

# **A guide to the market forces factor**

*A supporting document for the 2016/17 National Tariff  
Payment System*

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## Quick guide: the market forces factor and its use in the national tariff

The market forces factor (MFF) is an estimate of unavoidable cost differences between healthcare providers, based on their geographical location. The MFF is used to adjust resource allocations in the NHS in proportion to these cost differences, so that patients are neither advantaged nor disadvantaged by the relative level of unavoidable costs<sup>1</sup> in different parts of the country.

We give each NHS organisation an individual MFF value. The relative values of all organisations are expressed in two indices:

- the **underlying index**, which is used to adjust funding flows: in higher cost areas, commissioners receive higher levels of funding through the allocation formula so that they are able to meet the higher costs of providers for the same level of healthcare
- the **payment index**, which is used in the national tariff to adjust prices at the local level for each provider.

Unless otherwise stated, the index referred to in this document is the payment index.

We have not updated MFF values in 2016/17. Values for 2014/15 have been rolled forward<sup>2</sup> unless providers have undergone either a merger or dissolution before the start of 2016/17 financial year.

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<sup>1</sup>We use the term 'unavoidable costs' in this document to refer to costs that providers are unable to significantly influence due to their geographical location. For example, land, buildings and staff costs all include unavoidable elements - the level of these costs varies across the country.

<sup>2</sup> The calculation of which is explained here:

<https://www.gov.uk/government/publications/guide-to-the-market-forces-factor-201415>

## **Purpose of this document**

This document is an explanatory guide to the MFF, particularly in terms of how it applies to the national tariff.

**Please note:** For the 2016/17 national tariff, as with the 2014/15 national tariff, Monitor and NHS England have not changed the approach to MFF that was applied by the Department of Health (DH) in the 2013/14 national tariff. Therefore, many of the notes in this document, particularly those related to the calculation of MFF values, are taken directly from previous work by DH.

The remainder of this document explains:

- what 'unavoidable costs' means for the purposes of the MFF
- how the MFF is applied to both commissioner budgets and pricing
- what we are doing with the MFF in the 2016/17 national tariff
- how the DH calculated the MFF values that we are using.

## **Unavoidable costs**

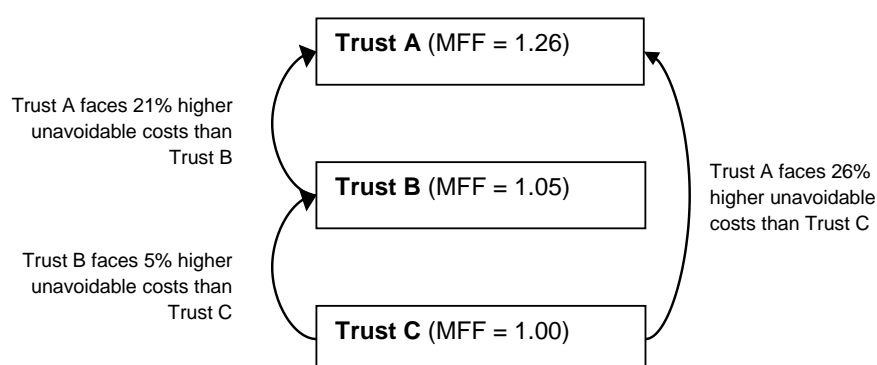
We use the term 'unavoidable costs' in this document to refer to the costs that providers are unable to significantly influence due to their geographical location. For example, land, buildings and staff costs all vary across the country for reasons that are beyond the control of healthcare providers.

Trusts are confined within a specific region and they must face the costs associated with their location. For example, hospitals that must be located in central London will face higher unavoidable costs than hospitals located in outer London.

## **Application of the market forces factor**

The MFF compares the unavoidable costs between organisations and ranks them according to the relative level of unavoidable costs they face (see Figure 2). In Figure 1, Trust C is the lowest cost provider, Trust B faces unavoidable costs 5% greater than C, and trust A faces costs 26% higher than C.

**Figure 1: Comparison of relative trust MFF values**



These relative levels of unavoidable cost are expressed in two MFF indices:

- the underlying index
- the payment index.

Both indices are based on the same set of data.

### **Underlying index is used to allocate commissioner funding**

The underlying index is used to inform clinical commissioning group (CCG) allocations. It is set so that the base to which all values in the index are relative is the average value; the underlying index has an average value of 1.0. Organisations facing higher (lower) unavoidable costs than the average organisation have a value greater (less) than 1.0.

