Jim McLean: Hello, I'm Jim McLean, a member of the Kansas Oral History Project Board and a former reporter for Kansas newspapers and public radio stations. It's January 23, 2026. I'm in Topeka to interview Dr. Robert St. Peter. Dr. St. Peter is a pediatrician, family practice physician. He's also a researcher and a policy analyst. For twenty-four years, he was the president and CEO of the Kansas Health Institute, [KHI] a nonpartisan, health policy research organization. This interview is taking place at KHI, which is located directly across the street from the Kansas Capitol.

This interview is part of the Kansas Oral History Project series exploring health issues in Kansas. The Kansas Oral History Project is a nonprofit corporation that collects and preserves the oral histories of Kansans. The project is supported by donations from generous individuals and occasional grants. Our videographer is former Kansas Representative Dave Heinemann.

Bob, right off the back, we should explain why I'm doing this interview with you. As we mentioned, this is going to be a series of interviews about the health issues in Kansas. I'm doing this initial interview kind of to establish your expertise, kind of like in a courtroom where somebody puts an expert on the stand, and they just want to establish that expertise with the jury. That's what we're doing here.

Robert St. Peter: I hope I pass the test.

JM: I have no concern about that. But you're going to do the remainder of the interviews. Let's just start out with your origin story. Let's talk a little bit about your biography. You're a Kansan.

RSP: I'm a Kansan.

JM: And your family, as I understand it, homesteaded in far western Kansas.

RSP: Yes, seven generations ago, relatives moved down from French Canada around the Trois-Rivières area and settled in Rooks County. I've actually stood inside the outline of the original dugout along a dried-out creek bed in Rooks County where they first settled. And then you see the progression from that to wood structures to stone structures to then they finally moved into town. So, yes, our roots go back a long ways.

JM: Yes, the French Saint Pierre, right?

RSP: Yes, there you go.

JM: I guess at some point your family moved to Wichita.

RSP: Right. In that time around the war, both sides of my family are actually from that same community, and both families moved to Wichita and started working in the aircraft industry, building airplanes for the war.

JM: That's where you grew up?

RSP: I grew up in Wichita.

JM: You went to KU? [Kansas University]

RSP: I went to KU for college.

JM: But you didn't stay there for medical school.

RSP: No, I went off to Duke University in North Carolina. I got my medical degree there and then did my training in pediatrics in Colorado, and spent a year in West Africa, and then came back and did some more studies at UCSF [University of California at San Francisco] and Stanford and ended up in Washington, DC.

JM: Essentially you did a residency in West Africa?

RSP: After I finished my chief residency year, I spent a year just working in a rural part of northern Nigeria right on the edge of the Sahara Desert, and just spent a year working there and traveling around that part of West Africa doing medical work.

JM: What prompted that? Any particular impulse there?

RSP: It wasn't a religious mission of any type. It was just a personal feeling of I'd spent all this time training and had been given a lot of opportunity, and I wanted to spend a year doing something worthwhile.

JM: What is your recollection from your time there? Does anything stand out?

RSP: I loved the people of Nigeria and northern Nigeria. I was there during a time when the first [President] Bush was in office, and [Prime Minister] Margaret Thatcher was in England. There was a lot of tension between the West and Muslims. Just getting to live in a culture and meet people and get to sort of understanding a basic commonality and humanism of the people over there.

JM: It opens your eyes to a lot of things when you travel, particularly when you're immersed in a culture like that.

RSP: Yes.

JM: Then you come back to the United States, and you do essentially a post-doc in kind of an academic setting, right?

RSP: Yes.

JM: The University of San Francisco, California. What were you doing there?

 

RSP: It was an opportunity to spend a couple of years doing any sort of research that was not biologic. I was doing health policy, understanding how to use large data sets, understanding federal policy. I did about half the curriculum for the MBA at Stanford and about half the curriculum for the MPH at the UCSF system and wrote papers and worked for a person there who ran the policy institute named Phil Lee. I actually took a job after that in Washington and was in Washington, planning to be there for just a short period of time, but Phil Lee got appointed to be the assistant secretary for Health shortly after I arrived. So, once Phil got to Washington, that sort of changed the opportunities and rules that I had.

