per registered patient, from 2013/14 to 2024/25 (2024/25 prices)



Source: **Investment:** NHS England, Investment in General Practice 2013/14 to 2022/23 (inc COVID-19, exc drug reimbursements); **Payments:** NHS England, Payments to General Practice 2013/14 to 2024/25 (inc COVID-19, exc drug reimbursements), not all PCN funding captured in payments and only PCN participation payments captured after 2022/23; **Per registered patient:** NHS England, Patients Registered at a General Practice using quarterly averages for FY 2013/14 to 2024/25; **Real terms conversion rates:** HMT, GDP deflators at market prices Dec 2025 for FY 24/25. · Global Sum = global sum or balance of PMS expenditure, QOF = Quality and Outcomes Framework, LIS = Local Incentive Schemes, DES = Directed Enhanced Services (excluding PCN DES), Acc and trans = Access and Transformation funding, Other = Other and Primary Care Organisation Administration, PCN= Primary Care Network related, COVID-19 = COVID-19-related payments. 2013/14 Payments to General Practice classed as experimental statistics and exclude prescribing and dispensing payments.

The expansion of PCN funding is a driver of some of the differences. In 2022/23, PCN funding represented an additional £1.78bn cash-terms investment in general practice (contributing 12.5% of reported investment, excluding drug reimbursement). But only around 41% of this funding is captured in data on NHS payments made to practices. This discrepancy is likely because many PCN-related payments are made to GP federations or other organisations supporting PCNs, rather than paid directly to practices. However, this means that it is currently not possible to tell how much of the money allocated to the PCN DES actually reached practices – and the lack of any investment data since 2022/23 means we cannot report on investment related to the PCN DES in the subsequent period, beyond practice-level PCN participation payments.

Despite this, practices will have benefited from PCN funding in a mix of ways, particularly through ARRS funding for new general practice staff, such as pharmacists and physiotherapists. This represented the largest proportion of PCN-related money and is visible in the substantial rise of other direct patient care roles in general practice workforce data (Figure 3). But our analysis suggests that PCN investment did not represent wholly 'new' investment, as after 2021/22 a proportion of PCN funding was offset by reductions in other funding streams (Figure 5).

Other drivers of differences between reported investment in and payments to practices are increases in central costs and accounting changes seen in the 'Other' category. These include the transfer of training costs from Health Education England to NHS England in 2016/17; additional employers' pension contributions funded centrally, introduced at 6.3% in 2019/20 and later rising to 9.4% in 2024/25; and clinical negligence payments, introduced in 2019/20, replacing the requirement for GPs to pay their own medical clinical negligence indemnity cover for NHS work.

A mix of other funding streams also have a notable gap, representing several billion pounds, between investment figures and payments to practices – including IT and premises, access and transformation funding, and local incentive schemes (Figure S2). Investment may have still reached practices but through a different route – for instance, through centrally procured IT services or national improvement programmes to support practice-level transformation.[77] But this is not clear based on the available data. It could also point to money earmarked for general practice being redistributed elsewhere in the health system.

General practice funding as a proportion of NHS spend

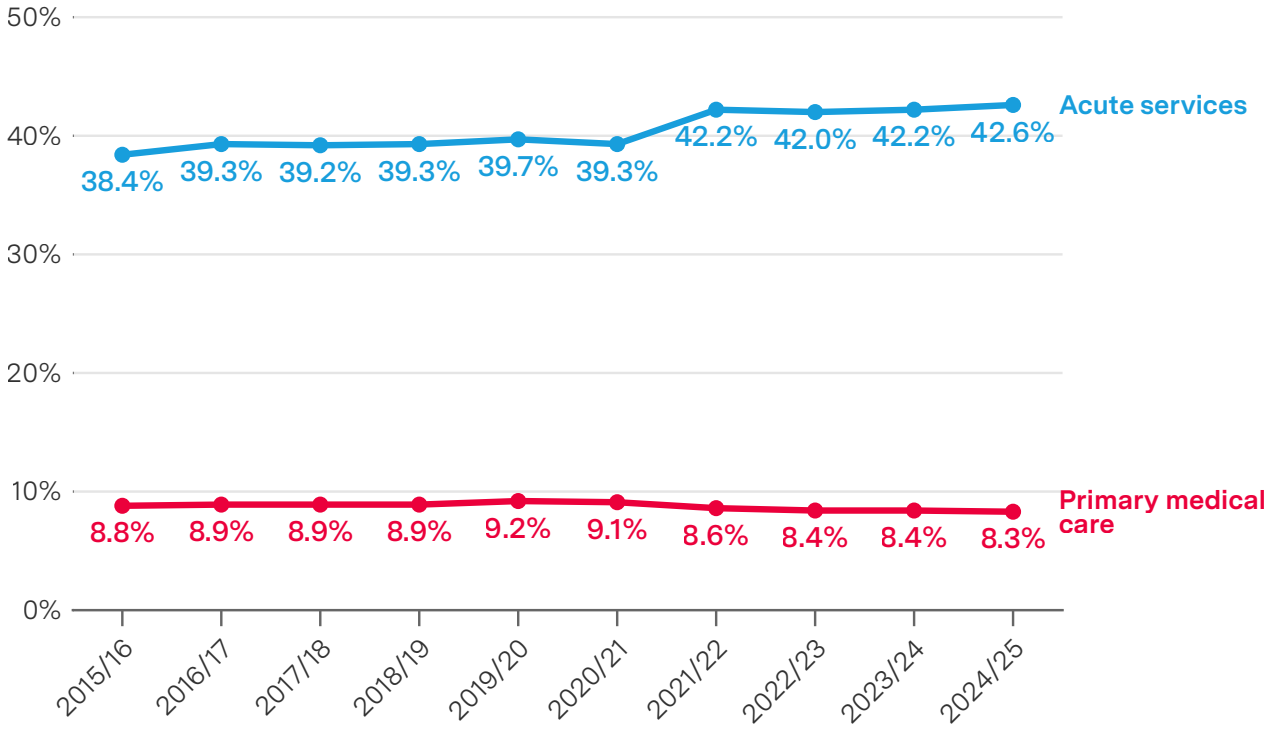
Policymakers have made repeated commitments to increase the share of NHS spending on general practice. In 2016, NHS England's *General Practice Forward View* committed to 'decisively' increase the share of funding going to general practice.[78] In 2019, NHS England promised that primary medical and community services funding would 'rise as a share of the overall NHS budget'.[79] And the Labour government's recent 10-Year Health Plan makes a similar commitment to shift the balance of resources from hospitals to primary and community services.[3]

Despite these promises, and a marginal increase to 9.2% in 2019/20, the share of NHS commissioning spend allocated to 'primary medical care' in England was lower in 2024/25 at 8.3% than a decade earlier in 2015/16 at 8.8%[65] (Figure 6). In contrast, over the same period, the proportion of spending on acute services, largely hospitals, grew from 38.4% to 42.6%, with a stepwise increase during the COVID 19 pandemic. Analysis of *NHS England annual report and accounts* suggests an even smaller proportion of NHS operating expenditure spent on 'GP primary care services' and a steeper relative decline, with the proportion falling from 8% in 2013/14 to 7.1% in 2024/25.[66,73] In summary, although investment in general practice rose in real terms between 2015/16 and 2024/25, it has not kept pace with broader growth in NHS spending over the period.[80]

Although investment in general practice rose in real terms between 2015/16 and 2024/25, it has not kept pace with broader growth in NHS spending.

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.

Assessing trends in general practice funding is challenging, due to fragmented data sources, significant gaps in the available data and delays in publication. As a result, it is difficult to hold the government to account on its funding commitments. Even with the additional funding agreed through the 2025/26 and 2026/27 GP contracts, it remains unclear what proportion will ultimately reach general practice, or whether it will reverse the decline in general practice's share of NHS spending.

In 2026/27, the announced value of the GP contract with the subsequent addition to meet DDRB uplift recommendations is equivalent to £219 (£209 in 2024/25 prices) per patient per year – including PCN funding. Based on current trends in appointment activity, for this money general practice will deliver in the region of five to six appointments per patient per year as well as cover most practice-related overheads and non-patient-facing activity.[43,81,82] This contrasts sharply with the unit

costs (2024/25 prices) of other NHS services – a single consultant-led outpatient appointment (£203), ambulance (£272) or emergency care episode (£280) cost nearly as much as or more than a patient's annual allocation for general practice.[28] A non-elective inpatient short stay costs nearly four times as much (£824).[28] While these comparisons should be interpreted cautiously, they nevertheless highlight how little is spent on general practice relative to the cost of single episodes of hospital-based care.

How is funding allocated to general practice?

Key findings

- In 2024/25, three-fifths of payments to general practices on average came from the global sum (Carr-Hill) capitation formula – with the remainder from a mix of earmarked, pay-for-performance and fee-for-service payments.
- Dispensing and drug reimbursement payments associated with dispensing practices were the main drivers of differences in payments across practices. Pay-for-performance and other ad hoc payments also contributed to funding differences, and were higher in practices serving less deprived populations.
- Although the current capitation formula allocates more funding to practices in socioeconomically deprived areas and to rural practices, this may not be sufficient to reflect the additional needs of populations and practices in these areas.

In this section, we look at the different sources of payments to general practice and how these are allocated between practices. We analyse what drives variation in payments between practices by different practice and population characteristics. Box 4 provides detail on the data and methods.

Box 4: Data on the funding allocated to general practice methods

In this section we use cross-sectional *Payments to general practice* data from 2024/25, the latest year available. Drug reimbursement payments are included to understand variation in total payments between practices – notably between dispensing and non-dispensing practices. Deductions for levies, pensions and contractual adjustments, taken directly from practice payments by NHS England, are also presented here.

All COVID-19-related payments are excluded. These payments were often channelled through a single PCN-nominated practice or GP federation so records do not reliably show whether payments reached individual practices. On average, COVID-19-related payments contributed to <1% of practice payments in 2024/25. Except for PCN participation payments, which are made to practices, no other PCN funding is included as it is not reported in the *Payments to general practice* data after 2022/23 due to data issues. In addition, discrepancies between NHS England's PCN investment and payment figures in previous years, combined with the fact that PCN funding is often channelled through a single PCN-nominated practice or GP federation before being redistributed, mean that including these amounts would lead to inaccurate practice-level estimates.

Figures are presented in their original 2024/25 cash values to align with the other sections of this report that adjust to 2024/25 real-terms values. We group the various funding streams into fewer categories to enable visualisation – see Table S3 in *Supplementary material*. We calculate percentages using the total per patient payment amounts as the denominator, including drug reimbursements and before deductions.

We exclude practices with <1,000 registered patients and with the lowest and highest 0.5% total payments per patient values on the basis that they are likely to be atypical and unduly skew the data. In total, 96% of practices (6,125 out of 6,375) were included in the analysis. Table S4 sets out the number and reasons for excluding practices.

Box 4 (continued)

We stratify practices by socioeconomic deprivation using Index of Multiple Deprivation (IMD 2019) quintiles.[34] Patients are assigned an IMD score based on their postcode and corresponding Lower-layer Super Output Area (LSOA), and practices are then classified according to the deprivation profile of their registered populations. Table S5 presents the number of practices and patients in each quintile and average weighting value based on the current Carr-Hill formula.

Table S6 provides details of the number and percentage of practices excluded in the analyses by practice characteristic.

Little is spent on general practice relative to the cost of single episodes of hospital-based care.

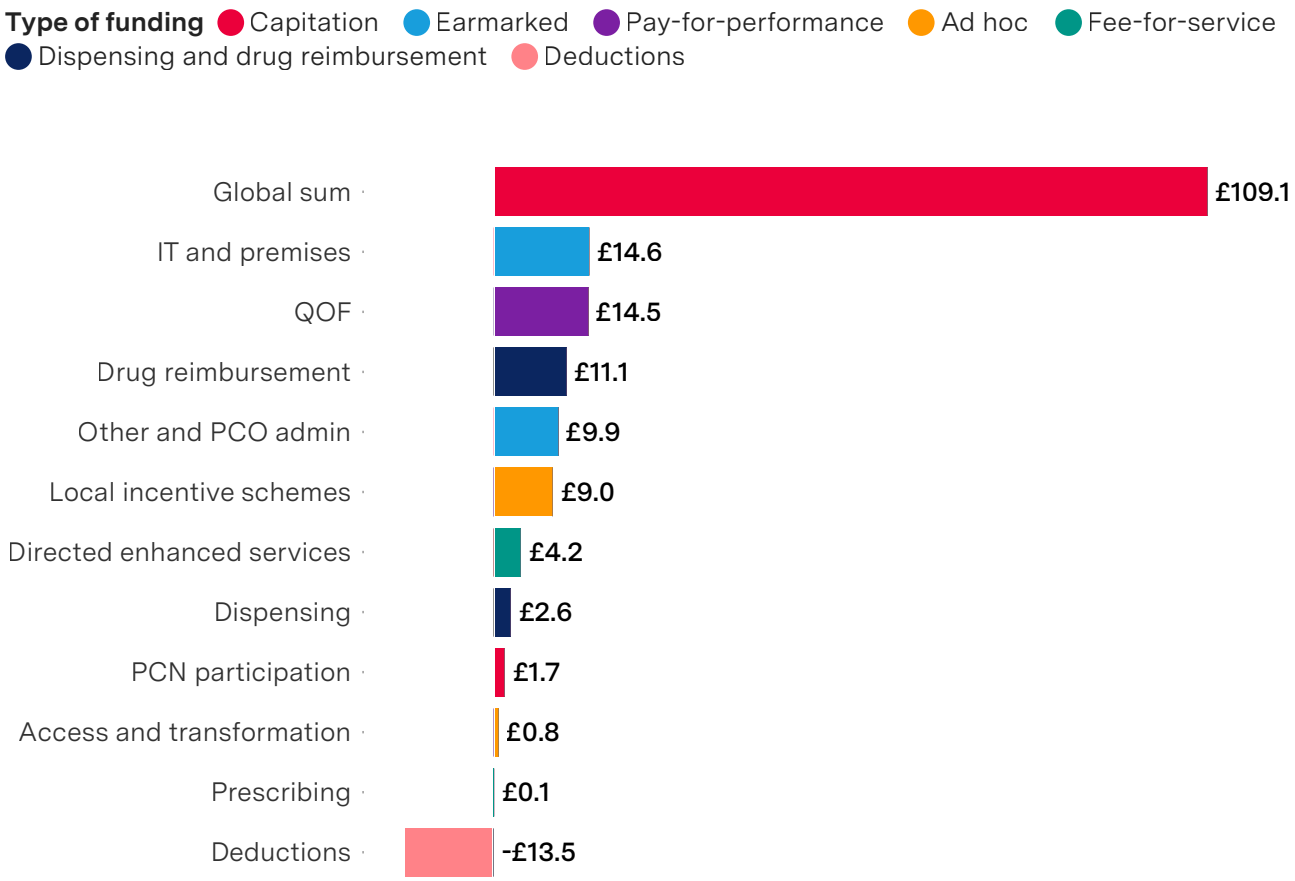
Average practice payments per patient

Global sum payments and deductions

In 2024/25, an average of 61% of a general practice's income (£109.10 per patient) came from the global sum payment. Practices have full discretion over how global sum funding is used. However, payments are subject to deductions for pensions and levies, which represented 8% of received payments (£13.50 per patient) in 2024/25 (Figure 7).