This approach is intended to ensure commissioners in any geographical area can afford the same level of care for their population. Commissioners receive different levels of funding depending not only on the size and needs of their population but also on the varying costs of services in different areas. Commissioners in higher cost areas receive additional funding to ensure they can afford the same level of services relative to need as those in other areas.

The underlying index is also used to calculate the Reference Cost Index (RCI). See Appendix D for further details and a worked example.

### **Payment index is used to adjust national prices**

The payment index is used to adjust national prices in the national tariff in proportion to the level of unavoidable costs for each provider. This index is set so that the base to which all values are relative is the minimum rather than the average. The payment index has a minimum value of 1.0. The organisation with the value of 1.0 faces the lowest unavoidable costs. Organisations with a value greater than 1.0 face higher costs. For example, an organisation with an

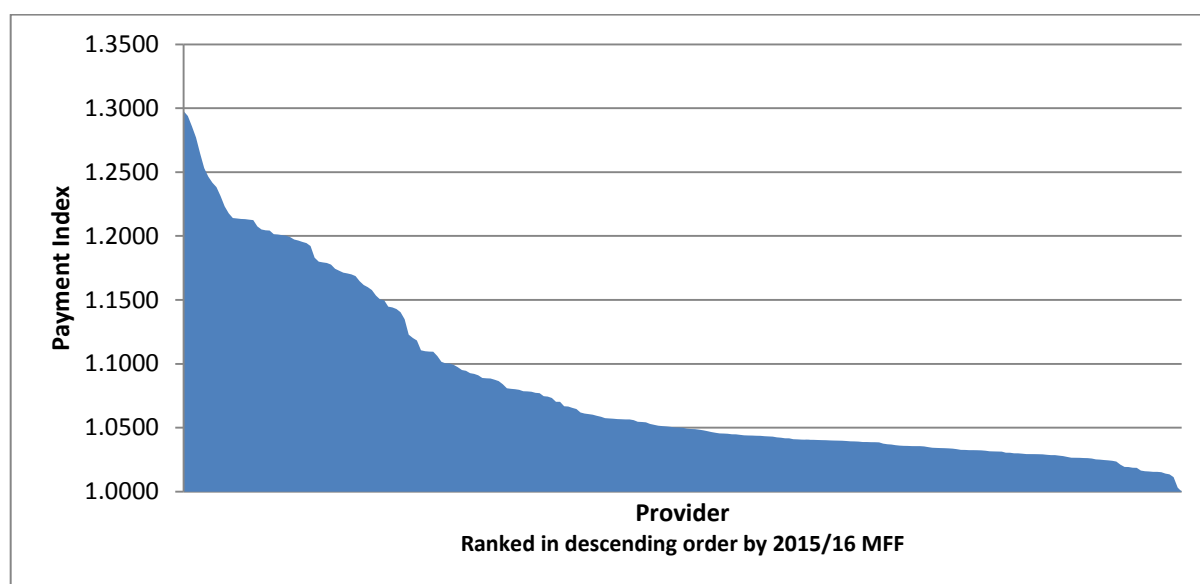
index value of 1.02 is estimated to face unavoidable costs 2% greater than the lowest cost provider.

As suggested above, use of the payment index separates avoidable and unavoidable costs. The national price reimburses the costs that all providers incur and the MFF separately compensates those facing more than the minimum level of unavoidable costs.<sup>3</sup>

Each provider has a different nominal MFF value in the underlying and payment indices, but the relativities between providers are the same. For example, if Trust A has unavoidable costs 15% higher than Trust B, then the MFF value of Trust A will be 15% higher than that for Trust B in both indices (see Appendix F for a more detailed explanation).

In the 2015/16 Enhanced Tariff Option (ETO) guidance<sup>4</sup> the payment index has a range of values from 1.0 to 1.2976. This is illustrated in Figure 2. The lowest value on the chart of 1.0 is Cornwall Partnership NHS Foundation Trust, and the highest value of 1.2976 belongs to University College London Hospitals NHS Foundation Trust.

**Figure 2: Range of market forces factor payment values in 2015/16 ETO**



<sup>3</sup> The DH made a corresponding adjustment to costs in 2013/14 (and previous years). By deflating each provider's costs according to their MFF payment index values, the DH was able to ensure that national tariff payments *after* the application of MFF at local level would match the average provider costs for each service as intended.