JM: The trajectory of your career. Phil Lee, based on our conversations prior to doing the interview, he's an important figure here because he was also an assistant secretary of health in the Johnson years.

RSP: The Johnson administration.

JM: He came back under [President] Bill Clinton. What position did he have then?

RSP: He was assistant secretary both times, interestingly. But he was around in that office when Medicare was created and was very influential in the development of that program and stayed involved over his career in all aspects of the Medicare program. He ran the advisory committee on physician payment rates for Medicare over the years.

JM: So you went back to DC to take a policy job, but you ended up actually as a member of the staff to the Labor and Human Resources Committee chaired by Senator [Ted] Kennedy.

RSP: I was working at [Health and Human Services] HHS. My immediate boss was a guy named Mike McGuiness who was a real leader in developing Healthy People 2000, those sorts of health goals that you probably heard about, a lot of the surgeon general reports on tobacco and nutrition. I was working with Mike, and Phil was the big boss. Apparently, he got a call from Senator Kennedy. The physician that was working for him at the time was sick, and they needed a physician to go spend some time up on the Hill working on the Labor Committee. The administration was working on the Health Security Act, a big Clinton bill.

JM: That's the bill that people famously remember was essentially the brainchild and certainly the project of First Lady Hillary Rodham Clinton at the time.

RSP: Yes.

JM: It was a pretty extensive reform effort at the time.

RSP: It was a very expansive, aggressive effort. The administration was developing the bill, but it would eventually have to go to the Hill, and it had been decided that the bill would go to the Labor Committee to be worked at that committee level, and Senator Kennedy was the chairman of that committee, and [Senator] Nancy Kassebaum was the newly appointed ranking member of that committee. So, being from Kansas, it was an interesting position. Several of her staff were college friends of mine and that sort of thing.

 

JM: You really got thrown into it. As I remember, that was a contentious and protracted debate over that bill.

RSP: It was. The big debate sort of at the higher level was whether they were going to do welfare reform first or health care reform. [Senator Daniel Patrick] Moynihan who chaired the Finance Committee was disappointed that they weren't going to work the welfare reform first. Once the Labor Committee got done working on the Health Security Act bill, which passed the committee, it was actually passed out of committee—

JM: Was it straight party line? Do you recall?

RSP: No, Jim Jeffords was a Republican who crossed over to vote for that. He was the ranking member at the time. But once the bill got to the Senate, Moynihan who was of course a Democrat and lots of others, it never went anywhere once it got out of committee.

JM: Did it also have to go through the Finance Committee to get it to the floor?

RSP: No, just the Labor Committee, but it never got much consideration and a positive vote in the full Senate.

JM: What was your role in that? What were you doing on a day-to-day basis?

RSP: I remember the day I fell asleep driving home. Literally, I was in Arizona giving a talk, and I got a call from my boss, from Mike McGuiness and then Dr. Lee saying, "Hey, we want you to go work up on the Hill for a few weeks," supposedly. So, I flew home from Arizona. The next day I showed up at the Hart Senate office building, and I didn't go home—this is a true story—for three days. I got there, and we were what they call "marking up the bill." The committee was getting ready to take that bill into consideration. So, I was the only physician working on the staff for the Labor Committee at the time. Anything that had a clinical aspect, but a lot of what I worked on was funding for residency training, graduate medical education. Senator Kennedy was from a state with a lot of teaching hospitals and a lot invested in how physicians are trained. So, I spent a lot of time on that and public health.

JM: Right. Of course, Senator Kennedy represented Massachusetts. You were there during that critical mark-up period, and it was a pretty intense period. You spent three days there? No sleep at all? Taking naps in the hallway?

RSP: Yes, working pretty much the whole time. I must have slept a little bit, but I fell asleep driving home finally that third day.