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.

Non-global sum payments

The remaining payments came from a mix of sources, including earmarked payments (covering IT and premises at 8% and other and PCO administrative payments at 6%); pay-for-performance schemes; and fee-for-service payments (such as for flu vaccinations). The contribution of pay-for-performance payments – mainly related to QOF – has diminished over time, representing only 8% of payments in 2024/25. This contrasts with 20–25% of payments when QOF was first introduced.[30,31]

Ad hoc Local Incentive Schemes (LIS) – usually fee-for or pay-for-performance services agreed with the local commissioner, such as incentives to improve prescribing – represented 5% of payments to practices on average. There are also ad hoc funding streams that vary each year to meet defined policy objectives, like improving patient access. These represented less than 1% of payments to practices in 2024/25.

Directed Enhanced Services (DES) are nationally agreed, optional services that are largely paid for as fee-for-services payments, such as for learning disability checks or certain vaccinations. They represented 2% of payments in 2024/25. PCN participation payments represented around 1% of payments – these are capitation-based payments paid directly to practices for forming part of a PCN (see Box 2).

Nearly all practices receive prescribing and drug reimbursement payments, with drug reimbursements representing 6% of practice payments on average. But dispensing practices have much higher volumes of these and also receive dispensing payments, which we explore further.

Variation between practices

Total payments received by practices per patient vary substantially. In 2024/25, after deductions, the mean payment per patient was £164.10 – but the median was £155.40, with payments ranging from £120.80 (5th percentile) to £276.50 (95th percentile).

Concerns about inequities in funding between practices are longstanding – most notably between practices in richer and poorer areas, but also by rurality and other factors.[83,84,85,86,87,88,89] This section explores these differences. It analyses variation in average actual payments made to

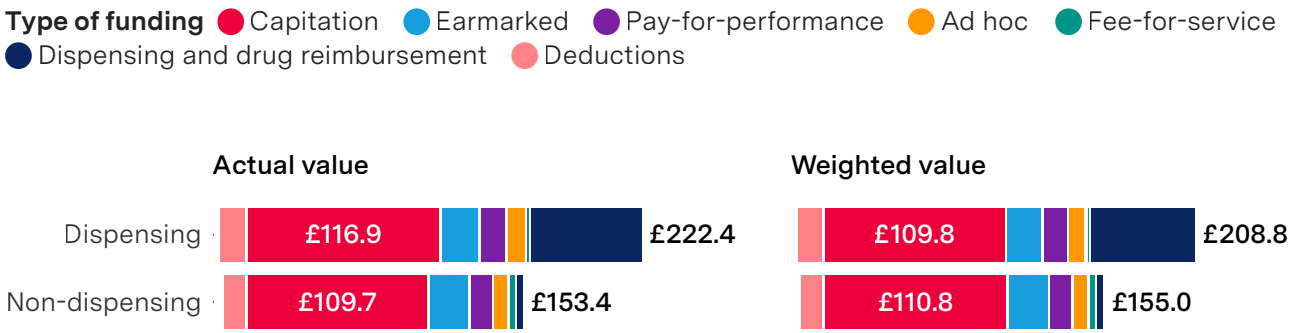
practices alongside average weighted payments, which are calculated by dividing total payments from all funding streams by the weighted-patient list based on the Carr-Hill formula (see Box 2).

Variation by dispensing practices

Substantial differences exist in payments received by dispensing and non-dispensing practices. On average, dispensing practices received 35% more (£155.00 vs £208.80) per weighted patient after deductions in 2024/25 (Figure 8). These differences are driven by drug reimbursement payments and dispensing fees for providing these extra services. The difference in total payments also changes the proportional contribution of capitation payments; in non-dispensing practices – the majority of practices – the proportion of capitation payments is 66%, compared with 49% in dispensing ones.

Figure 8: Dispensing practices receive markedly higher per capita payments due to dispensing and drug reimbursement funding

Average payments per registered patient by dispensing practices status, 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.

Variation by socioeconomic deprivation

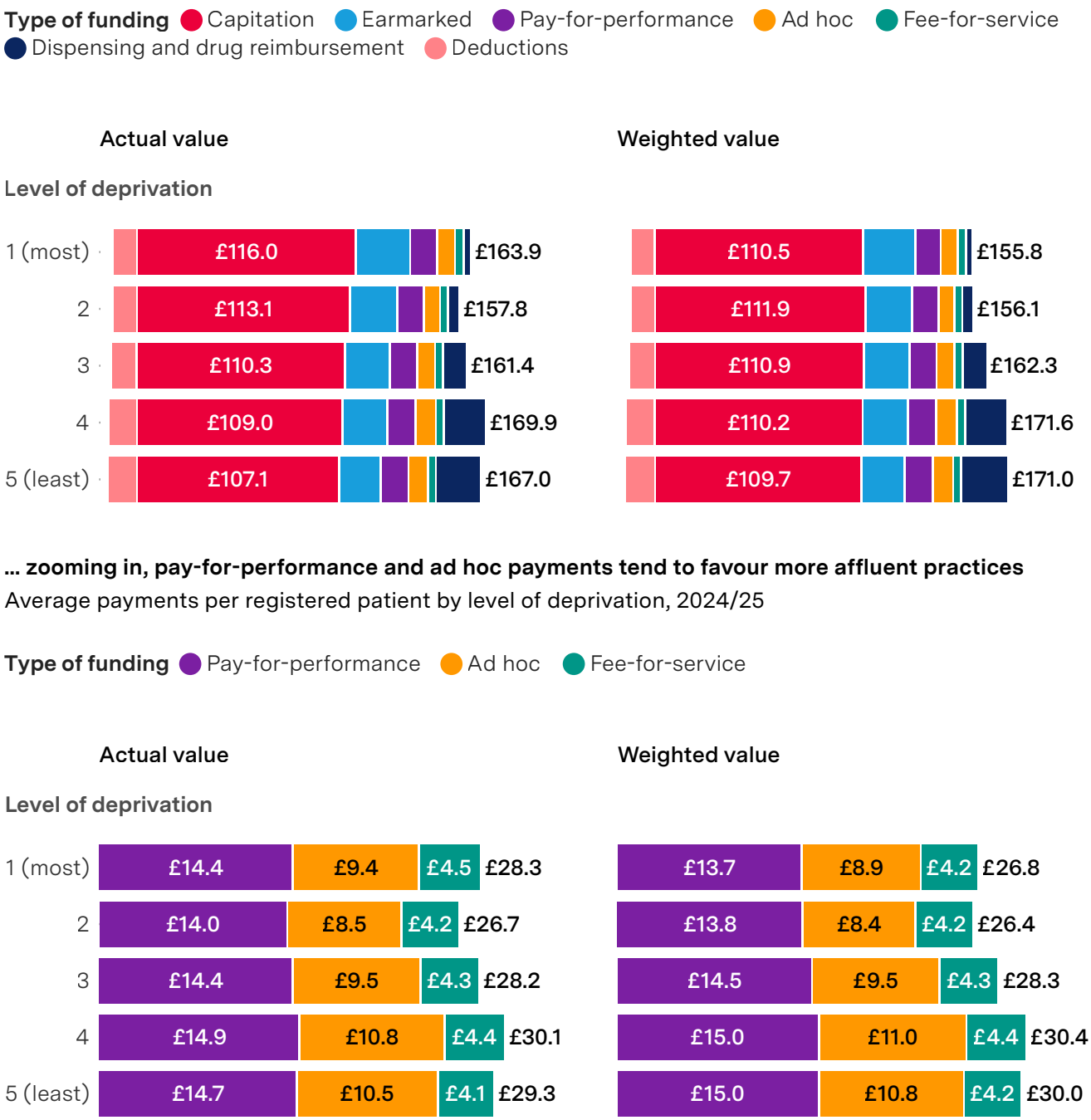
For practices in the most deprived quintile, capitation payments provided 8.3% more actual funding (£116.00), on average, than to those in the least deprived quintile (£107.10) (Figure 9). Earmarked payments were also higher in the most deprived quintile (£28.90 vs £22.10). However, once all other payments and weighting for greater need (based on the Carr-Hill formula) were considered, practices in the least deprived quintile (£171.00) received, on average, 9.8% more, after deductions, per weighted patient than those in most deprived quintile (£155.80).

However, it is not only dispensing and drug reimbursement payments that drive these differences. Looking more closely, pay-for-performance and ad hoc payments also tend to favour practices in less deprived quintiles, particularly once weighted values are calculated. This results in practices serving populations in the most deprived areas, which often have relatively greater needs, having less money at their disposal to provide care to patients.

> Practices serving populations in the most deprived areas [have] less money at their disposal to provide care.

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.

The principal reason that dispensing and drug reimbursement payments are the main drivers of differences across practice deprivation quintiles is because a greater proportion of patients registered to dispensing practices live in less deprived areas. These are also often rural areas (Table 1).

Table 1: Dispensing and rural dispensing practices by IMD quintile 2024/25

Practice IMD quintile	Number of dispensing practices (% of total dispensing practices in quintile)	Number of rural dispensing practices in quintile (% of dispensing practices within quintile that are rural)
1 (most deprived)	5 (0.5%)	0 (0%)
2	51 (5.6%)	22 (43.1%)
3	157 (17.2%)	110 (70.1%)
4	317 (34.7%)	233 (73.5%)
5 (least deprived)	383 (42.0%)	290 (75.7%)

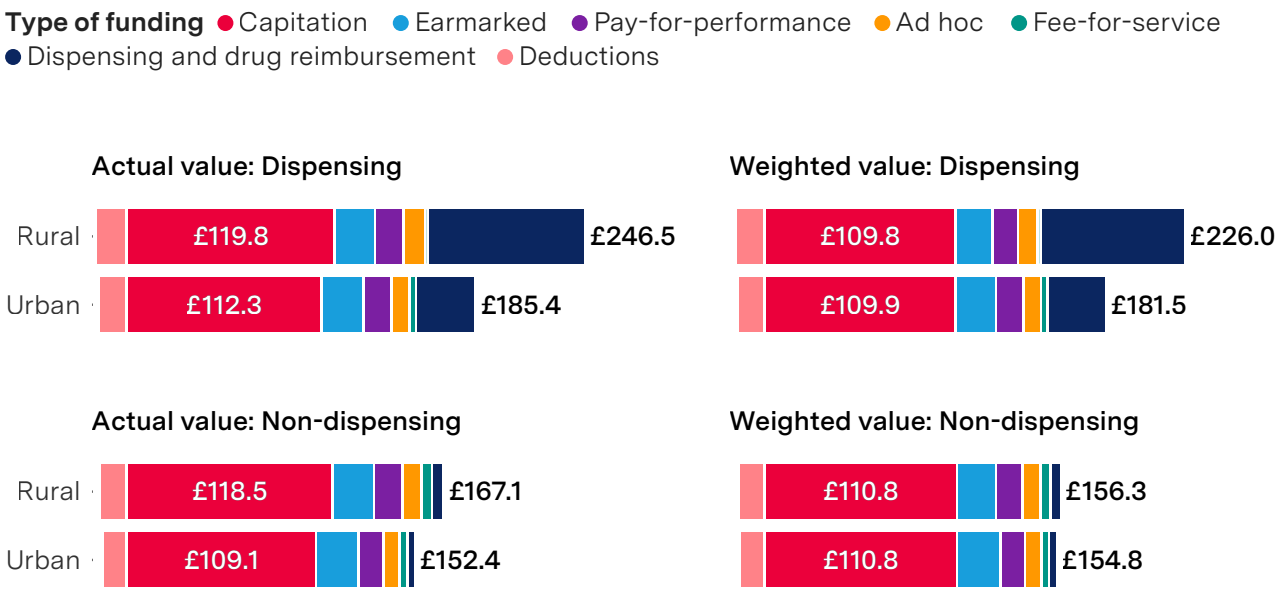
Source: NHS England, NHS Payments to General Practice, England 2024/25. · Practices below 1,000 registered patients and the top 0.5% and bottom 0.5% of practices by average payment per registered patient were removed. Deprivation is based on practices' Index of Multiple Deprivation (2019) quintiles using the LSOAs of their registered patients.