<sup>4</sup> Available at: [www.england.nhs.uk/wp-content/uploads/2015/03/2015-16-eto-guid-market-forces-payment.xlsx](http://www.england.nhs.uk/wp-content/uploads/2015/03/2015-16-eto-guid-market-forces-payment.xlsx)

For local payments to providers, the value for each provider is multiplied by the national price for each unit of activity:

$$\text{Provider income} = (\text{activity} \times \text{national price}) \times \text{MFF value}$$

As an example, Trust A has an MFF value of 1.20 and undertakes 100 units of activity with a national price of £500 per unit. For this activity Trust A receives a total income of £60,000, of which £10,000 is for MFF payments intended to compensate for the additional unavoidable costs they face compared to Cornwall Partnership NHS Foundation Trust due their geographical location.

$$\text{Trust A income} = (100 \times £500) \times 1.20 = £60,000$$

## **Changes to the market forces factor 2016/17**

We have not updated MFF values in 2016/17. The values for 2014/15 have been retained unless a structural change has taken place in the intervening period.

The remainder of this document contains further detail on the MFF

## **Components of the market forces factor**

The MFF accounts for variation in unavoidable costs in several elements of provider running costs. The elements are:

- non-medical staff
- medical and dental staff
- land
- buildings.

The level of cost differences within each element are calculated independently. They are then combined to create an overall payment index for each organisation. See Appendix A for an overview of the composition of the MFF.

### **Staff index**

The staff index applies to all non-medical NHS staff. Unavoidable variation in staff costs arise because national pay scales implemented by the NHS (including regional pay allowances) do not fully reflect the variation in employment costs evident in the broader labour market. If wages do not reflect the going rate for an area it can lead to indirect costs such as greater use of agency staff and higher vacancy and turnover rates. It can also lead to differences in staff productivity.

The staff index is based on variation in wages in the private sector. Appendix B provides further information of the reasoning behind this approach. The data source for the index is the Annual Survey of Hours and Earnings produced by the Office for National Statistics. For 2011/12 onwards, updated and more robust earnings data has been used (taken from the years 2007 to 2009).<sup>5</sup>

The staff index is based on the pattern of wages calculated within defined geographical areas (the previous Primary Care Trust (PCT) boundaries) and is intended to reflect local labour market conditions. As trusts do not only employ staff from the geographical area in which their sites are located, the first stage is to smooth<sup>6</sup> the variation in wage levels between areas to take into account the different labour market conditions. A second stage of smoothing, called interpolation,<sup>7</sup> is undertaken at trust site level and takes into account the precise location of a trust's sites within an area, and so their distance from other areas. Appendix B outlines the smoothing and interpolation techniques used.

Interpolation is not used in calculating MFF values for community trusts. As these trusts have taken over services previously provided by PCTs, activity is spread across the catchment area of the trust, and so it would not be appropriate to attribute all of the unavoidable cost differences to the location of the headquarters of a community trust. Instead, for newly created community trusts (ie those that have not merged with acute trusts) the staff MFF is calculated to reflect the full catchment area of the trust, based on the MFFs of the previous PCTs.

The values of the underlying staff index range between 0.8746 and 1.2340.

### **Medical and dental London weighting**

Analysis determined that medical staff costs do not vary in the same way as those of other staff groups.<sup>8</sup> Medical staff costs are however significantly higher in London than the rest of the country. The medical and dental (M&D) London weighting is required to compensate for this difference.

The M&D London weighting is applied to trusts in London and is calculated as the ratio of the average paybill per head for hospital doctors in 2008/09

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<sup>5</sup> For further information please see the Health Economics Research Unit (HERU) report *The Staff Market Forces Factor Component of the Resource Allocation Weighted Capitation Formula: New estimates*. Available at: [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_122621.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_122621.pdf)

<sup>6</sup> "Smoothing" is a form of weighted averages.

<sup>7</sup> "Interpolation" is the technique of using two or more values to create an intermediate value.

<sup>8</sup> Both RARP 31 and 32 draw this conclusion. RARP 31: Review of Specific Cost Approach to Market Forces Factor; RARP 32 Review of the Market Forces Factor following the introduction of Payment by Results (2005): Exploring the General Labour Market Method.



nationally to the average paybill per head excluding London. This ratio is 1.0224, and trusts within what was the London Strategic Health Authority receive this value; all other trusts receive an M&D value of 1.0.

