Bob St. Peter: Hello, I'm Bob St. Peter. I'm a pediatrician and the former president of the Kansas Health Institute. Today is June 18th, and I'm in Topeka, Kansas to interview Ed O'Malley and David Jordan. Thank you for being here. Ed is the president and CEO of the Kansas Health Foundation in Wichita, and David is the president and CEO of the United Methodist Health Ministry Fund in Hutchinson.

This interview is part of the Kansas Oral History Project, exploring health issues in Kansas. The Kansas Oral History Project is a nonprofit corporation that collects and preserves oral histories of Kansans. This series is supported by donations from generous individuals and a grant from the United Methodist Health Ministry Fund. Our videographer is former State Representative Dave Heinemann. Ed and David, thanks again for being here.

EO: It's great to be here.

DJ: Thanks for having us.

BSP: We're all in Topeka again. This used to be a common thing, not so much for me anymore.

EO: It's good to be back, I bet.

BSP: Yes. So, tell me a little bit about your backgrounds, and how you sort of came to the roles that you're playing now.

DJ: My background really is in policy and advocacy. I got my start working on health issues, actually of all places doing policy work for the Trade Association, for the Health Club Industry. Actually, even though I was working nationally, I worked on a Kansas issue to push back against sales tax on exercise in Kansas over twenty-five years ago.

BSP: I remember that.

DJ: But ultimately, I worked on large-scale campaigns to expand access to health care and to expand access to dental care by adding new dental providers to the dental team. I moved to Kansas once my wife and I got married about fifteen years ago. It's home and where we're raising children. I first led the Alliance for Healthy Kansas, which advocated for Medicaid expansion and passed it through the legislature in 2017, but ultimately was vetoed by Governor Brownback. I've been leading the United Methodist Health Ministry Fund since 2018.

BSP: Great, thanks. Ed?

EO: Before I say about myself, we are lucky to have you, David, in Kansas. In terms of advocacy and policy work, I don't know if I've ever seen somebody better than you at knowing how to identify an issue and work it through the policy halls to get it to fruition. So, I'm very thankful that you're—

DJ: Too kind.

EO: I don't think I am too kind. I really think Kansas is lucky that you now call Kansas home. It means a lot to have you here. So, Ed O'Malley, lifelong Kansan. I grew up in the Kansas City area, and my early part of my career was in government and politics. I worked for Governor Bill Graves right across the street here in the Capitol in my early twenties. I did some government relations work for the Overland Park Chamber of Commerce and somehow wound up in the legislature in my mid-twenties from a district in Johnson County. I served in the legislature for two full terms, was re-elected to a third term and then was offered the chance to become the president and CEO of this new thing called the Kansas Leadership Center, which was an effort funded by the Kansas Health Foundation, to build leader capacity across the state.

So, I left the legislature, moved to Wichita to start the Kansas Leadership Center. That's how you and I became acquainted because of the close connection between your work in the Kansas Health Foundation. I did that for sixteen years, and four years ago, became the president and CEO of the Kansas Health Foundation.

BSP: Great. Well, both really interesting backgrounds and stories to where you are. Obviously, foundations are a big part of both of your lives now. What is a foundation? In particular, what is a conversion foundation? Both of your organizations are similar in that way. Talk to me a little bit about foundations and what they are.

EO: I'll take a quick first stab. One thing that I haven't thought about until this moment is your foundation and the foundation I work for, we have the same origin story. I've known that. The fact that you and I are literally in these roles today, the people way back in 1985 when these foundations were created, but for them, we wouldn't be in these chairs today.

BSP: And I wouldn't have been in this building for twenty-five years.

EO: That's right. I mean, the quick story from my perspective is endowed foundations are places that have resources and try to use those for the greater good, and the Kansas Health Foundation and your foundation, the resources came from the sale of a hospital, Wesley Medical Center in Wichita, Kansas back in 1985, a nonprofit hospital sold to a for-profit company. Nobody gets to keep that profit. 220 million was the total sale. That became two different foundations, and we've been off and running ever since.

DJ: Both of our foundations are health conversion foundations. There are actually six health conversion foundations in Kansas, which the state benefits from. Each of the foundations may have slightly different missions, but we're largely united by the shared mission of improving the health of Kansans, and I think that's why you see so much activity in the health space, but each of the foundations is able to draw upon an endowment, and each year spend millions of dollars focused to improve the health of Kansans. So, we're very fortunate from that perspective.

BSP: And at one point on a per capita basis, Kansas had more philanthropic assets per capita than any other state. I know some other large foundations in other states have been created, but we have a real richness of that resource in our state.

EO: And I think sometimes people get confused that most of—at least the health conversion foundations really focus on trying to get it as upstream as possible in the work, so not as much dollars for charitable causes, for example. We're not spending these dollars giving grants to serve people who need charity today. While that's really important, these foundations are trying to get further upstream, trying to prevent some of the things that cause people to need charity in the first place.

BSP: So, the difference between a charity and maybe strategic philanthropy, strategic gift-making, do you want to say a little bit about that?