Variation by rurality

Drug reimbursement and dispensing payments also drive differences between rural and urban practice payments (rural dispensing £226.00 vs urban non-dispensing £154.80 per weighted patient). After removing these, while actual payments are higher in rural practices, and weighted payments between rural and urban practices are similar, this may still place rural practices at financial disadvantage, given it is often harder to recruit to rural areas and practices are more likely to be smaller and therefore not benefit from economies of scale (Figure 10).

Figure 10: Dispensing and drug reimbursement funding are driving differences in funding between rural and urban practices

Average payments per registered patient by rurality, 2024/25



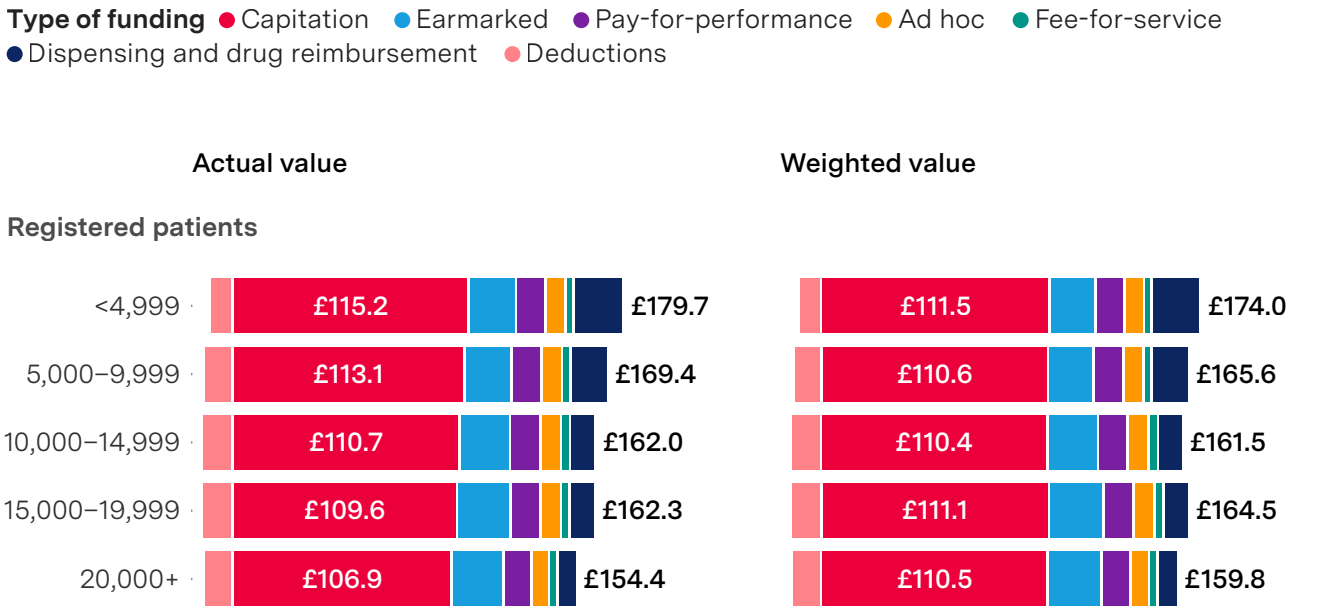
Source: NHS England, NHS Payments to General Practice 2024/25. · Practices below 1,000 registered patients and the top 0.5% and bottom 0.5% of practices by average payment per registered patient were removed. COVID-19 and PCN payments excluded apart from PCN participation payments. Weighted value = total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

Variation by list size

Looking at payments per patient related to list size, smaller practices appear to receive larger payments – most notably from the global sum, dispensing and drug reimbursement payments (Figure 11). Once weighting is applied, however, the differences are smaller and the gradient disappears once dispensing and drug reimbursement payments are removed.

As smaller practices are likely to have higher per patient overheads and fewer opportunities for economies of scale, a greater share of payments may need to be spent on management activity and fixed costs, resulting in a smaller share of total payments available for direct patient care. This is relevant for both practices serving patients in more deprived areas and practices in rural areas that tend to be smaller.[75,90]

Figure 11: Smaller practices receive higher payments per patient, but after weighting and without dispensing and drug reimbursements this trend disappears
Average payments per registered patient by practice list size, 2024/25

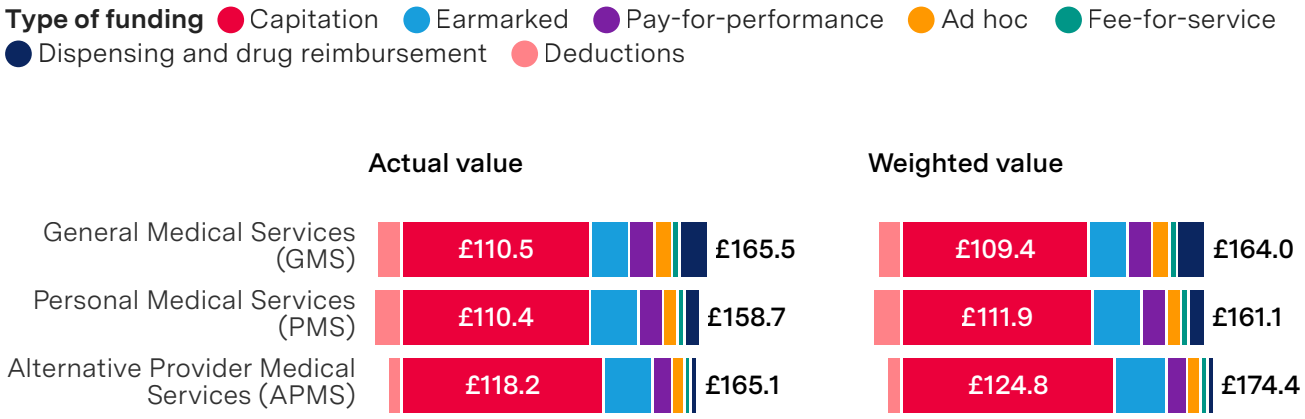


Source: NHS England, NHS Payments to General Practice 2024/25. · Practices below 1,000 registered patients and the top 0.5% and bottom 0.5% of practices by average payment per registered patient were removed. COVID-19 and PCN payments excluded apart from PCN participation payments. Weighted value = total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

Variation by contract type

Differences between practices with GMS and PMS contracts have been a source of contention in the past because locally negotiated PMS contracts could result in funding variations between otherwise similar practices.[17,19] Without dispensing and drug reimbursement payments, practices with PMS contracts received 3% more payments per weighted patient in 2024/25 than GMS practices (GMS £148.00 vs PMS £152.30). The overall difference in weighted payments between practices with these two contract types is relatively small (GMS £164.00 vs PMS £161.10). In contrast, practices operating under locally negotiated APMS contracts, that account for fewer than 5% of practices, received the highest weighted global sum payments (£124.80) (Figure 12). This may reflect the use of APMS contracts in areas with particular service challenges.

Figure 12: Differences between payments for GMS and PMS practices are relatively small after deductions; APMS practices receive the highest payments
Average payments per registered patient by contract type, 2024/25

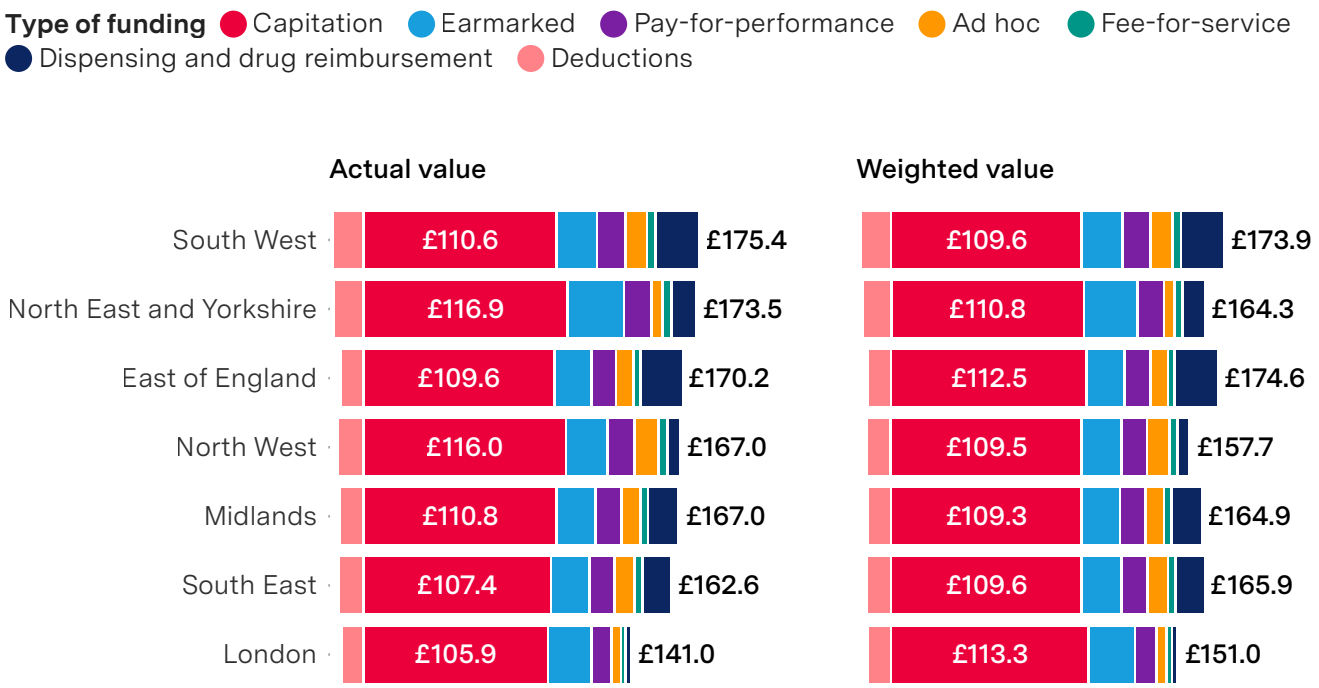


Source: NHS England, NHS Payments to General Practice 2024/25. · Practices below 1,000 registered patients and the top 0.5% and bottom 0.5% of practices by average payment per registered patient were removed. COVID-19 and PCN payments excluded apart from PCN participation payments. Weighted value = total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

Variation by NHS region

Payments per patient vary markedly across NHS regions (Figure 13). Despite the global sum providing some additional London weighting, London practices received the lowest actual (£141.00) and weighted (£151.00) total payments per patient on average. The relative absence of dispensing and drug reimbursement payments in London partially explains this. But there are also differences in other categories – including in ad hoc Local Incentive Schemes (which in London represented £4.80 per weighted patient, compared with, for example, £12.10 in the North West); and QOF related payments (with London receiving only £12.20 per weighted patient compared with, for example, £16.10 in the South West). Regional variation may be driven by differences in local population needs, workforce-related allowances (such as maternity leave locum cover), premises costs and local commissioning decisions, as well as practices' ability to achieve performance targets or deliver fee-for-service activities.

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.

Comparing capitation payments

Comparing practices by deprivation, dispensing status, rurality or list size made limited difference to the weighted capitation values, which only ranged between £109.40 and £111.90. This suggests that the current Carr-Hill capitation formula is broadly adjusting for differences in the population based on these factors. These adjustments, however, may still not be proportionally enough to account for the additional resources required to deliver care in some areas – for example, given evidence practices in more deprived and rural areas are often smaller, face greater challenges with recruitment and retention, and more deprived areas often have worse clinical outcomes.[83,84,85,86,87,88,89]

Comparing different weighting for formulas

Alternative approaches to weighting for patient need can produce different results, leading to different conclusions about the fairness of the current funding system. For example, studies that use weightings attempting to account for additional workload and unmet need in more deprived areas conclude that Carr-Hill based capitation payments do not do enough to shift resources to practices in these areas.[90,91] By contrast, approaches that give greater weight to recorded morbidity as a proxy for general practice workload may attribute higher need to sicker patients in more deprived areas but also shift funding toward practices serving populations with a greater proportion of patients with higher total levels of recorded illness.[92,111,112] These are frequently older populations, but also more likely to be found in less deprived areas, reflecting the association between affluence and longer life expectancy.[93]

A further complication arises when using weighted list sizes, aiming to capture need and/or workload, to calculate total per patient payments in blended payment systems. Using a practice's weighted list size to derive per patient values for non-capitated payments (such as fee-for-service) can reduce the apparent value of those payments. Therefore, increases in the weighted capitation payment will be offset by a corresponding reduction in the per patient value of non-capitated funding. This interaction can obscure the overall distributional impact of the payment system and complicate the interpretation of funding changes, or comparisons between different blended models.

How does money paid to general practice translate into GP earnings and expenses?

Key findings

- GP contractor income varied widely over time and between GPs, with peaks in income linked to the 2004 general practice contract reform and COVID-19 vaccinations.
- Higher GP contractor income is linked to working in larger, dispensing and London-based practices.
- A marked and growing difference between GP contractor and salaried GP income exists – with GP contractor income per session being nearly double that of salaried GPs (£409 vs £216) in 2023/24 (2024/25 prices).
- A gender pay gap exists among both contractor and salaried GPs, even after accounting for reported working hours, with female GPs receiving lower pay on average.

In this section, we analyse how much money invested into general practice translates into GP income by examining estimated GP expenses and earnings. We look at variation in income before tax between GPs, including by their employment status, type of practice they work in, gender and age. Box 5 provides detail on the data and methods.