### **Buildings index**

The cost of buildings includes an unavoidable element because, as an asset, buildings have a different worth in different parts of the country. In an area where a building is worth more, the trust will pay more in capital charges on this asset relative to a trust located in a lower cost area.

The buildings index remains based on historic PCT geography. The Building Cost Information Service (BCIS) analysed tender prices for public and private contracts between January 2007 and June 2010 to derive location factors. Average location factors for the period are provided for defined geographical areas (currently the previous PCT boundaries). To create the buildings index, the location factors were divided by the mean value, weighted by population. A trust site's buildings index value is determined by the PCT area where it is located. An average of the site indices weighted by available bed numbers is used to provide the trust buildings index. For community trusts, population rather than bed numbers is used as the basis for averaging across PCT areas.

The values of the buildings index range between 0.89 and 1.28.

### **Land index**

Land incurs unavoidable costs for two reasons:

- it cost trusts more to acquire land in certain areas of the country relative to others
- the capital charges paid on this land will also be higher.

The land index, unlike the other indices, is specific to each trust. The only exception is community trusts, which were formed to take over the provider functions of PCTs. Their land index value is based on the previous PCT index values.

A land index based on land value per hectare is calculated for each NHS trust and NHS foundation trust, using net book value of land at 31 March 2009 as reported in the audited summarisation schedules 2008/09. The land areas for each individual trust were aggregated from the site level data available in the 2008/09 Estates Return Information Collection.

While it would be possible to use average land values for pre-defined geographic areas, two drawbacks of this approach make the chosen method appropriate. Firstly, land prices are subject to variation within small

geographic areas and secondly, trusts have to pay capital charges relating specifically to the land value for the trust.

The land index has the biggest range: the lowest value is 0.016, the maximum is 19.550, representing a 1,200-fold difference. Given the gap between the lowest and highest values, the land index for providers with high values has a significant impact on their overall MFF value. This is in spite of the small proportion of costs that land accounts for (see the section 'Creating the market forces factor'). The land component can often explain differences between index values of organisations.

London trusts that have a significant non-London site have a land index for each site weighted together in proportion to the share of available beds at each site. The use of available beds recognises that land is typically used more intensively in central London compared with less urban areas.

### **Other**

The category of 'other' costs is included as an additional factor in the final MFF value. The costs included in this element are all those that are not considered to vary by location (such as equipment and consumables costs). As these costs do not vary by provider, all organisations receive a value of 1.

It is necessary for non-varying costs to be represented in the overall value as the MFF is applied to the full scope of costs, not just those with elements that vary by area. The MFF is a percentage of the national price. As the national price is based on total running costs per unit of activity the MFF must reflect all components of costs that drive this price.

### **Creating the market forces factor**

The overall MFF value for each organisation is a combination of the components outlined above (and listed again below). The elements are combined according to the proportion of total running costs that they account for. This value is determined based on national proportions of expenditure on each component of the MFF reported in NHS accounts. The proportion attributable to each element of the MFF is outlined below:

- staff 54.9%
- M&D London weighting 13.9%
- buildings 2.7%
- land 0.4%
- other 28.1%.

To create an overall MFF value for an organisation, the index value for each element of the MFF is multiplied by its proportion of total running costs. This approach applies a weight to each element of the MFF equal to its weight within total costs. The weighted index values are then added together to give an overall figure for the organisation.<sup>9</sup> See Appendix C for a worked example of the calculation for a trust with multiple sites.

### **Deriving a market forces factor value for newly merged trusts**

Organisations that merge will have a new MFF value calculated in accordance with the MFF methodology. For organisations merging at any time in the financial year this new MFF will apply from the beginning of the following financial year. In the interim the MFF previously attached to the location where services are delivered should be used for calculating payment.

The methodology means that each site of a merging trust will be treated not as a proportion of the trust to which it previously belonged, but as a proportion of the merged organisation as a whole. This is necessary as the staff and buildings components of the MFF are defined at site level. The site index values are combined according to their activity levels, proxied by bed numbers as per the calculation of multiple site organisations (see Appendix C for worked example).

In some instances, it may be necessary to make further adjustments to the calculation of the merged land index value. Where merging trusts have very different land index values and also vary significantly in the intensity of land use, the individual land index values will be combined according to trust activity levels (proxied by bed numbers). This is in line with the method used for the staff and buildings components of the MFF, and acts as an extension of the adjustments already in place to recognise the differing land use intensities for London trusts with significant sites outside of the capital.

