Allocating Limited Resources in a Time of Fiscal Constraints: A Priority Setting Case Study From Dalhousie University Faculty of Medicine

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Abstract

Facing a projected $1.4M deficit on a $35M operating budget for fiscal year 2011/2012, members of the Dalhousie University Faculty of Medicine developed and implemented an explicit, transparent, criteria-based priority setting process for resource reallocation. A task group that included representatives from across the Faculty of Medicine used a program budgeting and marginal analysis (PBMA) framework, which provided an alternative to the typical public-sector approaches to addressing a budget deficit of across-the-board spending cuts and political negotiation. Key steps to the PBMA process included training staff members and department heads on priority setting and resource reallocation, establishing process guidelines to meet immediate and longer-term fiscal needs, developing a reporting structure and forming key working groups, creating assessment criteria to guide resource reallocation decisions, assessing disinvestment proposals from all departments, and providing proposal implementation recommendations to the dean. All departments were required to submit proposals for consideration. The task group approved 27 service reduction proposals and 28 efficiency gains for the 2012/2013 fiscal year (FY) would be reduced by 3%, following the pattern over the last decade of reductions in postsecondary education funding. This decline in funding parallels that in other sectors in Canada, such as in health care. The Minister of Finance, for example, recently announced that future increases in the Canada Transfer Payment, which accounts for about 20% of all health care funding, will be tied directly to the nominal gross domestic product, indicating that affordability and sustainability are key principles for this government moving forward. Indeed, polls in Canada suggest that members of the public would prefer to see spending reduced in the public sector than to face increases in income or sales tax. Achieving financial stability and “living within one’s means” will be key challenges for Canadians and the Canadian government in the foreseeable future.

As with many modern medical schools, the Faculty of Medicine at Dalhousie University, the only medical school in Nova Scotia, follows a strategic plan laid out by university leaders. The 2010 strategic plan identified four major priorities for the Faculty of Medicine: educating the doctors and researchers of the future; enhancing patient care and population health; advancing an innovative research agenda; and organizational, operational, and fiscal renewal. Included in this document is the Faculty of Medicine’s goal of financial stability. Yet, universities and other public-sector organizations in Nova Scotia are facing tremendous fiscal constraints, as are similar organizations across Canada and in many other developed countries around the world. In short, senior administrators at postsecondary institutions are charged with the difficult task of meeting both expanding service needs and increasing demands whilst budgets are shrinking. Although we acknowledge that no easy fix to this challenge exists, the literature describes tools that are available to assist decision makers in prioritizing their goals to get the most benefit from their limited resources.

In publicly funded health systems, one approach to priority setting that has received much attention in the last 30 years is program budgeting and marginal analysis (PBMA). This framework has been used successfully...
many times in health service delivery
organizations to guide decision makers
in determining how best to spend
limited resources.6,9 The approach
includes eight steps: (1) Determine
the aim and scope of the activity, (2)
identify a representative priority setting
committee to provide recommendations
to a senior leadership team or single
senior administrator, (3) determine
how resources are allocated currently,
(4) identify a set of decision criteria,
then define and weight the criteria to
reflect their relative importance, (5)
identify options for investment and/
or disinvestment (depending on the
project aims), (6) assess the relative
value of those options and provide
initial allocation recommendations,
(7) validate the initial set of
recommendations and provide a window
for appeals, and (8) evaluate and refine
the process for future activities.

In recent years, many have used
multicriteria decision analysis (MCDA)
within the PBMA framework as the
main tool for assessing the benefits
of different health care delivery
options.10,11 In fact, various sectors
have used MCDA in decision making,
including the public sector because it
addresses the fundamental issue
faced by administrators—they often
must choose between multiple, and at
times competing, objectives.12 At its
core, MCDA recognizes that multiple
objectives, and thus multiple criteria,
are important in the decision-making
process of most complex organizations.
In MCDA, alternatives, or options
for change, are compiled using a
standard business case template, then
are assessed, with assessors giving
each option a rating for each criterion.
Assessors then combine ratings across
criteria and factor in the relative weights
of the criteria, which enables them to
calculate an overall benefit score for
each option.