Box 5: Data on GP earnings and expenses methods

NHS England publishes annual estimates of GP earnings and expenses based on a sample of HMRC self-assessment tax returns. Tax return data are linked to information from NHS England on practice characteristics and presented as aggregate mean values by dispensing practice status, GP contract type (only GMS and PMS), rurality, registered list size and region, as well as by individual GP characteristics including age, gender and ethnicity. Data are not provided by the general practice's IMD quintile or measures of quality. Earnings and expenses are reported separately for GP contractors and salaried GPs. Expenses are disaggregated by type. Income is reported before tax and employee pension contributions, but after employer pension contributions or their equivalent for GP contractors in order to make them comparable. For GP contractors, income relates primarily to work as NHS contractors but may also include income from other GP-related work. For salaried GPs, income is reported as employed GP income and self-employed GP income from 2014 onwards. We present salaried GP income from GP employment, unless otherwise stated. GPs working exclusively as self-employed locums, and those who do not submit a tax return – such as those that only received salaried income – are excluded. Full methods on earnings and expenses estimates data collection are published by NHS England.[94]

Selection of deflator: While it is standard practice to use the GDP deflator when reporting trends in public spending, as we have done in the previous sections, *GP Earnings and Expenses* time series estimates are also reported by NHS England using the Consumer Prices Index (CPI) and the Retail Prices Index (RPI). These measures aim to reflect changes in the cost of living and are more commonly used than GDP when examining income over time. However, RPI lost its status as a national statistic in 2013 due to methodological shortcomings that led it to overstate inflation. The Consumer Price Index with Housing costs (CPIH) is now regarded as a more comprehensive measure of consumer inflation than CPI alone, as it incorporates owner occupiers' housing costs and council tax. In 2017, CPIH became the ONS's leading measure of inflation. In view of this, we present time-trend and cross-sectional analyses here using the CPIH, averaged for the 2024/25 financial year.[95]

Box 5 (continued)

Adjusting for reported working hours: To adjust income for differences in working hours, data from NHS England's General Practice Workforce Bulletin Tables were used.[24] An FTE-to-headcount ratio was calculated for GP contractors and salaried GPs for each characteristic of interest – matching the average FTE and headcount values to the corresponding financial year of GP income data. A full-time GP (FTE = 1), based on working nine sessions of 4 hours and 10 minutes per week over 52 weeks, was assumed to work a maximum of 468 sessions per year. Multiplying 468 by the FTE-to-headcount ratio provided an estimate of the average number of sessions worked annually and was used to divide the average annual estimated income. This produced an estimated income per session. As FTE figures are not reported by ethnicity in the General Practice Workforce dataset, we could not adjust by reported working hours and therefore do not report on income by ethnicity. Reported FTE hours fell for both contractor and salaried GPs from, on average, 0.89 to 0.86 for contractors, and from 0.67 to 0.63 for salaried GPs between 2015/16 and 2023/24. It is important to flag that working hours are known to be under-reported, potentially by up to 50% – this may therefore overestimate income per session calculations.[96]

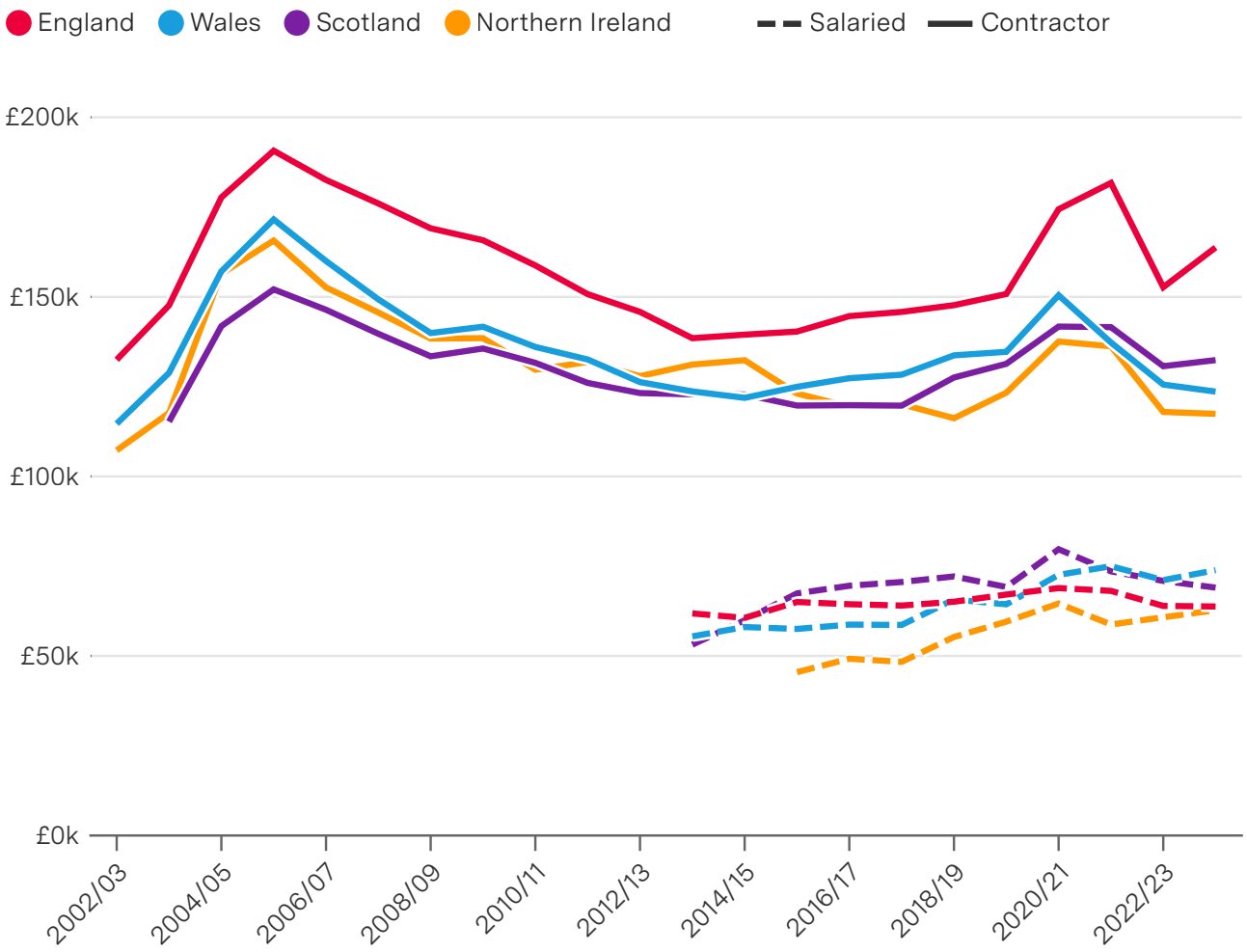
Average income over time

Average estimated GP contractor income, before tax and after adjusting for inflation, has fluctuated significantly over the past two decades. Peaks followed the 2004 contract reform and the COVID-19 vaccination programme, and a trough came in 2013/14 (Figure 14). In the decade between 2013/14 and 2023/24, annual GP contractor income rose by 18% in real terms, after adjusting for inflation. Comparing the four UK nations, GP contractors in England earned an average of £163,751 before tax – noticeably more than GP contractors in Scotland (£132,383), Wales (£123,613) and Northern Ireland (£117,422) in 2023/24.

Estimated salaried GP income in England has fluctuated much less – averaging £65,094 from employed income with a further £11,093 from self-employed income (between 2015/16, from when time series data are comparable, and 2023/24). Since 2015/16, salaried GPs in England have, on average, earned less through employment than their counterparts in Scotland and since 2020/21, less than their counterparts in Wales too.

Figure 14: GP contractor income varies greatly over time and is much higher than salaried GP income, with contractors in England earning the most

Estimated mean GP contractor income and salaried GP employment income before tax by country, from 2002/03 to 2023/24 (2024/25 prices)



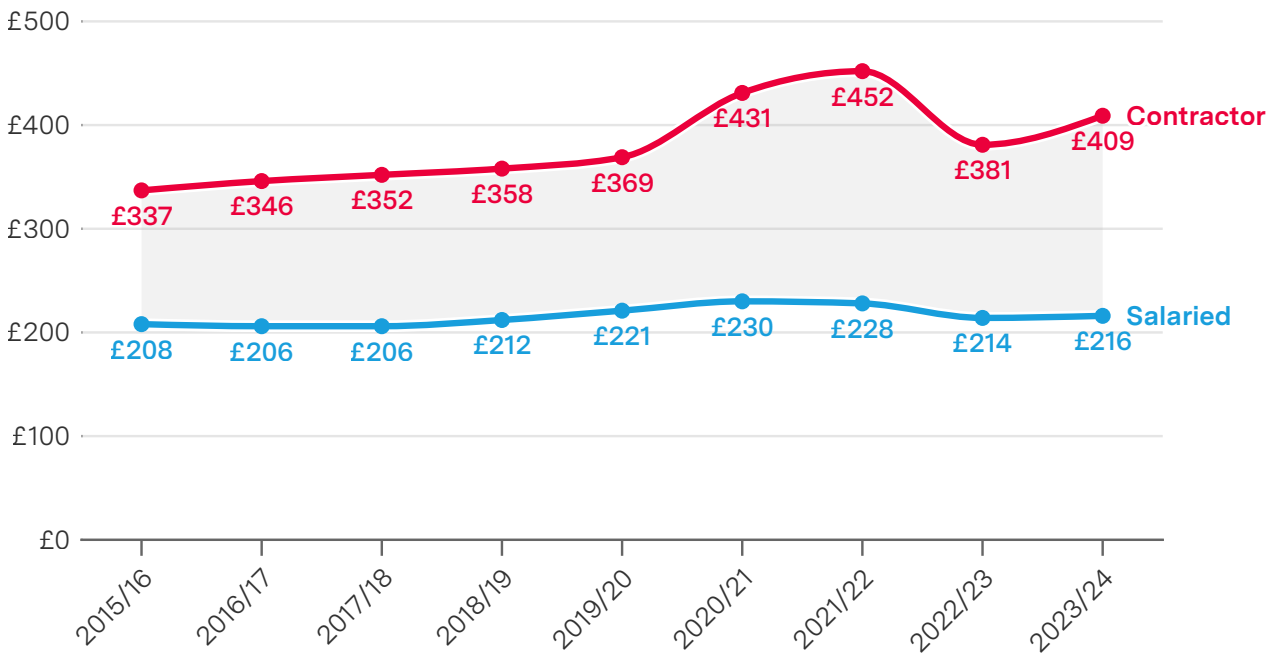
Source: NHS England, GP Earnings and Expenses Estimates, 2002/03–2023/24; ONS, CPIH deflator (2024/25 prices). · Estimates are based on a sample of HMRC Self-Assessment tax returns and include NHS and private GP-related income for full- and part-time GPs, excluding GPs working solely as locums. Figures show annual income after expenses and before tax, adjusted for inflation. Salaried GP figures exclude self-employment income. NHS England adjusts estimates for pension contributions to ensure comparability between contractor and salaried GPs. There is a break in the salaried GP income series in 2014/15 due to revisions to pension contribution adjustments.

Income per session for GP contractors and salaried GPs

After adjusting for reported working hours, our analysis shows that there is a marked and growing difference between GP contractor and salaried GP income – with GP contractor income per session (£409) being nearly double that of salaried GPs (£216) in 2023/24 (Figure 15).

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)



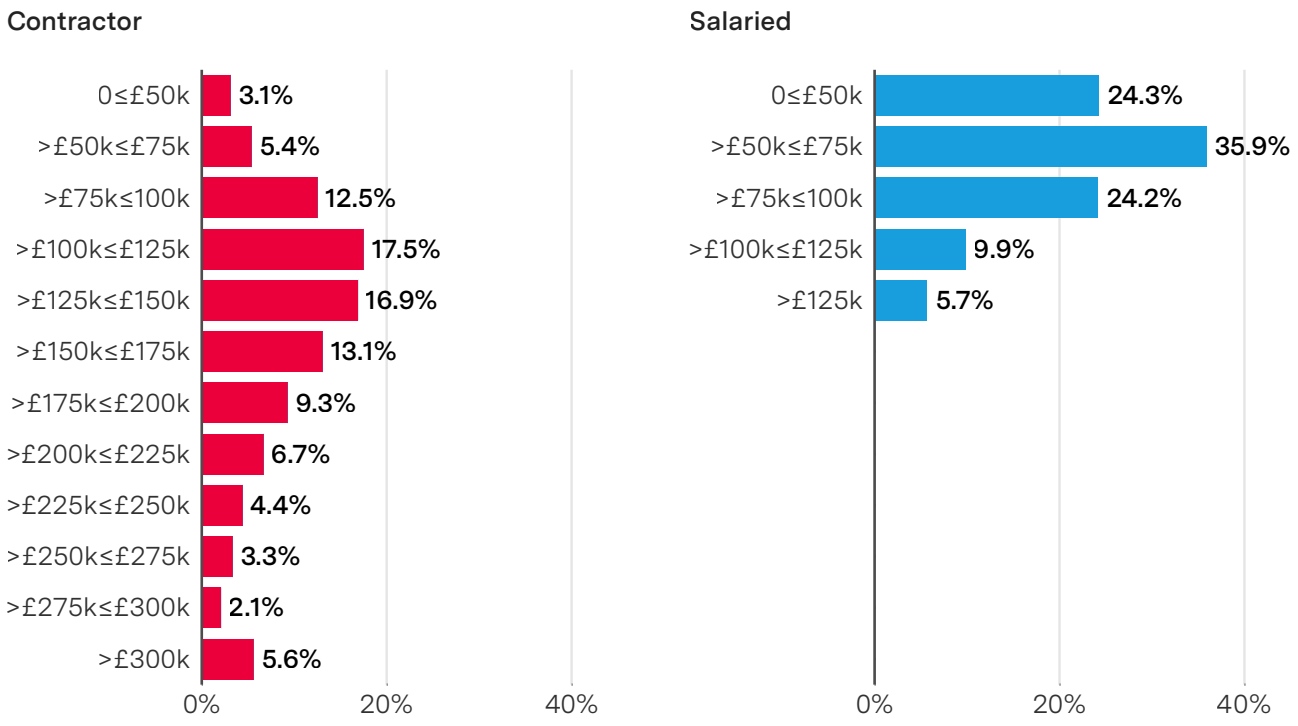
Source: NHS England, GP Earnings and Expenses Estimates, 2015/16–2023/24; NHS England, General Practice Workforce (FTE annual averages); ONS, CPIH deflator (2024/25 prices). · Estimates are based on HMRC Self-Assessment data and include NHS and private GP-related income. Figures show income after expenses 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.