### **Deriving a value for independent sector providers**

Independent sector providers take the MFF value of the NHS trust or NHS foundation trust nearest to the location where care is delivered.

### **Capping policy**

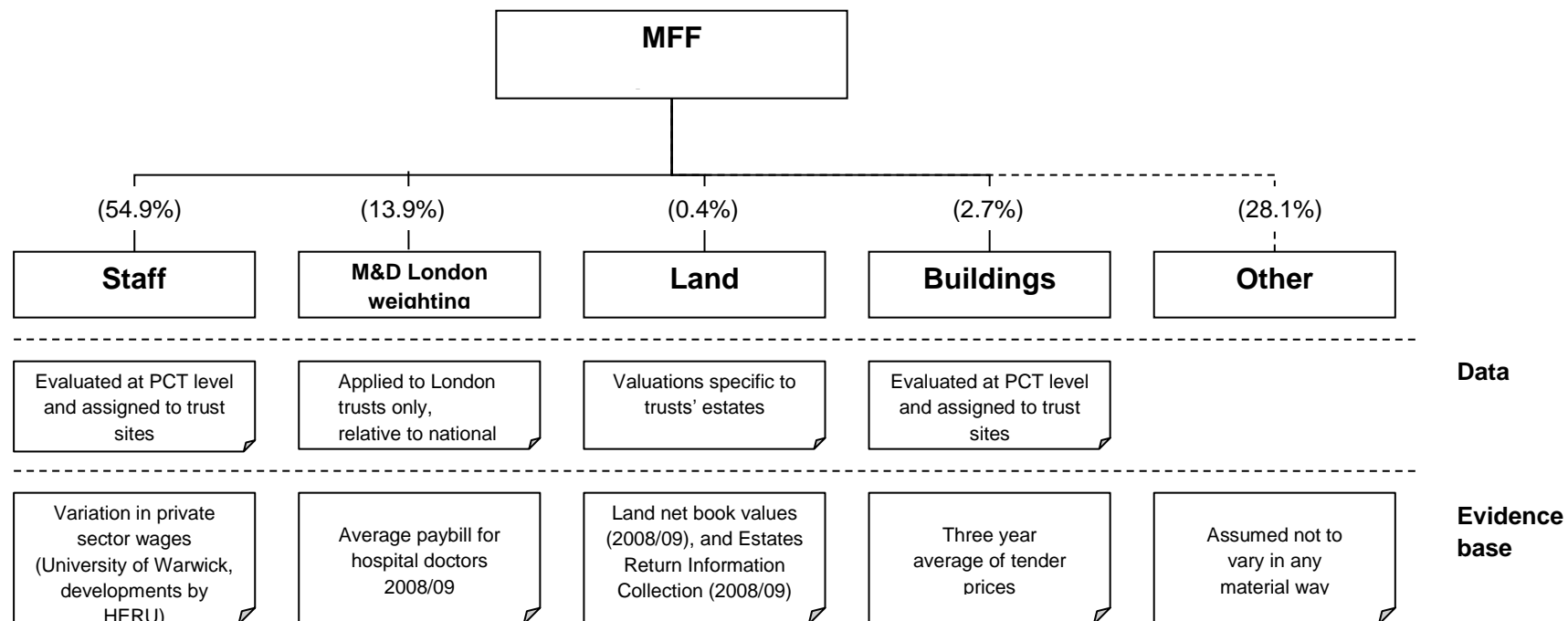
A capping policy was introduced in 2009/10 to reduce volatilities in income resulting from changes in MFF values. This meant that a provider's overall income should not change by more than +/-2% as a result of using the updated MFF (as opposed to using the previous year's MFF). By 2014/15 all

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<sup>9</sup> The impact of a single overall MFF value on an organisation's income is equal to the impact of applying the index value for each element separately to the proportion of costs it represents.

organisations had moved to their intended MFF values (ie the values that DH calculated before any capping was applied).

## Appendix A: Composition of the market forces factor



The index values of each of the four component indices (staff, M&D, land and buildings) are multiplied by the corresponding expenditure weight to give the overall MFF value. A worked example is included in Appendix C.

## Appendix B: The staff index

This appendix outlines the:

- rationale for basing the staff index on private sector rather than NHS wages
- application of smoothing and interpolation
- rationale for the medical and dental London weighting.