JM: I know you as kind of a dispassionate—you have the personality traits that are kind of essential for a researcher. You can detach yourself, and you can take—excuse the term—kind of a clinical look at things. How invested did you get in the effort to pass that bill? Do you remember? When you're working that hard on it, did you get some level of investment?

 

RSP: It's amazing. I was probably thirty or thirty-one when that was going on, and I was like the old guy. Most of the staff in Congress, especially in the Senate, are even younger than that.

JM: I remember that from my time in DC.

RSP: Senator Kennedy had some very seasoned staff that had been with him for a long time. That was a little bit unusual. But I realized pretty quickly that I really enjoyed the policy aspect of the work we were doing. I wasn't so much into the politics part of it, and it was expected of me at my level to work on the policy stuff and let other people handle the political part. But there were times when it's hard to avoid that.

JM: So, you got your first taste then, too, of trying to work something through the political process.

RSP: Yes.

JM: When you really know your stuff. You're dedicated and you know the answers to this and to that, and you hear objections or frankly even people voicing their support for a measure and they're off on a tangent that you probably think, "That's not exactly right." So you had your first taste of trying to navigate those political waters.

RSP: I can tell you a story about that where I learned it really quickly right up front. I showed up at a meeting to talk about graduate medical education and how to make payments to hospitals to train doctors basically, and I had spent hours and hours looking at all the information about how hospitals were doing in terms of margins and who could afford to pay a little bit more and who couldn't. We were meeting with a block of staff from senators' offices that represented large Midwestern states, upper Midwestern—North and South Dakota, Wyoming, Montana. I walked in the meeting and presented all of this information, showing why rural hospitals should participate in paying for this and not just the big city hospitals. After this great presentation with all the data, someone said, "Excuse me, Bob. You seem to think that this is about the data. This is about 'How do you get the votes from those eight senators on this bill, and what we need to get out of that bill in order to support it"—

JM: I see.

RSP: I was like, "Okay, let's have that conversation"

JM: And what do they need to get out of it? They needed to not have to pay anything and still get the residency slots? What was the bargain that they were after?

RSP: They needed some additional funding through the different funding sources that were going to be created for rural hospitals.

JM: So you were in DC for how long roughly?

RSP: Eight, nine years.

 

JM: Doing what? Not all the time—

RSP: A couple of years on the Hill, and the other time before that—I should say I was actually an HHS person who got detailed to work on the Hill, and then I went back to HHS. And then after the election when the Republicans took control of the Senate, I got sent backup for a short period of time because a lot of the committee staff for Senator Kennedy were no longer employed because their budgets were reduced. So, I worked there for a short period of time. But, really again, I was more interested in the policy side, and the same guy, Phil Lee, who at the time was the chairman of the Physician Payment Reform Commission that dealt with Medicare payments to physicians helped me land at a brand new enterprise called the Center for Studying Health System Change, which I went there as again the only physician research member of that staff.

JM: Obviously, that work set you up very well for the position you were eventually going to have for more than twenty years back in Kansas as the president and CEO of the Kansas Health Institute.

RSP: Yes.

JM: How did you get from DC back to Kansas into the Health Institute?

RSP: That's an interesting question. When the Kansas Health Foundation came up with the idea of creating an institute, they put together an advisory committee and through various connections, I was asked to be a member of that advisory committee. It was made up of very high-level people, and I was much, much younger and more junior than any of those people, but I was from Kansas, and the other members were from all over the country.

So, I was on the advisory committee that actually traveled around the state of Kansas by small airplane, by car to offer input to the foundation in setting up the institute. We wrote a report. The foundation considered everything and set up the institute. They recruited a director, and I went back, was doing my work in Washington and didn't really follow what was going on. Two years later, I got a phone call from a headhunter saying, "Hey, we have this thing in Kansas," and I'm like, "Well, I know about that. I was around when it was started." They were looking for a new CEO, and the headhunter had no idea that I was from Kansas or had that connection. Once he found that out, he was pretty intense on recruiting.