Distribution of income among GPs

Variation in total income among GPs is wide. Mean total income before tax exceeded the median for both types of GP in 2023/24: £163,751 compared with £146,210 for contractors; £74,498 compared with £70,061 for salaried GPs (including both employed and self-employed income) (2024/25 prices).

In 2023/24, in cash terms, 55% of contractors earned in total less than £150,000; 29% earned between £150,000 and under £225,000; 10% earned between £225,000 and under £300,000; and close to 6% earned £300,000 or more. By contrast, when employment and self-employment GP income are combined, 84% of salaried GPs earned in total less than £100,000, with the most common income band being between £50,000 and £75,000. Figure 16 presents these figures (Figure S7 provides CPIH 2024/25-adjusted values).

Figure 16: One-third of contractors earned over £175,000 in 2023/24
Estimated GP contractor and total salaried GP income before tax, 2023/24



Source: NHS England, GP Earnings and Expenses Estimates 2023/24. · Estimates are based on HMRC Self-Assessment data and include NHS and private GP-related income for full- and part-time GPs. Figures show annual income after expenses and before tax in 2023/24 cash terms. Salaried GP figures include both employment and self-employment income. NHS England adjusts estimates for pension contributions to ensure comparability between contractor and salaried GPs. Figure S7 in the supplementary material provides CPIH 2024/25 adjusted values.

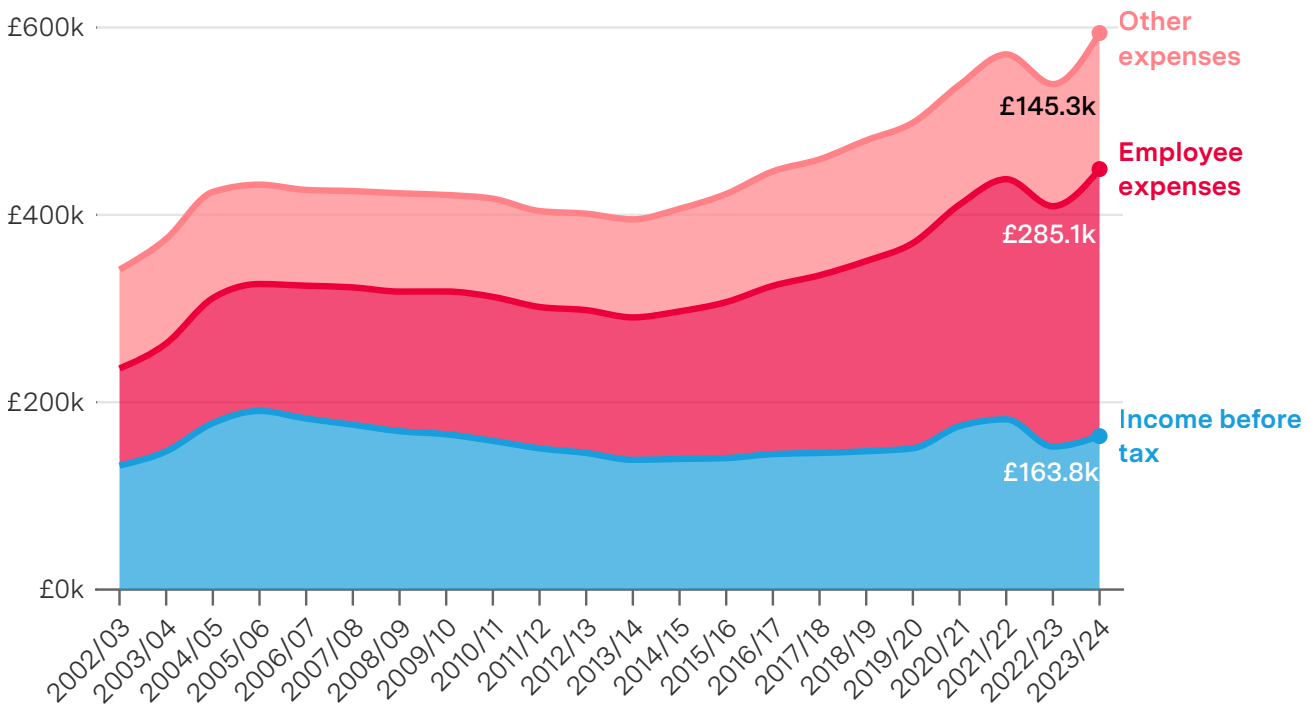
Expenses over time

GP contractor expenses have risen in real terms since 2002/03 – both in total after adjusting for inflation and relative to their income. The ratio of contractors' expenses to earnings was lowest in 2005/06 at 1.3:1 and increased to 2.3:1 by 2023/24 (Figure 17). This trend has been driven primarily by rising employee-related expenditure that accounted for 50% of total expenses in 2002/03, compared with 66% in 2023/24. This likely reflects a combination of factors, including the share of PCN funding flowing through GP partnerships to employ additional roles; rising cost-of-living pressures translating into paying higher staff salaries; growth in average practice size alongside a decline in the number of GP partners; and a corresponding shift towards greater employment of salaried GPs and other staff, resulting in a greater proportion of practice earnings being spent on employment costs.

As a greater proportion of practice earnings is absorbed by employment and operating costs, rather than translating into personal income, GP partners might perceive that they are financially worse off. GP contractors are also holding more risk, with larger practices and fewer partners. Nevertheless, except for a dip in 2022/23, on average contractor income before tax has also risen since 2013/14. Mean contractor income before tax rose 7% in real terms in the 1-year period between 2022/23 and 2023/24 – despite a fall in payments to general practice during the same period (see Figure 4). This suggests contractors during this period cut costs or generated efficiencies to increase their income on average.

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.

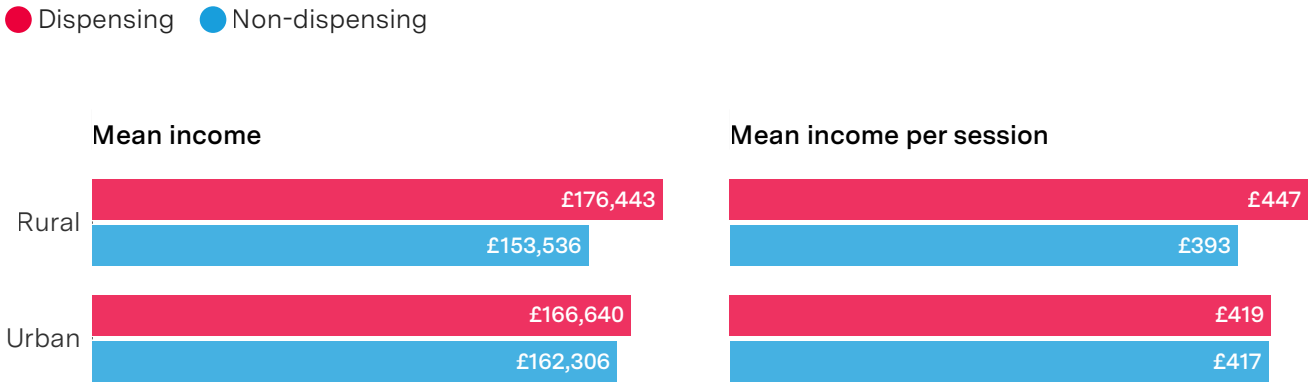
Variation between practices

Variation by dispensing practices and rurality

GP contractors in dispensing practices have higher mean incomes. When split by rurality, GP contractors in non-dispensing rural practices have the lowest mean annual income (£153,536) and income per session (£393). Rural dispensing GP contractors have the highest annual (£176,443) and per session (£447) incomes (Figure 18). This suggests that GP contractors in rural practices may be compensating for lower incomes through dispensing activity.

Figure 18: GP contractor income is highest in dispensing practices and lowest in rural non-dispensing practices

Estimated mean GP contractor income before tax by dispensing status and rurality, 2023/24 (2024/25 prices)

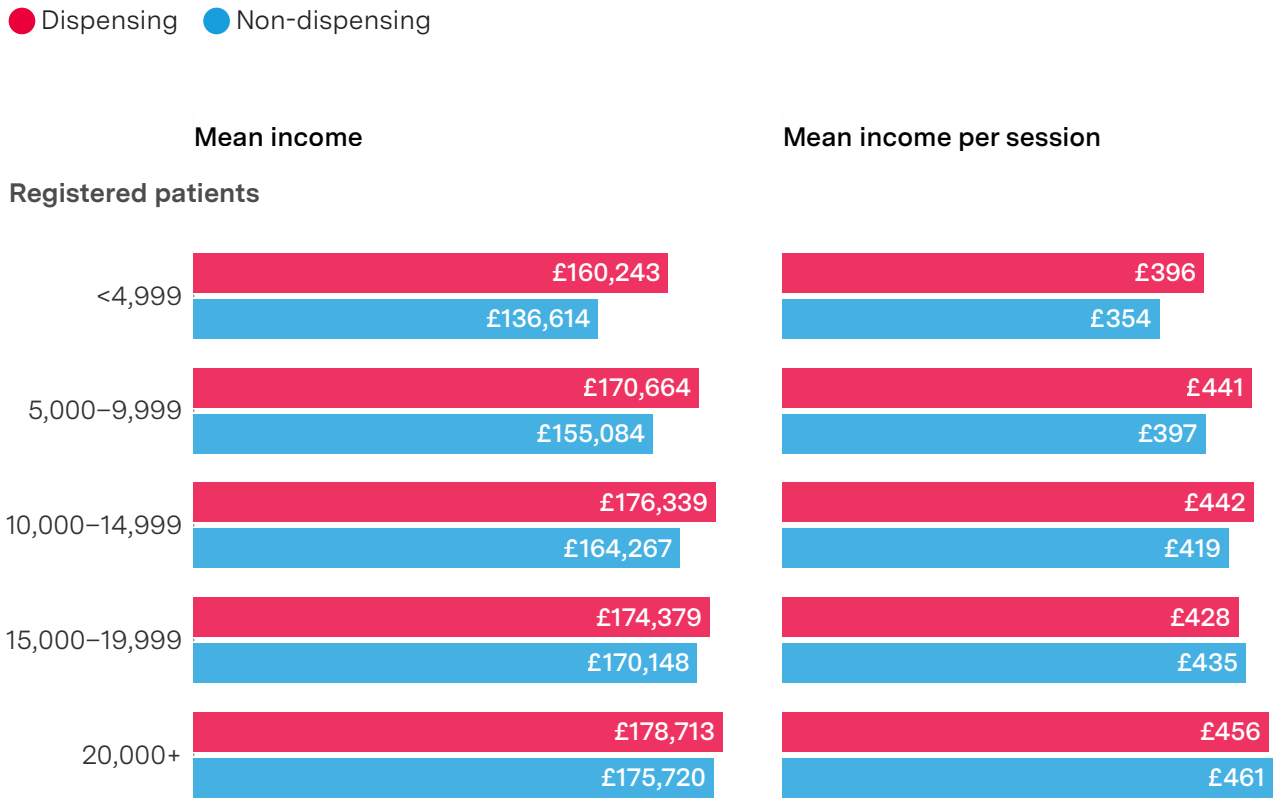


Source: NHS England, GP Earnings and Expenses Estimates, 2023/24; NHS England, General Practice Workforce (FTE annual average); ONS, CPIH deflator (2024/25 prices). · Estimates are based on HMRC Self-Assessment data and include NHS and private GP-related income. Mean income shows estimated annual income after expenses and before tax, adjusted for inflation. Mean income per session is based on reported FTE hours; reported FTE hours may underestimate actual hours worked and therefore overestimate income per session.

Variation by list size

GP contractor income varies by practice list size, with those in practices with the largest list sizes earning most – both in terms of annual income and income per session (Figure 19). This contrasts with payments per patient received by practices, with larger practices receiving lower payments per patient (see Figure 11). This suggests that economies of scale or differences in practice, population characteristics and associated workload may contribute to higher contractor income in larger practices. The GP contractor income gradient associated with practice list size narrows in dispensing practices. This suggests contractors in smaller dispensing practices, also more likely to be in rural areas, may be compensating with income through dispensing activity.