### Underlying data for the staff index

The staff element of the MFF is the largest component. Although the staff index is intended to reflect non-medical NHS staff cost variations, it is based on private sector rather than NHS wages. The rationale for this approach generates many queries.

The aim of the MFF is to compensate for unavoidable geographical cost differences between providers in the delivery of services. For staff expenditure, variation can occur directly or indirectly. Direct costs are the salaries paid to staff, indirect costs include expenditure incurred through labour turnover, agency staff costs, vacancies and reduced productivity.

High indirect costs of employment can arise for NHS providers where the wage rate they offer is below the prevailing wage rate of the area from which they draw their staff. Organisations offering relatively low wages are likely to experience higher vacancy and turnover rates relative to other employers. Lower wages are also associated with lower staff productivity. Research commissioned by DH<sup>10</sup> found evidence of these outcomes in a study into the variation in wages across NHS organisations.

Geographical variation in staff costs can be determined in two ways: using NHS employment costs, or private sector wages, as is the convention for the MFF. A brief overview of each approach is set out below.

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<sup>10</sup> RARP 32: Review of the Market Forces Factor following the introduction of Payment by Results (2005): Exploring the General Labour Market method, [http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH\\_4108515](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH_4108515)

### *Basing the MFF on NHS employment costs*

While it is possible to base the staff index on actual NHS costs, several problems with the approach make its use inappropriate. Research commissioned by DH confirmed the arguments against this method:<sup>11</sup>

- **Lack of national data availability:** Although it is straightforward to obtain information about high level direct employment costs within the NHS, there is currently limited availability of consistent detailed data on employment costs.
- **Distinguishing between avoidable and unavoidable costs:** Where organisations incur greater than average costs it is almost impossible to distinguish between avoidable and unavoidable components of expenditure. For example, by dividing the MFF range into quintiles of trusts, and controlling for trust type and location, there is 35% variation in the number of nurses needed for the same output between quintile 1 and 5. It is unclear whether the reasons for this variation are caused by drivers of avoidable or unavoidable costs.
- **Possibility of perverse incentives:** Using actual NHS costs, any relative changes in NHS staff costs would feed directly into the MFF calculation. Any trust with higher relative costs would then receive a greater staff index value when the MFF is recalculated. This creates an incentive for trusts to raise their indirect staff costs which would increase the staff component of their MFF (assuming that not all trusts did this thereby leaving relative wage rates unchanged) resulting in greater income.
- **Reduced incentives to improve efficiency:** Trusts using staff more efficiently will face lower staff costs relative to those with less efficiency. When the MFF is next calculated lower staff costs would be reflected in a lower MFF value and therefore a reduced (and relatively lower) income. Using the NHS staff costs approach, the incentives to improve efficiency would be reduced.

In light of these issues the research confirmed that the current approach (using external wage comparisons to determine differences in staff costs) is appropriate.

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<sup>11</sup> RARP 31: Review of the Specific Cost Approach to Market Forces Factor  
[http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH\\_4108515](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH_4108515)

### *Basing the MFF on external wage comparisons*

Basing the staff index on private sector wages was the approach recommended by the University of Warwick. The original argument was conceptual but supporting evidence is now available from work commissioned by DH.

The premise of the approach is that the private sector does not implement national pay scales and as such, wages offered reflect the cost of living and amenities in that area. These factors are the key drivers of relative differences in pay.

It would not be fair to simply take the actual average private sector wage in each area. This is because occupational mix varies. Some areas have a much higher proportion of staff working in highly paid occupations such as law and banking. These differences need to be taken into account in the MFF to ensure that we are making like-for-like comparisons across the country. Warwick do this using a statistical technique known as regression analysis, which works out what wages would be in an area if each area had the same mix of occupations. We similarly take account of differences in the age and gender mix of the private sector workforce in different areas.

The staff index compensates trusts for the unavoidable variation in direct staff costs and indirect employment costs arising where NHS wages do not reflect the local market rate.

To test for evidence of indirect employment costs, DH commissioned the Health Economics Research Unit (HERU) to determine the relationship between vacancy rates and the gap between NHS and private sector wages for different staff groups. For nurses, the evidence illustrates that vacancy rates are higher where the gap between NHS wages and private sector wages are greater.

DH and the Department of Communities and Local Government have undertaken a number of reviews of the approach to compensating for unavoidable differences in staff costs. Both departments concluded that this approach to the MFF continues to be the best available methodology.