Like in many other areas in the public
sector, the one proposed alternative
option to the current way of doing
things in a time of constraint is often
across-the-board spending cuts and/
or political negotiation. Yet such
approaches fall well short when they
are assessed in terms of both equity
and efficiency. With a desire to improve
our resource allocation practices at
the Faculty of Medicine at Dalhousie
University, we applied the PBMA
framework, using MCDA as a benefit
measurement tool, to address the critical
gap budget for FY 2011/2012. Although
other organizations may have employed
similar methods in the past, we were
unable to find a substantive literature
on this topic. Thus, we concluded
that this novel project is the first time
anyone has used the PBMA framework
in a postsecondary education setting.
In this article, we describe our case
study applying the PBMA framework to
address our projected deficit.

Applying the PBMA Framework

Often, the aim with PBMA is to examine
how resources might be reallocated
to produce the most benefit, defined
according to the key objectives of the
given organization or program area.
In our case study, our aim was to use a
criteria-based approach to assess and
rank the options for service reduction
(i.e., areas within the Faculty of Medicine
where we could cut spending) to meet
a budget gap for FY 2011/2012. The
total operating budget for the Faculty
of Medicine for FY 2010/2011 was $34.8M
(all figures Canadian; $1 CAD ≈ $1 U.S.),
with over 80% of the budget spent within
the basic science and clinical science
departments. The projected deficit by
the end of FY 2011/2012 should no action
be taken was $1.4M, and that figure was
expected to grow to over $3.5M by FY

Using the PBMA framework was one
of several approaches that leaders at the
Faculty of Medicine used to mitigate the
projected deficit. For example, they also
tasked a workflow solutions committee
with identifying potential efficiency
options in areas such as information
technologies, Web solutions, customer
service, finance, space utilization, and
human resource management. Over the
course of the project, the committee's work
integrated with the PBMA exercise.

Our application of the PBMA framework
followed a standard approach, as reported
in the health care literature.13

Phase I

We began Phase I in February 2011
by holding information and training
sessions for staff, the finance committee,
and department heads, as well as by
delineating the scope of the exercise
and structuring the project. An external
consultant supported the implementation
of our project, and a project management
committee, which included the associate
dean (operations and policy), the
director of finance, and a department
head representative, coordinated it. An
advisory panel made up of the associate/
assistant deans and department heads
provided oversight for project activities.

Carrying out the detailed activities of the
project was a task group that included the
associate dean (operations and policy),
director of finance, director of governance
and planning, five representative clinical
and basic science department heads, an
administrator representative, and the
chair of the finance committee. The task
group reported to the advisory panel,
which in turn provided recommendations
to the dean.

From the outset, the dean indicated that
all departments were to participate. For
the purposes of this project, we separated
the programs and departments into three
categories: (1) clinical departments, (2)
basic science departments, and (3) units/
programs/support services. Each cluster
was required to develop and submit
disinvestment proposals totaling 9%
of their budget. The director of finance
selected this 9% target to ensure that the
proposals totaled a savings greater than
the projected deficit to allow for the fact
that some projected savings likely would
not be fully realized on implementation
of the proposed changes.

Phase II

In March 2011, Phase II began, during
which the task group developed both the
assessment criteria and a formal rating
scale (see Table 1). They also formalized
the project guidelines and established a
detailed timeline and communication
plan. In addition, the task group
reviewed the current state of the budget
and determined the mechanics for
the implementation of the proposed
changes. They considered the proposed
changes as disinvestment proposals, or
proposed actions that would reduce the
operating costs of a program. These
proposals came in two basic forms: (1)
efficiency gains, whereby the services
the department provided would
remain the same but the resources they
used would decrease, and (2) service
reductions, whereby the resources
the department used would decrease
### Table 1

**Criteria and Rating Scale Used to Assess Service Reduction Proposals in a Priority Setting Process to Reduce Spending in the Faculty of Medicine at Dalhousie University, 2011**