JM: This was the late 1990s?

RSP: Yes, '97, something like that.

JM: Let's back up a little bit. The Kansas Health Foundation. It's very important in all of this.

RSP: Yes.

 

JM: The Kansas Health Foundation was established what? Through the sale of the Wesley Medical Center in Wichita.

RSP: Yes. It was one of the early and largest transactions of a private for-profit company buying a nonprofit hospital, and the proceeds of the sale of that hospital went to greatly expand the Kansas Health Foundation. They had an existing foundation with Wesley Hospital, but it transformed when it got a couple hundred million dollars in its endowment. Some of the money also set up the United Methodist Health Ministry Fund in Hutchinson.

JM: Two very important foundations to this day.

RSP: Yes.

JM: In Kansas. So, the Health Foundation decided they wanted to set up a policy institute.

RSP: Yes.

JM: Why was that?

RSP: Well, as they came into this very large amount of money, they were trying to figure out what they should do with it, how they should use that money to improve health and well-being in Kansas. As they went around the state talking with people, they kept hearing that it was difficult to get good data, get good information about what really was going on in Kansas regarding health. They said, "That's kind of interesting." They looked all around the country at different models of state-based policy institutes, and again, with the input from this advisory committee that they put together just decided to set up a free-standing organization right in Topeka—as you said, we're across the street from the Statehouse, and with relationships with the universities, but not based at a university.

JM: That was a critical decision.

RSP: Yes.

JM: An independent research entity, not affiliated with one of the universities.

RSP: Right, or any other organization. Some states had the medical society sponsored a policy institute or whoever it might be. Or even within the foundation—some states set up policy institutes within foundations. But they really wanted it to be a totally freestanding, independent, nonpartisan organization.

JM: Do you think that was an important decision in terms of just the trustworthiness of whatever research and information came out? Was that a critical decision even at that point to keep it independent like that?

RSP: I think the foundation originally and to this day has been incredibly giving freedom and the ability of the institute to operate independently like that. Still there's that history of the linkage to

 

the foundation, the funding coming from the foundation that causes people to ask questions. So, it helped, but I think the work of the institute had to earn and maintain that independence over time.

JM: So, the whole point was you have a policy body right across the street, and they have a legislative staff, for sure that has expertise in various topics. It's a nonpartisan, bipartisan staff. They serve both sides of the aisle. And yet, at least the foundation determined that there was a need for a policy institute that really focused in on health and that could share information, do research, share information, and become a resource for the policy group. I mean, the legislature is right across the street. How did that play out over time, over your tenure as the president and CEO here?

RSP: It waxed and waned over the years, just based on the political dynamics. One important aspect of the foundation's vision was that this institute would address health very broadly defined. It wasn't just medical care and doctors' offices and hospitals. They really wanted the institute to look at a broad set of issues that influenced how healthy we are as a city, as a county, as a state. So, that was always a part of our ambition, but it was sometimes hard to get the attention of policymakers around those sorts of issues, public health, and how education or housing, transportation, how they influenced health.

So, we had to focus appropriately on health care. That's where all the money is, and what people are interested in, especially people that control the state budget. So, we did a lot of work around Medicaid and the implementation of Health Wave at the time, the children's Medicaid expansion that occurred. But I would say that there's a lot of skepticism of think tanks or policy institutes, largely skepticism on the right that institutes like that are just going to have a natural bent towards the left. I think that we tried to be very cautious about conveying any of that in recruiting people and in the editing process and the questions that we looked at. The convenings that we did, we tried to make sure that people felt that all the views were being fairly represented. And, again, I would say we had varying degrees of success over the years with that.

JM: I can certainly attest to the effort. Full disclosure, I worked at the Kansas Health Institute for a while when you were in charge there, and it was a revelation to me—that kind of gets us right to the heart of the matter about what we want to talk about in this series of interviews. Essentially, what constitutes health? You're right. Most people just always gravitate to health care. In other words, how good are the hospitals? How good at the doctors? What kind of care? Do people have access to health care?