### **Smoothing and interpolation**

Smoothing and interpolation are two approaches used to refine the staff MFF index values so that the values for each organisation better reflect the local labour markets from which they recruit.



### *Smoothing*

The methodology of the staff index creates the cliff edge problem whereby neighbouring PCTs receive markedly different staff cost values because of their geographical boundaries. Cliff edges may lead to an inaccurate representation of staff costs faced by a provider. This problem is particularly evident for providers within different PCTs but in close proximity and facing similar local labour market pressures. Smoothing techniques soften cliff edges to produce a more continuous profile of staff costs across PCTs.

HERU recommended that smoothing take into account the relative staff index of every PCT rather than just neighbouring ones as previously. This approach recognises that NHS organisations draw their labour force from a variety of PCT areas. Smoothing adjusts the relative level of staff index in a PCT by accounting for relative staff index in surrounding PCTs. The weights of the relative costs in surrounding areas fall the further the distance from the base PCT. Smoothing brings each PCT's MFF more in line with those of its surrounding PCTs.

### *Interpolation*

The smoothed relative costs for PCTs described above still result in cliff edges between trusts. Two trusts operating near the border of neighbouring PCTs might have different relative staff costs but operate in the same labour market. As a result, HERU introduced a further refinement to smoothing: interpolation.

Interpolation takes account of the location within a PCT area of the trusts' sites, and thus the distance from other PCT areas. It involves a second stage of smoothing carried out at trust level, after smoothing at PCT level, and further reduces the impact of cliff edges. It works the same way as smoothing in that the staff index of a trust is the distance weighted average of the surrounding PCTs' staff indices.

Interpolation is carried out at trust site level. Where a trust has more than one site, the different indices for each site are weighted together in proportion to activity, using bed numbers as a proxy, on each site.

### **Medical and dental London weighting**

The scope of the staff component of the MFF has been progressively expanded and since 2003/4 has included the whole workforce. The research by HERU found no supporting evidence for the application of the staff MFF to doctors. As such, the coverage of the staff index was reduced in 2009/10 and a new element, the Medical and Dental (M&D) London Weighting was incorporated. The M&D weighting reflects the greater cost of these employees in London relative to the rest of the country.

HERU found that pay setting mechanisms between medical and non-medical staff differ, negating the need to apply the staff index to medical staff. Although there is no national variation in medical staff costs, there is a significant difference in the costs of doctors in London relative to the rest of the country. As such, a weighting for medical and dental staff is applied to trusts in London.

## Appendix C: Worked example of the market forces factor calculation

This worked example shows the calculation of the MFF for Provider A.

### Staff index

The staff index for a hospital trust is calculated based on the staff index values for individual trusts. There are two sites to Provider A. These are in the locality of PCT area Y and PCT area Z.

Sites	PCT area	Staff index	Activity
1	Y	1.0385	89%
2	Z	1.0101	11%

The staff MFF for Provider A is:

$$(0.89 \times 1.0385) + (0.11 \times 0.0101) = 1.0354$$

### Medical and dental London weighting

This index is calculated as the ratio of the average hospital paybill of these staff groups in 2008/09 including London weighting, to the average paybill excluding the London weighting.

Provider A has no sites located within London and therefore receives a weighting of 1.00.

### Buildings index

The Buildings index is calculated in the same way as the staff index.

Sites	PCT area	Building index	Activity
1	Y	0.9497	89%
2	Z	0.9693	11%

The calculation is:

$$(0.89 \times 0.9497) + (0.11 \times 0.9693) = 0.9519$$

### Land index

The index value of Provider A's estate is 1.5374.

## Overall index

The four components are combined using the breakdown of national expenditure between staff, buildings, land and other costs. The latter is assumed not to vary across the country.

Index	HCHS Expenditure	Index Value	Weighted Index
	(a)	(b)	(c) = (a)*(b)
Staff	54.9%	1.0354	0.5684
M&D	13.9%	1.0000	0.1390
Buildings	2.7%	0.9519	0.0257
Land	0.4%	1.5374	0.0061
Other	28.1%	1.0000*	0.2810

\*index value is the same for all trusts.

This gives an overall target MFF value of:

$$0.5684 + 0.1390 + 0.0257 + 0.0061 + 0.2810 = 1.0203$$

The above value is the underlying index value for Provider A. This index is centred around 1. To ensure that all trusts receive non-negative payment of the MFF, the underlying index is converted to a payment index with a minimum value of 1.