Figure 19: GP contractors in practices with larger list sizes have higher incomes, although being a dispensing practice helps compensate somewhat for this difference
Estimated mean GP contractor income before tax by patient list size and dispensing status, 2023/24 (2024/25 prices)



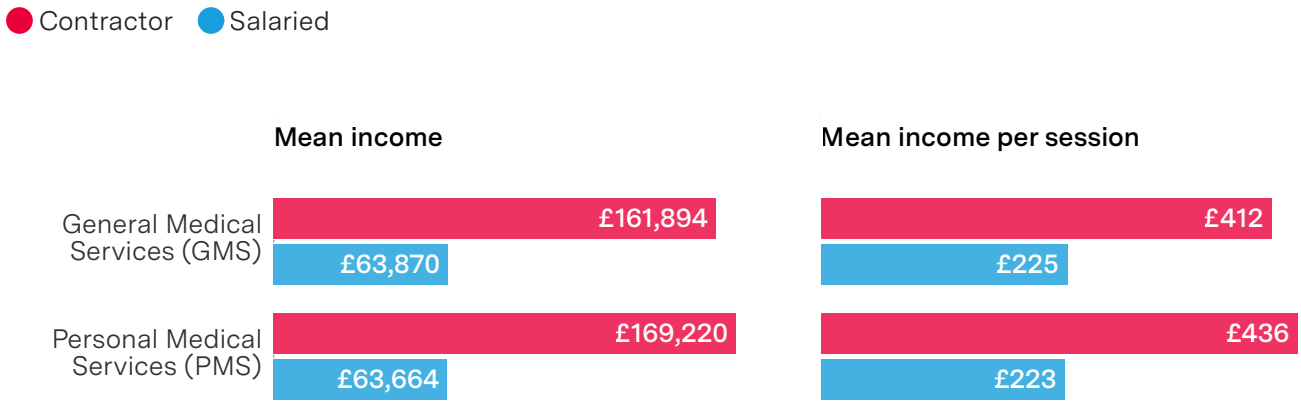
Source: NHS England, GP Earnings and Expenses Estimates, 2023/24; NHS England, General Practice Workforce (FTE annual average); ONS, CPIH deflator (2024/25 prices). · Estimates are based on HMRC Self-Assessment data and include NHS and private GP-related income. Mean income shows estimated annual income after expenses and before tax, adjusted for inflation. Mean income per session is based on reported FTE hours; reported FTE hours may underestimate actual hours worked and therefore overestimate income per session.

Variation by contract type

Despite previous concerns about differences in the income between GMS and PMS practices benefiting GPs with PMS contracts, analysis of trends between practices with different contracts between 2002/03 and 2024/25 suggest that the difference has narrowed over time (Figure S8 in *Supplementary material*). In 2023/24, there was a 4.4% difference in annual income between GP contractors with different contract types – with PMS contractors earning more (GMS £161,894 vs PMS £169,220) and a 5.7% difference in income per session (GMS £412 vs PMS £436) (Figure 20). Data on GP income from APMS practices are not published.

Figure 20: GP contractor income is higher in PMS than GMS practices on average, with little difference among salaried GPs

Estimated mean income before tax by contract type, 2023/24 (2024/25 prices)



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

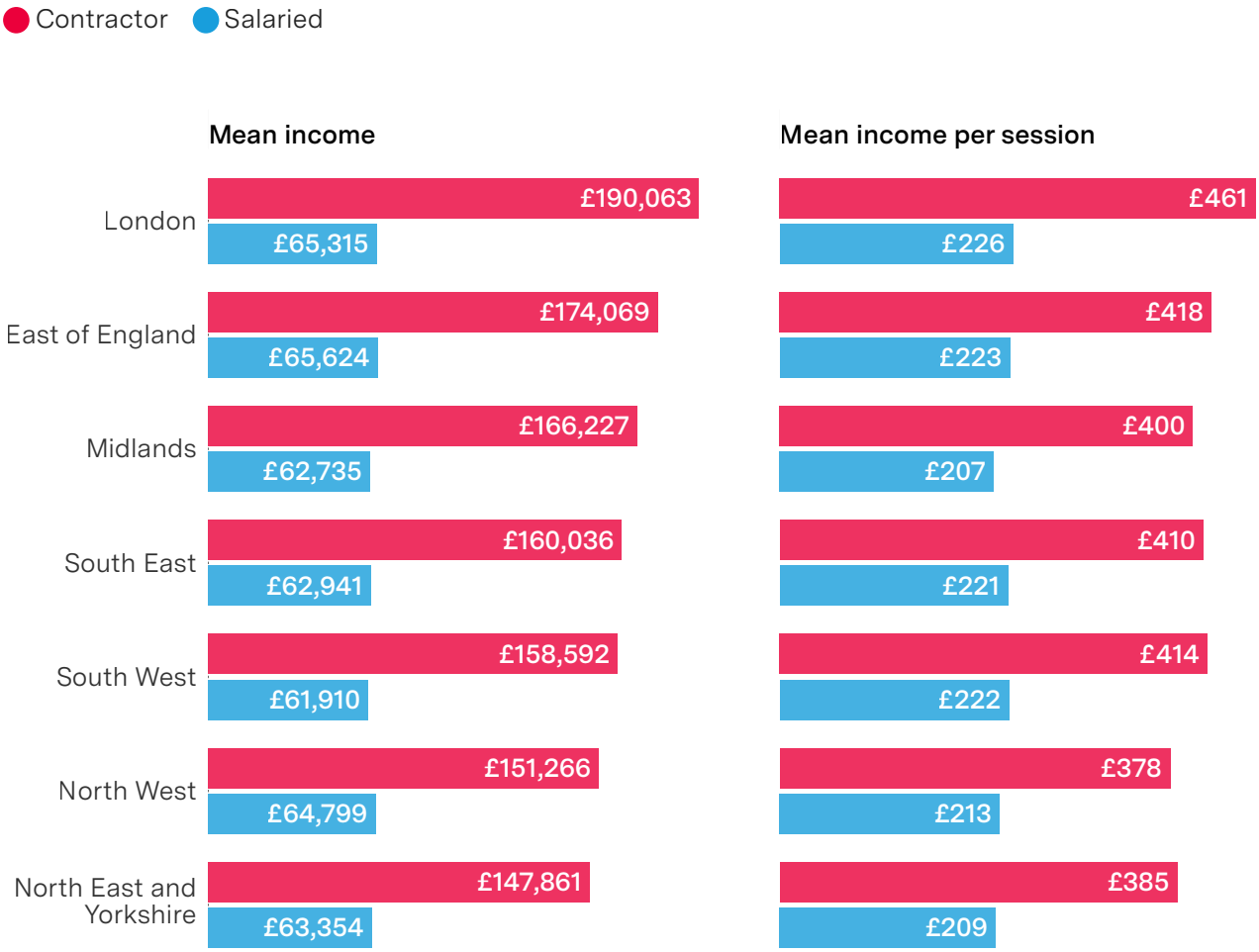
Variation by NHS region

Variation in contractor income by region (Figure 21) does not appear to follow the same pattern in variation as payments per patient by region (see Figure 13). Despite receiving the lowest payments per patient, contractors in London had the highest mean estimated annual income (£190,063), 29% more than contractors in the North East and Yorkshire, who had the lowest (£147,861). After adjusting for reported working hours, contractors in London still earned 20% more than contractors in the North East and Yorkshire per session (£461 vs £385). This suggests that contractors' ability or drive to maximise income through efficiencies or cost savings varies across the country. This may be due to differences in populations and/or workforce models. Greater income from non-NHS GP work or a proportion of high earners skewing the average income may also contribute to the differences.

Contractors in London had the highest mean estimated annual income (£190,063), 29% more than contractors in the North East and Yorkshire.

Figure 21: GP contractor income varies markedly across England, with less variation seen among salaried GPs

Estimated mean income before tax for GP contractors and salaried GPs by NHS region, 2023/24 (2024/25 prices)



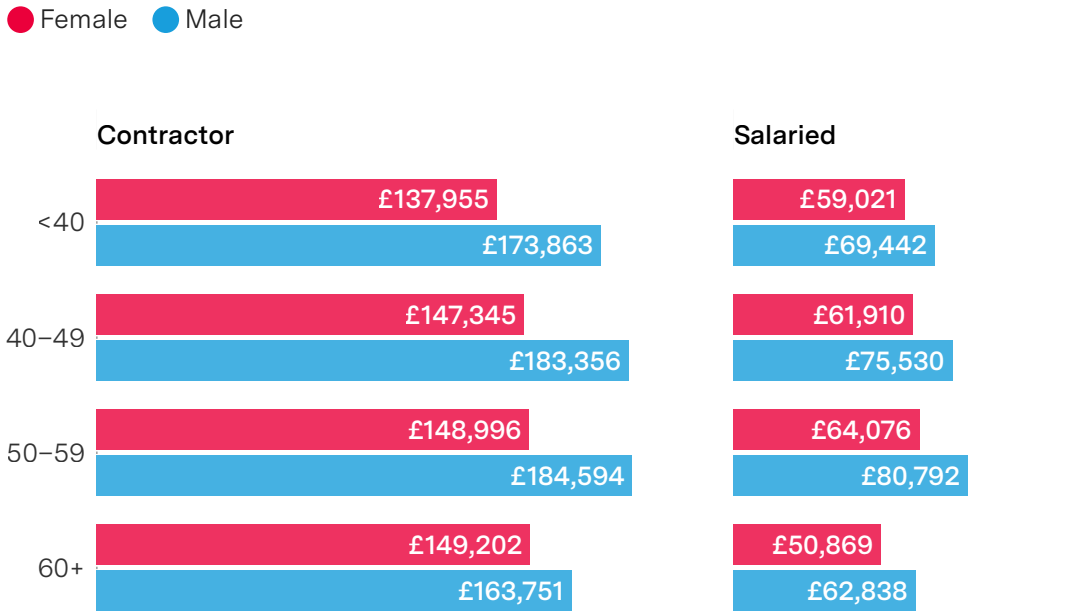
Source: NHS England, GP Earnings and Expenses Estimates, 2023/24; NHS England, General Practice Workforce (FTE annual average); ONS, CPIH deflator (2024/25 prices). · Estimates are based on HMRC Self-Assessment data and include NHS and private GP-related income. Mean income shows estimated annual income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

By contrast, salaried GP income by region shows much less variation. Analyses of salaried GP income by rurality and practice list size show salaried GPs in rural and larger practices earn marginally more than in urban and smaller practices. However, salaried GPs earn more once working hours are accounted for in smaller practices (Figures S9 and S10 in *Supplementary material*). There is little difference in salaried GP income by contract type (Figure 19). Data for salaried GP income by dispensing practice status were not available.

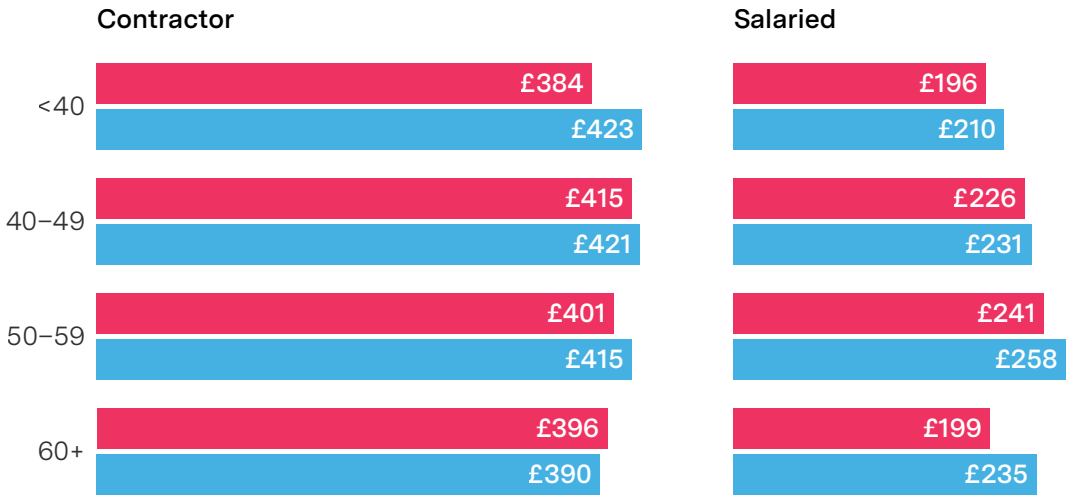
Variation by GP gender and age

Differences exist in GP income by gender and age. Although this is often attributed to differences in working hours, a pay gap persists even after adjusting for reported working hours (Figure 22).

Figure 22: A gender pay gap exists across contractor and salaried GPs
Estimated mean GP income before tax by age and gender per year, 2023/24 (2024/25 prices)



… and persists across most age groups after adjusting for reported working hours



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

Male GPs earned more than female counterparts in all age groups and roles, except for contractors aged 60 years and older per session. The gap in income was notable among those aged younger than 40 years, with male contractors and salaried GPs respectively earning 10% and 7% more per session than female counterparts (contractor female £384 vs male £423; salaried female £196 vs male £210 per session). The difference in income per session was largest between salaried GPs aged 60 years and older, with an 18% difference in estimated mean income per session (female £199 vs male £235 per session).

Male GPs earned more than female counterparts in all age groups and roles, except for contractors aged 60 years and older per session.

Discussion

Policymakers have repeatedly promised to increase investment in general practice. The government's 10-Year Health Plan commits to 'increase the share of NHS resources spent in the community and decrease the share spent in hospital'.[3] Yet debates about general practice funding are often based on a limited understanding of how much money is invested and the way this flows through the system. We analysed a range of general practice funding data to inform policy decisions on funding and reform in primary care.

Summary of findings

Overall, we find that the real-terms rise in general practice investment between 2015/16 and 2024/25 has been lower than the rise in total NHS investment. This means the share of NHS spending going towards general practice has fallen. Additional investment in general practice has been largely driven by primary care network funding, accounting changes and funding streams that have not translated into direct payments to practices, although some have indirectly benefited GPs (eg clinical negligence cover). As a result, after accounting for population growth and inflation, payments made to practices were lower in 2024/25 than a decade earlier and practices now have less discretion over how to spend the money invested in general practice. Despite a rise in investment via the GP contract subsequent to 2024/25, the percentage of the NHS budget invested in general practice remains low relative to what it provides.