But what really opened my eyes when I got to the Health Institute was, as I say, it was a revelation to discover that what constitutes a person's health or a population health, too, the health of the whole population, has so much more to do with not only genetics, which is obvious, but also the environmental factors, what you call social determinants of health. That was a really heavy lift when you were trying to communicate that to policymakers, but it's essential to understanding what drives health outcomes, right?

RSP: Absolutely. I was lucky in the sense that my mentors, both Dr. Lee and Dr. McGuiness in Washington, were early believers in this concept of social determinants of health. And then the

 

guy who chaired that advisory committee to the foundation in setting up the institute was a large figure in that whole realm. So, it was sort of part of my background which matched very well with the foundation's interest, but I think that if you try to think about how healthy you are as an individual, it's easier to immediately go to the medical care side of it. But when you think of a whole group of people, whether that's people who are new immigrants to the country or people who are older or people who live in rural parts of a state, then you have to really start considering some of those contextual things that really influence how healthy and the well-being of people.

JM: I remember hearing you give a talk several times, you had a graph, and you talked about the things that contribute to health. You had broken it down by percentage: this much is genetics. This much is the health care you receive. I was astounded to understand that really it's a fairly small sliver that health care occupies. The social, the environmental factors are far more powerful in determining health. Could you just give us a quick tutorial, reprise that speech for me here in a couple of minutes?

RSP: And I'll say that wasn't work that I did, or that KHI did. That's sort of the body of science that everybody came to understand I would say in the last part of the nineties and the early 2000s.

JM: But you worked hard to communicate those research findings to policymakers.

RSP: Yes. Absolutely. We won't quibble about the specific numbers, but 20, 25 percent of population health and well-being is attributable to traditional medical care, which is shockingly small. Another chunk is genetics. We're learning more and more about genetics. That piece of the pie is getting a little bit bigger over time. But there are other things like the physical environment, the built and the physical environment, how cities are built, water, outdoor space. And then the biggest chunk is what's called behavioral type of things. So, what are the things that influence our behavior that then determine how healthy we are over time? Things like diet and exercise, substance use, intentional and unintentional injuries, those sorts of things. So, when you put them all together, those really do have a much larger impact at the population level than health care itself.

JM: But even on the individual level, if you stop and think about it, if you drink excessively, if you smoke, if you don't get any exercise, if you eat a very poor diet, even individually we understand that that has a direct impact on how healthy are. But when you spread that all over the population, it gets very complicated because then you say, "Okay, somebody eats poorly. Why is that?" Well, could it be because they don't have access to a real grocery store or their income level doesn't allow them to buy the kind of fresh fruits and vegetables that are beneficial to them, or are they subject to this mirage of advertising for fast food and everything else that causes them to default to a fast food diet? It becomes a very complicated question.

RSP: There have been some really interesting studies of cafeteria lines in schools. Just based on where they place different products—all the school lunch program data is all easily available—you can see just by where you put different things, the choices that the kids make in going through the cafeteria line. So, if you learn about those things, you can impact the choices that they're making on the food that they're eating at lunch.

 

JM: When you were at KHI, you did a lot of research, there was a big debate in the state about banning smoking in restaurants and so forth. I know that KHI did some research that helped the Sunflower Foundation, another conversion foundation, kind of spearhead that effort, and that was very helpful to policymakers.

RSP: Yes. That's a good example for a number of reasons. There is a lot of information from a lot of states that clean, indoor air ordinances, otherwise known as smoking bans, don't impact the bar and restaurant industry or the general economy of the community.

JM: Because that was the argument against it.

RSP: Yes.

JM: You were going to cost them money.

RSP: That you were going to hurt a whole industry and in some communities, that's really an important part of their business. But there's a lot of data from other states and other cities around the country that that didn't happen. But the policymakers across the street wanted to know about Kansas. How will that play out in Kansas?