To set the minimum of the payment index to 1, the underlying index, with an average of 1, is divided through by the minimum value. In 2015/16 the minimum value is 0.9263. The final MFF value for Provider A to be used for payment is:

$$1.022/0.9263 = 1.1033$$

## **Appendix D: Reference cost index**

The reference cost index (RCI) is an index of the relative cost efficiency of NHS organisations. The RCI is adjusted by the MFF to ensure a fair comparison between organisations across England.

For the RCI to be comparable year-on-year the index must have an average of 100. To ensure this, the application of the MFF to reference costs must be cost neutral, ie the total national value of reference costs submitted must be the same whether it includes or excludes the MFF. To obtain cost neutrality the underlying MFF is scaled. The extent of this scaling depends on the percentage difference between the amount of reference costs prior to the application of MFF and after it.

The following example shows how the MFF is used to calculate the MFF-adjusted RCI.

Table 1 shows how the underlying MFF is scaled so that the total amount of reference costs is kept constant at £4,500. This is necessary to ensure the national average RCI is 100. The factor used to scale the underlying MFF is the percentage difference between reference costs prior to the application of the MFF and after its application (sum of column C divided by sum of column B).

**Table 1: Scaled market forces factor for reference cost index**

	A	B	C = B / A	D = A * sum (C) / sum (B)	E = B / D
	Underlying MFF	Total reference costs (£)	Total reference costs adjusted for underlying MFF (£)	Scaled MFF	Total reference costs adjusted for scaled MFF (£)
Provider A	1.0249	1,250	1,220	0.9622	1,299
Provider B	1.1021	1,000	907	1.0346	967
Provider C	1.3349	1,000	749	1.2532	798
Provider D	0.9270	1,250	1,348	0.8703	1,436
		4,500	4,225		4,500

## Appendix E: National price calculation

The table below gives an example calculation of the national price for an HRG. The underlying MFF is rebased so that the minimum value is 1 (column D) by dividing the index through by the minimum value in the relevant year (for example, for 2016/17, 2013/14 reference costs were used). The lowest underlying MFF is 0.9263. Total costs are then divided by these MFF values (column E). The income for a provider is the product of national price, activity and rebased MFF (column F).

**Table 2: Rebasing the market forces factor for national price calculation**

	A	B	C	D = C/min C	E = B/D	F = National price * A * D
	Activity	Total costs (£)	Underlying MFF	Rebased MFF to 1	Total costs adjusted for rebased MFF (£)	Income (£)
Provider A	60	1,250	1.0249	1.1064	1,130	1,528
Provider B	50	1,000	1.1021	1.1898	840	1,369
Provider C	20	1,000	1.3349	1.4411	694	663
Provider D	40	1,250	0.9263	1	1,250	921
Total	170	4,500			3,913	4,483

National price  
 = Total costs adjusted for MFF / national activity  
 = sum of column E / sum of column A  
 = £3,913 / 170  
 = £23.02

## Appendix F: Creating an index

An index is a ranking of numbers relative to the same base such that they can be directly compared. In the example below, an index value can be attached to each of the numbers in column A. An index is constructed by dividing each number by the base value of the index. In common with the MFF, the first index created is in column B, which has an average value of 1.0 like the underlying index. This index is constructed by dividing each number by the average of the index, 100.

Values	Index with an average of 1	Index with a minimum of 1
<b>A</b>	<b>B</b>	<b>C</b>
50	0.50	1.00
95	0.95	1.90
125	1.25	2.50
130	1.30	2.60
100	1.00	2.00

Average value: 100

Minimum value: 50

The index in column B represents a ranking relative to the average value in the list. The average of the values in column A is 100. The value 50 in column A is half of the average so as a relative value 50 can be expressed as 0.5.

Column C represents transformation of the index to have a minimum value of 1, akin to the payment index. 50 is the lowest of all the values in column A and so in the index in column C it has a value of 1.0.

As stated in the guidance, irrespective of the version of the MFF index, the relative unavoidable cost differences between organisations are maintained. In the example above, the relative difference between the values 50 and 100 in column A is the same in both columns B and C, that is, 0.5 is half of 1.0 and 1.0 is half of 2.0. This also holds for every other combination of values. For example, 50 is 0.4 times less than 125. In columns B and C the relative difference in the associated index values is also 0.4 ( $0.50/1.25 = 0.4$ ) and ( $1.0/2.5 = 0.4$ ).