Money flows to general practice through a blend of funding streams – the largest being the global sum (Carr-Hill) capitation formula. While Carr-Hill allocates more funding to practices in more deprived and rural areas of England, this may not be sufficient to account for the additional health and care needs of these populations or the staff recruitment and retention challenges practices face in these areas. Taking all funding streams together, a socioeconomic gradient exists favouring more affluent practices.

Substantial variation exists in GP contractor income over time and between contractors. Higher GP contractor income is associated with running a dispensing, larger or London-based practice. While practice expenses have risen significantly since 2013/14, contractor income before tax has also increased in real terms. Even after accounting for reported working hours, on average, there is a near double difference in estimated

income before tax between contractor and salaried GPs. A gender pay gap also exists favouring male GPs, among both contractor and salaried GPs, that persists after adjusting for reported working hours.

This analysis brings together a broad range of datasets on general practice for the first time. While this provides a comprehensive picture, there are limitations to consider when interpreting our findings (see Box 6). We report on the methods used, but differences in how data sources are constructed and updated required judgements to be made about how to group and compare funding streams.

Box 6: Limitations

Gaps in data: Important gaps in national datasets limit transparency, the kind of analysis possible and may skew the available data (see tables S4–S6). At the time of publication, no *Investment in general practice* data have been published since 2022/23, including PCN funding. The full content of some categories in both *Investment* and *Payment* datasets is not publicly available. While data have been adjusted to represent real-terms figures for 2024/25, any conclusions based on comparing cross-sectional data from different years and adjustments for inflation must be interpreted with caution. Our analysis also only examines NHS-related spend on general practice and does not capture private expenditure on general practice – which is reported to be increasing.[11] It also may not capture all other potential sources of investment, such as by local authorities or from elsewhere in government.[97]

Differences between list sizes and population estimates: Known discrepancies between general practice list sizes and ONS population estimates may affect any figures reported on a per patient basis. ONS population estimates were around 7% lower than registered practice lists in 2024, and the gap has increased over time.[7,98,99] This is likely to reflect a combination of factors, including 'ghost patients' arising from duplicate registrations and delays in deregistering individuals who have left England. Underestimation of some population groups in ONS estimates is also possible. The true gap between registered lists and the resident population is therefore uncertain. Nevertheless, per patient funding and workforce estimates would generally be higher if based on ONS population estimates, and the scale of any discrepancies may vary between practices, likely affecting those with high patient turnover more.[98]

Box 6 (continued)

Limitations of earnings and workforce data: *GP earnings and expenses* are estimates based on a sample of HMRC self-assessment tax returns and have several important limitations: GP contractor income may include other GP-related earnings such as private work; salaried GP figures do not capture those who do not submit returns; and data are provided in pre aggregated form, restricting further analysis. It is not possible to link GP earnings and expenses data with practice socioeconomic deprivation levels, practice activity (eg number of appointments), quality of care or patient satisfaction. Reported estimated income before tax also does not adjust for working hours. We have used NHS England's *General practice workforce data* on reported FTE hours by GP role to estimate income per session. However, there are limitations to this data, which are reported by practice managers, and FTE figures are known to underestimate true working hours, meaning income values adjusted by reported working hours may overstate typical earnings per session.[96]

Simplification and accessibility: While we have presented median alongside mean values for key figures, the use of mean values in some sections may have obscured skewed distributions and wide ranges. Although we stratify practice payments and GP income by a range of practice, population and GP characteristics, further analysis using multivariable models would help explain how these factors relate to each other and funding, as well as to other variables of interest such as quality of care and patient satisfaction.

Different approaches to weighting need by socioeconomic deprivation: We generated a practice-level measure of deprivation based on the registered patient list and IMD score to generate practice-level deprivation quintiles. This can also be done using the IMD's health domain alone or another combination of IMD domains. We use weighted patient list size as reported by NHS England (which is based on the Carr-Hill formula) to convert actual total practice payments (within which the global sum component is based on the Carr-Hill formula) into weighted payments per capita. Other weighting formulas – such as that proposed in the 2007 review, the ICB Primary Medical Services allocations formula or other proposals, may have produced different distributions of payments across the various practice and population characteristics that we examined.[20,36,90] We anticipate that the Carr-Hill formula review and any proposals for new formulas would carefully examine what effect a different weighting formula would have on the current distribution of payments for different population and practice characteristics.

Box 6 (continued)

What counts as 'general practice funding' varies: Some costs are not reported in funding flows related to general practice in England. This includes the costs of diagnostic tests requested in general practice but undertaken in the community or local hospitals, or prescriptions issued in general practice but delivered by community pharmacies. These, however, arguably also contribute to the total investment in general practice and to some degree lie within the control of general practice. We have included analysis of dispensing and drug reimbursement payments as these drive differences in payments as well as GP contractor income, and prescribing behaviour, between practices.[100,101,102] Arguably, however, dispensing activity may be viewed as a distinct separate activity in the same way as community pharmacy, and therefore GP income related to dispensing activity could be considered separately.

Policy implications

Our analysis points to five policy implications for general practice in England: (1) set clear investment targets; (2) review all funding streams; (3) balance new contracts with core general practice; (4) close pay gaps; and (5) test modifications or alternatives to the partnership model.

1. Set clear investment targets

NHS spending is growing more slowly than the historical average and the share of NHS spending going towards general practice declined in the decade up to 2024/25. While the increase in funding via the GP contract subsequent to 2024/25 is welcome, significant additional investment in general practice will be required to deliver on the government's promises to boost prevention and shift more care out of hospital. Funding is needed to recruit and retain staff, invest in digital infrastructure and modernise general practice estates.

International evidence suggests primary care is often underfunded relative to its contribution to improving health and reducing inequalities, and better funded general practices are associated with better patient experience and clinical outcomes.[103,104,105,106] Given the volume of care provided in general practice and its role in preventing more costly hospital treatment, underinvestment risks increasing costs elsewhere in the health system. Yet general practice is expected to meet rising demand, improve

access, deliver more preventive care and reduce pressure on hospitals while receiving a relatively small share of NHS funding.

This is not new. Policymakers have repeatedly promised to shift NHS investment towards primary and community care.[78,79] But hospitals dominate the agenda due to visible pressures on services, high-profile targets to reduce hospital waiting lists, and short-term funding and political cycles.[107] The most recent government's 10-year health plan again commits to increase the share of NHS investment in primary and community care.[3] But what this means in practice is unclear and – as our analysis illustrates – multiple definitions and datasets for general practice funding make it difficult to track investment and hold government to account for spending decisions. Plans to introduce integrated health organisations (IHOs) in the NHS, likely to be led by large NHS trusts, could also make it harder to shift resources towards general practice.[108,109]

A clear policy commitment is needed to increase the share of NHS spending allocated to general practice. This could be achieved through a minimum investment standard – nationally or potentially set at ICB level – requiring a year-on-year rise in the proportion of NHS spending allocated to general practice over a defined time period. This should be accompanied by greater transparency and consistency in how funding reaching general practice is measured and reported, and clarity on the outcomes policymakers expect from the extra investment. Policymakers also need to reduce the uncertainty around GP contracts, which are often negotiated behind the scenes and published with a 1–2 month lead-in time. Longer term contracts that set out the scale and conditions of new funding commitments may reduce risk-averse behaviour among GP contractors, such as reluctance to reinvest profits or employ new staff.

2. Review all funding streams

Any potential boost in funding raises questions about how this would best be allocated across general practices. Each funding stream flowing into general practice is underpinned by a formula that aims to calculate a 'fair' amount for the service provided. Inequities or inefficiencies in how funding is allocated can happen for a mix of reasons – for instance, because there is a large gap between reimbursement formulas and actual costs.

The government is currently reviewing the Carr-Hill formula to ensure it adequately accounts for the extra work and unmet need encountered

by practices in more deprived areas.[39] This is welcome. Carr-Hill does direct additional funding towards practices in more deprived areas, however, this may not be enough to account for additional needs – and the market forces factor within the formula may be counteracting the intended effects.[35] But our analysis illustrates the need for the government to look at all funding streams going into general practice – not just Carr-Hill. Pay-for-performance and ad hoc payments for practices may be contributing to inequities in funding, and our analysis finds the biggest drivers of differences in payments between practices are dispensing and drug reimbursement payments – both greater in less deprived areas. This aligns with the work of others in this area.[110]

Revising the general practice funding formula is not straightforward and depends on political priorities. Analyses of the relationship between funding and deprivation can use different methodological approaches and produce different results. Recent analysis of the 'workload' component of the Carr-Hill formula, after removing the market forces factor, found Carr-Hill placed higher weights on deprived areas compared with a proposed alternative aiming to account for differences in health care use using up-to-date electronic health record data.[111,112] The authors recommended that equity concerns be addressed through payment mechanisms other than the workload aspect of the formula. Recent multivariable analysis of total payments to general practice, excluding drug and premises reimbursements, found greater funding was associated with deprivation, but differences were small and the effect diminished at higher levels of deprivation.[113]

Ultimately, the 'right' answer for how to allocate funding will depend not just on technical considerations about how to best measure health needs and adjust for inequalities between practice populations, but also on judgements about the core purpose of general practice. This includes how far the payment system and general practice are designed to respond to existing demand for care as well as altering future patterns of disease and tackling inequalities.[114]

Any significant revision to general practice funding allocations risks creating winners and losers. Changes need to be phased, transparent and combined with iterative evaluation. For any reform to be accepted by GPs, revisions also need to ensure that no practices lose out, even though some practices may not gain as much as others. Some NHS

ICBs have developed their own approaches to addressing inequities in general practice funding and could offer lessons for how to navigate the changes.[40,115,116,117] Alternative models of funding are also emerging with the aim of providing greater resources to general practice through LIS funding and variations to the existing PCN DES that will merit evaluation.[118,119]

3. Balance new contracts with core general practice

Policymakers must also decide where any additional investment should flow. Funding for general practice can be channelled at different levels: directly to individual practices; to primary care networks or other community-based organisations coordinating primary and community care services; or to larger integrated providers spanning secondary, primary and community care. It may also be delivered through organisations with different ownership models, ranging from GP partnerships and NHS bodies to social enterprises and private companies. These choices involve trade-offs between local autonomy, public accountability, financial incentives, equity and the extent to which funding reaches front-line services.

Each approach offers pros and cons. For example, capitation payments made direct to practices offer GPs flexibility to decide how funding is used to meet local needs. But this funding can be used in a variety of ways – including, under the current model, increasing GP contractor income – and may not deliver the service changes policymakers want to achieve. On the flipside, earmarked funding for defined services or funding routed through larger organisations can be used to encourage collaboration across services and the development of new models of care. But – when additional funding is scarce – these approaches can detract from the provision of core general practice and may reduce flexibility to tailor services to local needs. Our analysis shows that, over time, an increasing share of investment in general practice has been tied to specific purposes or channelled through larger organisations. As a result, the proportion of funding that practices can deploy flexibly has fallen. The government's 10-year plan and Neighbourhood Health Framework suggest this trend will continue, with organisations larger than individual general practices likely to take on a growing role in delivering community-based services through the proposed small and medium neighbourhood provider contracts.[109,120]

Policymakers must ensure that funding for core general practice services is not diluted through these changes. Improving access to general practice is one of the public's top priorities for the NHS – meanwhile the evidence for continuity of care is strong and research suggests that what many patients want is straightforward but too often scarce: an appointment with a GP they know and trust.[9,121,122] Larger neighbourhood organisations may play a growing role in community-based care, but the test of any funding reform is whether it strengthens access to high-quality, comprehensive and equitable general practice.

4. Close pay gaps

If the NHS is to recruit and retain more GPs, significant pay gaps within the profession must be addressed. First, the gender pay gap in medicine has been well documented, and our analysis suggests it persists among both contractor and salaried GPs, even after accounting for reported working hours.[123,124] Closing this gap is not only a matter of fairness but also of workforce sustainability. Women now outnumber men in the GP workforce, yet evidence suggests they face disadvantages across multiple aspects of their careers, including barriers to partnership.[125] Improving transparency in GP earnings, supporting equitable access to partnership and ensuring that flexible working does not carry financial penalties could help reduce these disparities.

Second, policymakers need to better understand why GP income varies between different types of practices and assess whether differences represent appropriate rewards for different services, risks and responsibilities, or whether they reflect funding arrangements that inadvertently undermine efficiency, equity or quality. These differences are likely to be underpinned by a mix of reasons with different implications (see Box 7).

Third, policymakers must address the large and growing gap between contractor and salaried GP pay. International comparisons suggest salaried GPs in the UK earn below the OECD average for GPs relative to national average wages, while GP contractors earn well above it.[127] GP contractors play a vital role in running practices and take on substantial managerial and financial responsibilities. They now represent only around 8% of the total workforce in general practice and the high number of practice closures and mergers in recent years suggests they are operating under considerable pressure. Some difference in pay between contractors and salaried GPs is therefore expected.