We actually got tax data—sales tax, liquor tax from certain communities that had implemented or had not implemented smoking bans, and we could demonstrate that there actually was a very small decrease in some tax revenues shortly after the ban was implemented, and it rebounded and actually went at a level higher than you might have anticipated prior to the ban.

Once we had Kansas specific data that we could show to the legislature, we must have got called over there a half a dozen times in the heat of debate in a committee or something, and then we'd walk into the room. It would be crowded, and they'd say, "Get the KHI people up here to tell us again about that study."

I think that those data were believed by all sides. It was hard to argue that. Again, we didn't have an agenda. We wanted the legislature to make a good, informed decision. If they made a policy decision, they would understand the implications of that and how that would play out over time.

JM: It's a little bit like being a reporter. You might have had a personal agenda, but you did not have an organizational agenda, and you were very clear about that.

RSP: Yes. Everybody obviously has their own biases and preconceived ideas, but we worked very hard to prevent those from coming through in the work that we did.

JM: Let the data tell the story as it were.

RSP: Yes.

 

JM: So, that was essentially a proof of concept that 1) the data you provided was important to a policy decision, which was exactly what the foundation wanted, when they set up with the health institute. That wasn't the only one, but that was proof of concept that this experiment was working.

RSP: Another one that you will remember well, I'm sure, was when Governor [Kathleen] Sebelius was developing her health reform proposals. She had appointed a director of health policy. There had never been a director of health policy in the governor's office before, but they didn't have a place to put that person. So, they actually asked us if he could house here within the institute for a period of time until the offices were ready.

So, that director, Bob Day, and his deputy, Karen Briman officed in the Kansas Health Institute for some time. They were working on the governor's proposals. We weren't working on it. We would look at what some other states were doing in certain areas and provide that information to them, but we weren't working on the governor—we didn't know what the governor was going to propose or working on.

At the same time that that was going on, the Republicans in the legislature that controlled both chambers were very opposed to what the governor's ideas were. They wanted to come up with an alternative to have ready to put out there when the governor put her proposal forward. So, we were working with the leadership in the House and the Senate both, again understanding how other states were approaching some of the issues that they were interested in. So, there were days where we had the governor's policy director and senior members of the Senate or the House in our building, and I was hoping they didn't bump into each in the hallway. That was sort of an interesting time.

JM: Again, proof of concept that you could be a resource for all sides. You were just supplying information and help them make the best decisions that they were inclined to make.

RSP: That was our goal. I would say again that ebbed and flowed over time in how much trust and interest there was in the input and work of the institute. There were some transitions in the governor's office primarily, some in the legislative leadership. We had to work hard to build relationships with people that they would actually have confidence in the work we did and turn to us and ask us to do things.

JM: I think one of the big initiatives, too, that I recall was the establishment of the Legislative Health Academy where you took the legislators from both sides of the aisle, and you put them through a year-long curriculum. Talk about that a little bit.

RSP: Yes. I just give so much credit to the legislators who participated in this program. We had two cohorts of legislators, about a dozen in each group, and they had to commit to spend eleven days over the course of a year learning about health policy. We focused on health policy on systems engineering. How does the design of a system influence outcomes? It's like a balloon. You push one part, and the other part bulges out.

 

JM: Amazingly enough, I don't want to digress too much here, but that's an important thing because I learned so much systems analysis. Outcomes, policy outcomes are entirely predictable if you take that approach. It becomes almost an engineering exercise because people are prone to knee-jerk reactions. The liberals always want to spend more money, and conservatives don't want to spend any money. What you find out when you do the systems analysis is that if you do this, the outcome can become predictable, and they talked a lot about getting caught in negative feedback loops where you try the same things over and over again, and you don't move the needle.