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Definition</th>
<th>Weight</th>
<th>Scores and definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alignment with long-term vision</td>
<td>Extent to which the proposal takes the Faculty of Medicine away from its long-term vision</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>Alignment with current priorities (2010–2013)</td>
<td>Impact on the thematic priorities of the Faculty of Medicine (i.e., education, patient care/population health, research)</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Integration of services</td>
<td>Impact across services; extent to which the proposed change creates a gap or a bottleneck that would affect capacity</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Impact on the efficiency of functions performed and services provided (e.g., duplication, streamlining)</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Number affected</td>
<td>Number of individuals (i.e., students, staff, faculty, external stakeholders) affected</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Magnitude of impact</td>
<td>Size of the impact on those affected</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Disparities</td>
<td>Impact on priority health and social needs of the communities and marginalized populations served; impact on inequalities in access to education</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Innovation</td>
<td>Impact on the creativity and learning culture of the Faculty of Medicine and on its leadership in knowledge transfer and the implementation of novel advances</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Implementation challenges</td>
<td>Degree of expected resistance, political or other risks, capacity to enact the change, ability to reverse the change</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Workplace</td>
<td>Impact on workplace, including staff satisfaction, teamwork, well-being and safety, personal and professional growth, equity policies, and morale</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

In 2011, in response to the need to reduce spending, the Faculty of Medicine at Dalhousie University conducted a disinvestment exercise. The task group, which included an academic dean, a director of finance, and faculty from different departments, worked together to propose service reductions. The task group developed a standard template and criteria to assess the impact of service reduction proposals. The proposals were then assessed using a prioritization matrix that included criteria such as alignment with current priorities, integration of services, and workplace impact. The proposals were analyzed using a scoring system that considered the impact on the creativity and learning culture, disparities, and other factors. The proposals were then ranked and recommended for implementation. The validated efficiency gains proposals were automatically ranked at the top of the list of overall disinvestment proposals, as they represented dominant strategies (i.e., lower cost changes with the same benefits; no impact on service). The task group assessed the service reduction proposals by applying the PBMA criteria and weights (see Table 1). They rated each proposal according to each of the criteria; they then calculated an overall score by multiplying the proposal’s rating for each criterion by the weight of the criterion and summing those scores across all the criteria. These ratings represented a summary evaluation of the ability of each proposal to assist the Faculty of Medicine in meeting its goals. Once the task group had calculated the ratings, they ranked the service reduction proposals and made funding recommendations. They then

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sent the ratings, ranked list of proposals, and their recommendations to the advisory panel for review and approval. Finally, the advisory panel sent their final recommendations to the dean for his decision.

**Impact of Our PBMA Project**

In total, the task group approved 27 service reduction proposals and 28 efficiency gains proposals, totaling approximately $2.7M in savings across two years (see Appendix 1). In percentage terms, the proposals ranged from a 0% disinvestment to a 9.64% disinvestment across departments (see Figure 1). Additional Faculty of Medicine–wide efficiency gains savings proposed by the workflow solutions committee, along with a limited number of revenue-generating proposals, brought the total savings to $3.1M. A multiyear assessment indicated that the annual savings generated by implementing these proposed changes would be about $1M over the next two fiscal years, which provided the Faculty of Medicine additional leeway in their financial outlook.

The task group approved the majority of the service reduction proposals submitted because they found the benefits loss to the Faculty of Medicine to be reasonable when they assessed the proposals using the formal rating tool. On a scale of 0 to −300, very few proposals ranked below −200, and the vast majority ranked higher than −125, suggesting that the benefits loss would be minimal. The task group also approved nearly every efficiency gains proposal. They reviewed these proposals for validity and gave them a yes/no approval.

Following the task group’s initial ranking of the submitted proposals, we determined that some programs were attempting to game the project. Instead of submitting valid and realistic proposals like their colleagues, some programs submitted no proposals and others submitted proposals that were not credible. We flagged these proposals, and, on consultation with the advisory panel and ultimately the dean, we agreed that one program would be exempt because of mitigating circumstances, three programs would be required to resubmit more credible proposals, and five programs would be informally exempt because they were undergoing restructuring at the time but would be expected to produce disinvestment options outside of the PBMA process.