Box 7: Potential reasons for differences in GP contractor income by practice type and implications

- Higher GP contractor incomes in dispensing practices may reflect both the provision of an additional service and the need to cross-subsidise income in rural practices. However, given documented differences in prescribing behaviour, this may not always align with efficient resource allocation or patients' interests.[100,101,102]
- Higher GP contractor incomes in larger practices may reflect economies of scale, but the relationship between practice size and performance is mixed indicating potential trade-offs between scale, income and quality of care.[85,144]
- London practices receive the lowest payments per patient but have the highest GP contractor incomes alongside the lowest GP to patient ratios.[24,126] This may reflect workforce model decisions that could have implications for patient safety and quality of care and/or greater numbers of 'ghost' patients with implications for fair resource allocation.[98]
- Although we could not analyse GP income by deprivation, national survey evidence suggests GPs working in more deprived areas report lower incomes alongside greater workload pressures creating financial disincentives to work in areas often with the greatest health needs.[14]

However, our analysis suggests that the gap is now substantial, even after accounting for reported working hours, and in some cases GP contractor income is substantially higher than roles that may be considered to have equivalent responsibility, such as NHS consultants or other senior public sector roles.[128,129] At the same time, reports of GP underemployment and unemployment sit alongside continued difficulties accessing NHS general practice. This raises important questions about whether the current model is providing sufficient opportunities and incentives for the growing salaried GP workforce.

The DDRB already recommends pay levels and uplifts for salaried GPs, but whether these are fully funded and passed on by practices varies. Firmer mechanisms to ensure uplifts are applied could be considered in England, such as those introduced in Wales.[130] Previous policies requiring the publication of GP earnings have generated opaque data and it remains unclear what impact they have had.[131] More transparent reporting of GP earnings and employment arrangements, particularly where there

appear to be very high patient to GP ratios, could also help policymakers understand where funding is flowing and whether it is supporting recruitment and retention, and safe care.

More broadly, if the NHS wants to recruit and retain more GPs, any funding reform must consider how pay, working conditions and opportunities to earn compare with those available to NHS consultants – given they will compete from the same graduate doctors.[132] Recent public polling found that over half the public is supportive of NHS GP income being on par with that of NHS hospital consultants.[9]

5. Test modifications or alternatives to the partnership model

Finally, falling contractor numbers, practice closures and disparities in GPs' earnings inevitably point to increasingly frequent questions about the future of the GP partnership model in England.[25,133,134,135,136] Partnership is no longer an aspiration for many trainee GPs and, in many areas, partnership opportunities for those who want them can be hard to find.[136,137] As a result, the number of younger GP partners is falling.[24]

Alternative models for managing GP services have emerged in England – including 'super-partnerships', community interest companies, limited companies and NHS trusts running GP services in some settings.[138,139] New IHOs might be expected to take a more active role in managing primary care. Yet evidence in favour of a more 'vertically' integrated model is limited in England and mixed internationally.[41,140,141,142,143]

The partnership model can benefit GP autonomy, provide flexibility to respond to local needs and for innovation. At the same time, if GPs became salaried NHS employees – like NHS consultants – there could be potential for more structured career progression, better management support, less individual financial risk and a reduction in the significant gaps in pay. Recent public polling found over half the public is supportive of general practices being run as NHS organisations, where no individual makes a profit or is liable for debts and losses, versus only 6% supporting the current partnership model of unlimited liability and uncapped profits.[9] However, the overall cost of a fully salaried model could be higher than the current model and may not have the desired effect on recruitment and retention, or quality of care.

Any potential shift away from the predominant independent contractor model would need to be approached with considerable care. Rapid or wholesale restructuring would likely result in distraction, additional costs and unintended consequences. But modifications or alternatives to the partnership model – developed in collaboration with policymakers, general practice and the public – could be explored and carefully evaluated to understand whether they may offer a more sustainable future for general practice in England.

Conclusion

General practice is central to the NHS's ability to function, yet its funding has not kept pace with the role policymakers expect it to play. Despite repeated commitments to strengthen care in the community, the share of NHS spending on general practice has declined, and much of the apparent growth in investment has not translated into flexible funding for practices. At the same time, a complex blend of payment streams may have contributed to inequities between practices and created incentives that do not always support improvements in quality or effective resource allocation.

These funding pressures are closely intertwined with challenges facing the GP workforce. Wide and growing differences in pay between contractor and salaried GPs, and differences between male and female GPs, raise concerns about fairness and long-term sustainability of the GP workforce. Current funding and incentive structures risk undermining recruitment and retention efforts unless addressed.

If the government is serious about delivering a shift from hospital to community care, general practice funding will require more than incremental adjustments. A clear, multi-year commitment to increasing investment is needed, alongside reform to how funding is allocated and used. This includes addressing inequities and inefficiencies across funding streams, improving transparency of GP earnings, and aligning incentives with both the needs of patients and the workforce. Without these changes, general practice will remain under strain – leaving ambitions to expand access, improve population health and reduce pressure on hospitals unlikely to be realised.

Glossary of key terms and abbreviations

Term/abbreviation	Definition
Access and transformation funding	NHS funding to support GP practices in improving access to care and transforming service delivery, including through digital tools, service redesign and changes to practice workflows.
ACRA	Advisory Committee on Resource Allocation – provides advice on funding allocation formulas in the NHS (including primary medical care allocations).
Adjustment	A change made to a practice's funding calculation to reflect factors such as population need, deprivation, rurality or local costs, so that funding is distributed more equitably between practices.
APMS	Alternative Provider Medical Services – a GP contract type that can be held by non-traditional providers (eg private/third sector/NHS bodies) and is typically time limited.
ARRS	Additional Roles Reimbursement Scheme – PCN DES-related funding earmarked to employ specified additional staff roles (eg pharmacists, physiotherapists, social prescribers).
BMA	British Medical Association – trade union/professional body that negotiates aspects of GP contracts through its GP Committee.
Borrowing costs reimbursement	NHS reimbursement of eligible mortgage or loan costs incurred by GP practices that own their premises (previously known as 'cost rent').
Capitation	Payment method where providers are paid a set amount per registered patient (often adjusted for need).
Carr-Hill (formula)	The global sum capitation formula – introduced with the 2004 GP contract, adjusting payments for workload and need (using factors including morbidity/proxy measures, age/sex, list turnover, rurality, etc).
CCG	Clinical commissioning group – former commissioning bodies in England (replaced by ICBs).
Clinical negligence cover	Insurance/indemnity arrangements covering clinical negligence liabilities.
Commissioning	The process of planning, purchasing and monitoring health care services for a defined population.
Contractor expenses	The costs of running a general practice and providing services, including staff, premises, equipment and administrative costs. These expenses are deducted from earnings to calculate GP contractor income.
CPI	Consumer Price Index – a measure of inflation.
CPIH	Consumer Price Index including owner occupiers' housing costs – ONS's lead inflation measure (used in the report for deflating GP income time series).

Term/abbreviation	Definition
CPRD	Clinical Practice Research Datalink – a UK primary care electronic health record research dataset (used to inform workload/need measures in funding formula development).
DDRB	Doctors' and Dentists' Review Body – makes recommendations on pay for doctors/dentists, including evidence relevant to GP earnings.
DES	Directed Enhanced Service – nationally specified 'optional extra' services beyond core GP contract services that practices can opt into.
DPC roles	Direct patient care roles (often used in the context of PCN workforce expansions under the ARRS), including patient-facing roles that are not doctors or nurses, eg pharmacist, physiotherapist, social prescriber.
Earmarked funding	Money allocated for a defined purpose or cost category (eg premises reimbursement), rather than at the practice's full discretion of use.
Fee-for-service	A payment system in which providers are paid for each service or activity they deliver.
Full-time equivalent (FTE)	A standardised measure of workforce time relative to a full-time post. Full time in general practice is considered to be nine sessions per week (at 4 hours and 10 minutes each) or a total of 37.5 hours per week.
GDP deflator	Gross Domestic Product deflator – an economy wide measure of inflation used to convert cash spending into 'real-terms' spending.
General practice	NHS primary medical care delivered by general practices for registered patients, including first-contact, ongoing and coordinated care, diagnosis and treatment, prevention, long-term condition management, and referral to other services where needed.
Ghost patient	A patient incorrectly remaining on a GP practice register due to delayed deregistration or duplicate registration.
GMS	General Medical Services – the main national GP contract framework in England.
GP	General practitioner – a doctor working in general practice.
GP contractor (partner)	A GP who is a self-employed contractor (often a partner) providing services under a GP contract – income is typically an 'operating surplus' after expenses.
GP earnings and expenses	NHS England series estimating GP income and expenses (typically using HMRC tax return data, aggregated).
GP contract value	The published/announced total value of the GP contract at the start of a given year. The contract value at the start of the financial year may vary from that at the end of the year, once in-year adjustments have been made – for example following DDRB recommendation on pay uplifts. GP contract value includes all PCN-related investment.

Term/abbreviation	Definition
GP primary care services	Category used in *NHS England annual report and accounts* to capture GP primary care service operating expenses.
Goodwill	The intangible value of a business, such as its reputation and future earning potential. NHS GP contracts do not permit the sale of goodwill.
ICB	Integrated care board – NHS statutory body responsible for planning/commissioning services in an area (replaced CCGs).
IHO	Integrated health organisation – a proposed/illustrative model for more integrated provider arrangements between primary and secondary care.
IMD	Index of Multiple Deprivation – official small-area measure of relative socioeconomic deprivation in England (often grouped into quintiles or fifths of population).
Income before tax	A GP's earnings after allowable expenses but before income tax. Published estimates are adjusted for superannuation (pension) contributions so that employer pension contributions are excluded from contractor GP income and employee pension contributions are included in salaried GP earnings, ensuring comparability between GP groups and over time.
Investment in general practice	NHS England publication series estimating 'investment' in general practice, including some items not paid directly to practices (eg centrally funded costs).
Levies/deductions	Amounts deducted from gross practice payments (eg pensions, contractual adjustments), reducing net payments received.
LIS	Local Incentive Scheme – locally commissioned incentive payments for specified activities (varies by area/ICB).
List size	The total number of patients registered with a general practice. In some funding mechanisms, list size is weighted to account for differences in population need.
Locum	A clinician providing temporary cover (often sessional work) rather than a permanent post. Ad hoc locums cover short-term sickness or annual leave. Long-term locums cover workforce gaps such as maternity leave or unfilled posts.
LSOA	Lower-layer Super Output Area – a small geographical area used for the collection and reporting of statistics in England, typically containing around 1,600 residents or 650 households.
MFF	Market Forces Factor – an NHS defined adjustment intended to reflect geographic cost differences (eg staffing cost pressures).
MPIG	Minimum Practice Income Guarantee – payment mechanism introduced to protect practices from losing income during contract changes following the 2004 contract reforms. This was phased out over a 7-year period ending in March 2021.

Term/abbreviation	Definition
NAO	National Audit Office – independent body that audits government spending and examines whether public services, including the NHS, deliver value for money.
NHS England	National body responsible for leading the NHS in England (functions/ structures subject to reform over time).
Notional rent	NHS reimbursement paid to GP practices that own their premises, based on the property's assessed current market rental value.
ONS	Office for National Statistics – UK national statistics agency (eg publishes CPIH and population estimates).
Out-of-hours (OOH)	GP services provided outside core hours (evenings/weekends), funded through separate arrangements. Most practices opted out of providing this services following the 2004 GP contract.
Pay-for-performance	A payment system in which part of providers' funding is linked to achieving specified performance or quality targets.
Payments to general practice	NHS England publication series of payments made to general practice, largely reflecting funding paid directly to practices (with known exclusions/coverage changes over time).
PCN	Primary care network – groups of practices serving a local population, introduced with the PCN DES in 2019 and providing additional funding. PCNs typically cover 30,000–50,000+ patients.
PCN DES	Primary care network Directed Enhanced Service – the contractual mechanism underpinning PCNs, including specifications and funding such as ARRS.
PCN/Network participation payment	A payment linked to participation in the PCN DES made direct to the practice rather than via PCN accounts (reported in the Payments dataset even when other PCN flows are not).
PCO	Primary care organisation – historical/administrative term used in some dataset categories (often not fully transparent).
PMS	Personal Medical Services – locally negotiated GP contract type introduced in 1998 (used less over time).
Parliamentary question	A formal question submitted by a parliamentarian to a government minister to seek information or challenge government policy and performance.
Primary care	The first point of contact with the NHS for most people, encompassing general practice, community pharmacy, dentistry and optometry. In this report, where the focus is general practice funding, 'primary medical care' mainly refers to NHS-commissioned general practice services.

Term/abbreviation	Definition
Primary medical care	The spend category for services commissioned by NHS England and the integrated care boards (ICBs), formerly the clinical commissioning groups (CCGs), using audited figures between 2015/16 to 2024/25. Prescribing and delegated pharmacy/ophthalmology/primary and secondary dental all sit within the 'Other' category, and therefore not under 'Primary medical care'.
QOF	Quality and Outcomes Framework – pay-for-performance scheme introduced in 2004, based on achieving specified indicators.
Real terms	Values adjusted for inflation.
Registered patient list	The total number of patients registered with a general practice making up their list size. In some funding mechanisms, list size is weighted to account for differences in population need.
RPI	Retail Price Index – older inflation measure no longer a national statistic (can overstate inflation).
Salaried GP	A GP employed on a salary (rather than self-employed partner/contractor).
Session	A unit of GP working time commonly treated as 4 hours 10 minutes; nine sessions per week is considered full time.
SLLI	Standardised Limited Long-Standing Illness – a measure of the prevalence of limiting long-term illness in a population, adjusted for differences in age and sex so that rates can be compared across areas. Can be used as an indicator of health need.
SMR<65	Standardised Mortality Ratio under age 65 – a measure of premature mortality comparing the number of deaths among people younger than 65 years with the number expected based on national mortality rates, adjusted for population structure. Can be used as an indicator of health need and inequality.
Weighting	The adjustment of a practice's registered patient list to reflect the relative health care needs of its population and the costs of delivering services.

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