RSP: Absolutely. So, we wanted to build in an understanding of that systems engineering. And then the third element was ethics, understanding what's the ethical moral approach to the responsibility that people have as decision makers. I think that was a really interesting part of the academy. But we would bring these legislators off-site, out of Topeka, to a very nice place, and we'd have them for a day to three days. We would work hard during the day, have speakers from all over the country and around the state come in to talk to them about different issues. And then we'd get together and have dinner. I will say that there were a couple of nights that cigars and Scotch were broken out. Just to see legislators from across the political spectrum interacting, and some of the very personal, emotional conversations that happened in that context that then we saw play out in committee settings where two members from opposite political positions and parties both were in the academy, in a committee setting, they would look at each other and say, acknowledge the deference they were giving because of that experience that they had.

It was a very expensive, extensive effort, but I think it reflects—in Washington, it's reflected in the sense that it used to be people got elected to Washington, and travel was more difficult. Members of Congress spent their time there. Their families were there. They socialized. Their kids went to school together, and they got to know each other.

Well, that doesn't happen now, and that's played out on the state level also, where people don't get to know each other as much. This academy, that experience I think really provided the opportunity for them. It's hard to demonize somebody that you know at a personal level.

JM: One of the reasons I think the Kansas Oral History Project wanted you to get involved in this project is because you're going to have a series of conversations that just take a deeper look at some of the health issues in Kansas. One of the issues is that Kansas at one point in the early 1990s ranked very high statistically when overall health of the population was measured.

Over the recent decades, that ranking has slipped considerably, and one of the things that you're going to explore in this series of conversations is why that is. Talk a little bit about how you intend to explore that question and whether or not that is central to understanding some other things about the health of Kansans.

RSP: One of the things that through these interviews, I'm going to try to explore with a couple of different people is this concept of rankings. How helpful are rankings? Whose rankings am I going to believe? You have your rankings; I might have my rankings. How do you judge the quality and usefulness of a set of rankings if you are a policymaker?

 

JM: An important question.

RSP: But the ones you're talking about for the United Health Foundation are generally regarded as very credible and believable. They've been around for decades now, as you've said. The highest I believe that Kansas ranked was in 1991, we ranked as the 8th healthiest state in the country, and that gradually declined over time to a low point of ranking 31st in 2022.

Now, since then, we've slowly sort of climbed up. In the most recent rankings, Kansas has ranked 27th, but at one point, we were 8th in the country, and now we're somewhere in the high 20s, the low 30s. That should catch anyone's attention that's interested in the well-being of people in our state. The Kansas Health Foundation, Steve Cohen, Ed O'Malley, the leadership there has really focused on that issue and tried to get people to address that. It's a very complex set of issues to dig into, but one that's worth doing.

I want to point out one important thing, which is health in Kansas isn't getting worse. People in Kansas are living longer. We're generally experiencing lower rates of cardiovascular disease, stroke, all the things that we worry about. So, it's not that our health is getting worse. It's that our relative standing compared to other states is getting worse. So, other states are doing better faster than Kansas in improving those sorts of health outcomes that we're interested in.

JM: What does that conclusion mean to the average Kansan?

RSP: Well, I think it means we should ask the question you did: Why is that happening, and what can we do about it? Is our goal to be below average in terms of health and well-being for the state? That's where we fall in terms of a lot of metrics, but I don't think a lot of leaders think that that's where we should be.

So, if you look at the areas where we tend to not do as well, there are some that are certainly addressable, and there's been some attempts at the policy level to address them. One is shortage of dental and mental health providers. That has been a chronic problem.

JM: Particularly in rural areas.

RSP: Particularly in rural areas.

JM: But also in some parts of urban areas.

RSP: Yes, even in urban areas. Being a pediatrician, it's very difficult to find mental health providers for children in our state, very difficult. Obesity is another one. In fact, that's our worst relative rating to other states is our obesity rate. We rank 42nd I believe there. Only eight states have a higher obesity rate than Kansas. The insurance coverage, we tend to be about average, and I will say that we used to be above average, but as more and more states have implemented Medicaid expansion as part of the ACA, the uninsured rate in other states has tended to move down. So, again, our relative position compared to the rest of the states has worsened.