**Implications of our PBMA Project**

We introduced the PBMA priority setting framework within the Faculty of Medicine at Dalhousie University to provide guidance for leaders in addressing a worsening budget deficit. The PBMA framework provided an explicit, rigorous, and transparent approach to making resource allocation decisions. It acted as the framework for assessing the net impact of possible changes (direct or indirect) to the current configuration of services on the benefits those services produced. The task group measured that net impact by rating each proposed change (e.g., service expansion or reduction) against a set of criteria that they developed specifically for this process. These criteria linked directly to the strategic priorities and the vision of the Faculty of Medicine, including achieving “value for money,” a critical goal for postsecondary education institutions to reach longer-term sustainability in a time of overall financial constraints.

Although the Faculty of Medicine was in a much better position financially after only one year as a result of our PBMA project, the task group did ask what impact, if any, the proposed changes would have on the quality of the services provided. They concluded that the quality of the services would

<table>
<thead>
<tr>
<th>Department</th>
<th>Percentage Disinvestment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>0.79%</td>
</tr>
<tr>
<td>Division of medical education</td>
<td>3.12%</td>
</tr>
<tr>
<td>Humanities</td>
<td>3.50%</td>
</tr>
<tr>
<td>Informatics</td>
<td>0.22%</td>
</tr>
<tr>
<td>Medical research development</td>
<td>8.20%</td>
</tr>
<tr>
<td>Operations &amp; policy</td>
<td>4.63%</td>
</tr>
<tr>
<td>Post-graduate medical education</td>
<td>7.71%</td>
</tr>
<tr>
<td>Rural &amp; regional</td>
<td>0.91%</td>
</tr>
<tr>
<td>Undergraduate medical education</td>
<td>1.26%</td>
</tr>
<tr>
<td>Animal care</td>
<td>0.13%</td>
</tr>
<tr>
<td>Building services/stores</td>
<td>0.99%</td>
</tr>
<tr>
<td>Continuing medical education</td>
<td>7.33%</td>
</tr>
<tr>
<td>Cores facilities</td>
<td>4.50%</td>
</tr>
<tr>
<td>Global health office</td>
<td>9.64%</td>
</tr>
<tr>
<td>Learning resource center</td>
<td>0.53%</td>
</tr>
<tr>
<td>MedIT/Institutional support</td>
<td>0.00%</td>
</tr>
<tr>
<td>Anatomy &amp; human biology</td>
<td>0.31%</td>
</tr>
<tr>
<td>Biochemistry</td>
<td>1.42%</td>
</tr>
<tr>
<td>Biomedical engineering</td>
<td>0.45%</td>
</tr>
<tr>
<td>Microbiology</td>
<td>1.04%</td>
</tr>
<tr>
<td>Pharmacology</td>
<td>8.40%</td>
</tr>
<tr>
<td>Physiology</td>
<td>4.01%</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>4.94%</td>
</tr>
<tr>
<td>Bioethics</td>
<td>4.59%</td>
</tr>
<tr>
<td>Community health &amp; epidemiology</td>
<td>5.88%</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>0.00%</td>
</tr>
<tr>
<td>Family medicine</td>
<td>5.76%</td>
</tr>
<tr>
<td>Medicine</td>
<td>8.39%</td>
</tr>
<tr>
<td>Obstetrics &amp; gynecology</td>
<td>9.00%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>9.00%</td>
</tr>
<tr>
<td>Pathology</td>
<td>0.79%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>7.84%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>8.97%</td>
</tr>
<tr>
<td>Radiation oncology</td>
<td>2.58%</td>
</tr>
<tr>
<td>Radiology</td>
<td>9.00%</td>
</tr>
<tr>
<td>Surgery</td>
<td>8.82%</td>
</tr>
<tr>
<td>Urology</td>
<td>9.00%</td>
</tr>
</tbody>
</table>

**Figure 1** Percent disinvestment across two years by department of approved proposals in a priority setting process to reduce spending in the Faculty of Medicine at Dalhousie University, 2011.
be negatively affected. However, most of the service reduction proposals did not score particularly low on the ratings scale, meaning that the negative impact was not great. The task group did not recommend implementing those proposals with particularly low scores, for which they deemed the impact to be quite high. Still, without an explicit evaluation process, the task group was unable to know the precise nature of the negative consequences of the service reduction proposals. This uncertainty is not new—in the mid-1990s, when the Canadian Faculties of Medicine reported drastic cuts in funding, they could not provide clear indication of the impact of the cuts relative to the goals of the medical schools affected.\textsuperscript{15}

In contrast, the efficiency gains proposals had no negative impact. One may ask whether these opportunities were “low hanging fruit” and why we needed a formal process to achieve these gains. In fact, this point arises often in priority setting discussions, and the response is a simple one—in bureaucratic organizations, often a formal process with a change management component is needed to enact even the most obvious changes. Over time, however, the more obvious proposals are implemented, and the organization is forced to look at genuine service reduction options either to erase a pending deficit or to make available resources, thereby reallocating funding to areas for greater perceived benefit.

We conducted a small evaluation with key stakeholders within the Faculty of Medicine and found that the majority of participants would like the project to continue. In addition, faculty morale appeared to have improved, despite the Faculty of Medicine’s uncertain financial future, because of the positive collaborations and partnerships that developed through this project. Specifically, faculty members and department heads were required to work together, which is often difficult in academic contexts. Yet, at our institution, it became a very fruitful endeavor that resulted not only in the task group identifying where standardization across the Faculty of Medicine might improve efficiency but also in the sense of having a shared mission that developed to meet the institution’s large deficit. Still, several respondents to our evaluation indicated that future process improvements should focus on how the dean communicates his final decisions as well as how to better encourage faculty members to participate. Faculty members in several of the clinical departments also felt that the complexity of their funding with respect to both university and clinically generated revenue should garner further consideration in this type of process. Overall, respondents were very clear that they preferred the PBMA process to across-the-board spending cuts.

Several features of our project are noteworthy. First, MCDA is an important tool for public-sector decision making\textsuperscript{10} and was viewed favorably by members of the Faculty of Medicine, a postsecondary education institution. With MCDA, the key is to ensure that the criteria are well defined, that they do not overlap, and that they genuinely reflect the main objectives of the organization. Second, the principles of fair process, as espoused in the health care priority setting literature,\textsuperscript{16} must be upheld. We ensured that the process at our institution was as transparent as possible, so that the stakeholders had a clear understanding of the criteria, the decisions being made, and the rationale for those decisions. Third, strong support from institutional leaders is an important factor for success in any priority setting activity.\textsuperscript{17} For us, the dean and senior administrators provided strong support for the project. In addition, we periodically updated Dalhousie University administrators on our work and informed them of the final decisions. Fourth, apart from hiring external consultants to support the project, staff, faculty, department heads, and administrators conducted all the work as part of their day-to-day activities, and thus the project required only very few additional resources. Finally, another key factor to the success of our project was that the faculty previously had taken part in a mission-based funding approach project that aligned resource allocation with outcomes achieved across academic departments.\textsuperscript{18} Although this approach had been used in the early 2000s during the tenure of a previous administration, we felt that the faculty would be more receptive to a PBMA approach because they had previously used another explicit, proactive budgeting tool.

As with any process of this nature, we faced some initial obstacles. One of the central tenets of our project was to ensure equal participation among those involved in the process (as opposed to equal, across-the-board cuts in funding). That is, most within the Faculty of Medicine understood that across-the-board cuts would not necessarily affect their departments equally, as this approach does not recognize the departments’ different financial starting points or the disparate effects that loss of funding would have on each. Still, all faculty members agreed that all departments should take part in the project. When some programs did not initially provide proposals (or in some cases credible proposals), a number of the academic department heads voiced concern. Although the dean had to require that specific departments participate, the project did continue. When exceptions were granted, they were done so in full transparency and in the full knowledge of the advisory panel.

Because of the tight time constraints initiating this new project, we encouraged all stakeholders to do the best they could. The literature suggests that, over time as individuals become familiar with the concepts and tools of the process and as activities become more streamlined and integrated fully into the budget cycle, the process provides a mechanism for successful resource reallocation (i.e., shifting between disinvestment and investment options).\textsuperscript{19,20} When the focus of the process is solely on disinvestment, it implies that no new resources will be forthcoming (i.e., the anticipated financial shortfall must truly be addressed) and that stakeholders must buy in to the task at hand, which is a challenge to overcome, especially in an academic setting where faculty tend to prioritize their own research program over the mission of the university.