 

JM: I'm glad you brought that up. That brings you right into whenever you're discussing policy and the things that move the needle, and you're just taking a fact-based approach, a research-based approach because the whole question of Medicaid expansion is obviously a very intense political discussion.

RSP: Yes.

JM: Kansas is one of the relatively few states that has decided not to expand Medicaid. You immediately then—people start picking sides politically, but it's a simple fact that Medicaid expansion expands coverage, and when you don't do it, it has the opposite effect. You're not saying right or wrong; you're essentially pointing out a fact. It's just factual, right?

RSP: Right, and there are trade-offs to having more people with insurance: less dependence on federal money coming into the state. Some people believe it creates more of an incentive for people to maintain employer-based insurance, all these sorts of arguments.

JM: Correct.

RSP: So, again, there are arguments on both sides, but back to the point about sort of who listens to what we're doing. We've done years and years of very extensive analysis of the potential impact of Medicaid expansion in Kansas in terms of the number of people covered, the cost to the state, all those sorts of things. And our staff was at lunch one day, ten or twelve of us at a lunch at a restaurant in Topeka, and it was during election season, and we saw two commercials in the same break using our data—one from a Republican candidate and one from a Democratic candidate, both cherry-picking the pieces of the report that we did to emphasize the point that they wanted to make on that particular issue.

JM: When it comes to rankings, again, I think you pointed this out, you alluded to this a moment ago, moving the needle on those rankings, there's not a policy lever that can move everything.

RSP: Yes.

JM: But there's policy levers that can move some of those things, right?

RSP: Yes, and I want to mention the other one that we generally don't do as well is tobacco use and vaping. That's one where we tend to be a little worse than average. The insurance coverage, the health care providers, and obesity are the other ones. If you had to say, those are sort of the areas where we're a little bit below other states.

JM: So, you're going to talk to people who are essentially the head of the State Hospital Association. You're going to talk to people who administered hospitals over the years. You're going to talk to legislators, people involved in the health policy questions, people involved in the philanthropic, the foundation world, too. What is it you hope to—the throughline, the narrative throughline. When you're done with these interviews, what is it you hope people will better understand?

 

RSP: I hope people can begin to understand the challenges that we have as a state, what some of those issues are, and how they can be addressed constructively through good policy and good programs, good services delivered at a community level that can make us healthier. One issue we haven't touched on much, Jim, is the challenges that our state faces from a demographic perspective.

JM: I was going to ask you about that.

RSP: The loss of population in so many parts of our state and the challenges with health care and lots of other services as well, not just health care. Education, sanitation, roads, environmental, all those sorts of issues that are challenging local communities. We've got some real issues that we need to address as a state. I hope that it can support a conversation that really tries to dig into the issues and identify ways to begin to address it.

JM: That's a really good way of putting it—support a conversation. I think that's the objective. And you're right—the depopulation particularly in rural areas in the state is astounding. We have some counties that are now approaching frontier status again, populations that we haven't seen since the late 19th century in some of these counties. How do you sustain a good health care system in counties with a population that small as well as education, infrastructure, a whole bunch of other things?

One of the big issues that I'm sure you'll touch on as you have these conversations is Kansas was a leader in establishing the kind of critical access hospitals is what they're called, small hospitals that don't have the capital needs that maybe the bigger hospitals have. A whole federal law was developed to establish those hospitals. I think at one point Kansas had more of those hospitals per capita than any other state.

RSP: Still do, even on an absolute number, we have more.

JM: But even those hospitals now have become too big to sustain in some rural areas. So, there's another model out there. You're going to have conversations that talk about the evolution of the policy environment relative to rural health care.

RSP: Absolutely.

JM: Well, Bob, I wish you luck in these conversations. I can't wait to see what unfolds. I know you have a really stellar line-up of people. I much appreciate you taking the lead on these conversations.

RSP: Well, I appreciate the opportunity. It's an interesting endeavor.

JM: All right. Thanks a lot, Bob. I appreciate it.

RSP: Thanks.

[End of File]

 