Over the course of FY 2011/2012, the director of finance tracked the progress of the proposed changes, and 72% of the projected savings were realized. This success speaks to the importance of setting targets beyond the needed reduction in spending because inevitably some projected savings will not be realized. Even still, we met the short-term financial obligations of the Faculty of Medicine in FY 2011/2012, and, because of the annual savings and future-year reductions, we eliminated the longer-term projected deficit for FY 2015/2016.
In Conclusion

By engaging faculty members and staff and drawing on a priority setting approach that has received much attention in health services delivery organizations, the Faculty of Medicine at Dalhousie University was able to meet its financial obligations, including evidence-based service reductions, in an open and transparent manner. At its core, the project relied on formal assessment criteria against which proposals for disinvestment were evaluated. Within the Faculty of Medicine, this priority setting work was embedded in the most recent iteration of the strategic plan (2012); thus, going forward, the tools we outlined here will be used to address fiscal challenges as well as to provide a mechanism for shifting or reallocating resources in an explicit manner. In addition, this work should serve as a useful example for other academic institutions that need to set priorities within fiscal constraints.

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References

15. Thorne S. Medical schools seeking new ways to cope with funding cutbacks. CMAJ. 1997;156:1611–1613.

Appendix 1

Summary of Approved Proposals in a Priority Setting Process to Reduce Spending in the Faculty of Medicine at Dalhousie University, 2011

Efficiency gains proposals:

- Basic science: centralized start-up funds
- Biomedical engineering: purchase phones
- Building services: scale down laboratory renovations
- Building services: coordinate small jobs with facilities management
- Continuing medical education (CME): reduce printed course materials
- Communications: restructure
- Centralized operation of research equipment and supports: implement 4.5% reduction for next two years
- Dean’s office: post retirements
- Division of Medical Education: eliminate outsourced Web site design
- Emergency medicine: reduce staff training and travel
- Global health: restructure office (implemented)
- Medicine: implement 9% overall reduction
- Microbiology: increase staff replacement flexibility
- Obstetrics-gynecology: implement 9% overall reduction
- Operational endowment spending
- Ophthalmology: implement 9% overall reduction

(Appendix continues)
Appendix 1, Continued

- Postgraduate medical education (PGME): reduce contracted services and external computing services
- PGME: reduce program salary costs by 50%
- Psychiatry: reduce research support
- Radiology: implement 9% overall reduction
- Radiation oncology: head travel
- Radiation oncology: conference travel
- Student affairs (letter)
- Surgery: align salaries and functions
- Undergraduate medical education (UGME): reduce purchase of online resources
- Urology: implement 9% overall reduction
- Workflow solutions: administrative reductions
- Cadaver efficiencies

**Service reductions proposals:**
- Anesthesia: reduce secretarial salary support
- Anatomy: retirements and recruitments
- Biochemistry: reorganize teaching program to reduce limited-term appointments
- Bioethics: reduce administrator position to 0.5 full-time equivalent (FTE) (implemented)
- Outsource central stores
- Community health and epidemiology: eliminate community health and epidemiology graduate student scholarship
- Community health and epidemiology: defer biostats recruitment for two years
- CME: reduce honoraria paid to Faculty of Medicine members
- Departmental surveys
- DME: eliminate research associate positions
- External headship recruitment
- Family medicine: retirements and nonreplacement of two faculty members
- Family medicine: divest of School of Pharmacy faculty salary
- Family medicine: eliminate funding for temporary salary support
- Family medicine: reduce preceptor payments
- Global health: office staff share
- MedIT: eliminate integrated services digital network–lines based video conferencing
- Pathology: review histology lab
- Pathology: reduce residents’ and graduate students’ travel fund
- Pediatrics: internal reallocation of endowed chair
- Pharmacology: reduce faculty and staff complements
- Physiology: defer recruitment of 1.65 FTE faculty for two years
- Psychiatry: reduce research summer studentships
- Psychiatry: research faculty reduction
- Research: eliminate assistant dean position
- UGME: eliminate or reduce rural week
- UGME: reduce preceptor payments

**Revenue-generating proposals:**
- Learning resource center
- Microbiology
- UGME
- PGME visa trainee electives