DJ: Sure. I think charity is a really important piece. That's really typically more responsive, more meeting the needs of the moment and just dealing with the problem in front of you, and I think you may be giving dollars to the United Way. They're working just responsibly in that community, and I think that's just a really important function. But I think the benefit of strategic philanthropy, which I would say all six of the health foundations in Kansas participate in is really to take a really strong look at what's holding the state back in terms of health, and how can we strategically invest in solutions that help move the state forward versus being responsive and just dealing in the moment. I think Ed categorized it really well, thinking about dealing with upstream drivers of health, which may not always be what happens in a doctor's office, but maybe whether or not there's access to healthy food or quality early childhood care in a community. I think that's where all of the foundations work together with the broader mission of health, but some of us may be working on food access and some of us may be working on social/emotional development, and I think all of that focus is needed to move Kansas forward and make it a healthier state.

I think the other piece that Kansas has been a leader in, both the Kansas Health Foundation and the Health Fund and our partners at the other conversion foundations, Reach, Sunflower, Health Forward, Wyandotte, it's really recognizing in order to improve health, we need to change policies and systems. Some of that is funding advocacy. Some of that is funding research. We really need to change how we think about health.

BSP: Great. We'll get into some of those issues quite a bit. Before we move away from the origin stories, talk to me about the relationship with the United Methodist Church Conference. I know that that's been an important part of the history of your two foundations in particular.

DJ: As Ed mentioned, both of our foundations resulted from the sale of Wesley Medical Center, but previously the Kansas West Conference of the United Methodist denomination owned that hospital. When they sold it, ultimately, the 220 million dollars broke into the two entities; 30 million dollars to the Kansas West Conference, which established the United Methodist Health Ministry Fund, 190 million dollars which ultimately—first it was the Wesley Medical Center, but ultimately Kansas Health Foundation. Both of us enjoy still—we're support organizations of the Great Plains United Methodist Conference. That's important because it allows us to have the tax status necessary to engage in advocacy and policy which we see as critical to improving the health of Kansas.

EO: The relationship is important very much for the reason David just mentioned. I think also just the historical connection to the largest—I believe it's the largest denomination in terms of the number of churches historically in Kansas. The United Methodist Church has a lot of footholds across Kansas. We're trying to evolve something across the state, engaging those congregations, which you guys have done an incredibly good job of and something that we're trying to figure out how to do more of, how to connect even more to that history of that lineage, and leverage it for the greater good.

DJ: We have a program, a Healthy Congregations program where we engage nearly 100 churches in Kansas and Nebraska, and really try to help provide them resources, really small mini grants but to help them, facilitate them taking leadership in their congregation or their community to improve health. We really want to tie it to the congregations and to the history of the foundations but also an exercise in leadership and in grassroots development.

BSP: Great. So, these foundations have financial resources, strategic resources. What are foundations uniquely situated to do in a state like Kansas? What do foundations do well, and what maybe are some of the challenges that foundations have in operating in states in Kansas and in our situation?

EO: I'll take a stab on this one first. I think foundations, endowed foundations—there are some foundations that exist that are raising money and then spending that money. Endowed foundations like ours are a different set-up as we've discussed. One of the beauties of an endowed foundation is to be able to take a longer time horizon, to work on things that might take longer. We don't have to be controlled by an election cycle. We don't have to be controlled by "Do we have a business model that can keep the lights on?" That allows endowed foundations to look at the bigger picture, take a longer time horizon, maybe wade into issues that are harder to talk about, maybe focus on things that would be harder to focus on if you had to raise money in order to focus on those things. So, there's a lot of value.

There are some challenges, too. There are plenty of pitfalls of philanthropy. When you literally are running a business model that can't get out of business, assuming you run it right, that is beautiful but also sometimes it cannot create the sense of urgency that might be useful to be able to really get something done. Overall, it's a good thing, but there are, as I know, David, you have to do this, too, we have to manage the pitfalls that come with being in this type of work.

DJ: Yes, I think the reality is if you've seen one foundation, you've seen one foundation. They all can operate very uniquely, but I think Ed's right. There's a lot of upsides in terms of having the flexibility and the resources to commit to a long-term vision and then to execute on that long-term vision. But the challenge becomes if there's not those same external pressures, it's easy to wait until tomorrow, and there's not as much need to deliver in the short term. I think sometimes those pressures are really helpful. As a relatively smaller foundation in terms of the size of our endowment, I actually think that's the least exciting way you should be looking at foundations, like what's your asset base, but it's easy to say that. As a foundation with a smaller asset base that gives out less each year is that we need to be creative. If we're going to make an impact, we need to find ways outside of just the giving that we do to make an impact. So, we do have some of that pressure, but I do think you always need to be cognizant and tie it back to the mission The

advice I got from my predecessor is like, "Don't forget who you're serving. Those western Kansas Methodists who made this foundation possible, what are you doing on a regular basis to make them healthier and their community healthier?" I think you need to be anchored to that.

EO: I think what I would add—I know we've got other things to talk about beyond foundations, but I think there's a misconception sometimes that foundations have a gazillion dollars. We have different asset bases, but neither one of us and all six of the conversion health foundations combined in Kansas don't have enough money to like solve health problems in Kansas with our money. We have enough dollars if we use them creatively to catalyze activity, to shine attention on issues that need broader engagement from the legislature or local policy makers or the private sector, but the gross domestic product of Kansas is something like 250 billion dollars a year now. If we think like economists and we think of that 250 billion creating a system that is giving us the results that we're getting, so it's giving us the health outcomes we're getting, we don't have hardly any money compared to a 250-billion-dollar system. So, using it creatively, using it strategically, using it in ways that catalyze other investment is what the game is all about. I think a lot of people don't understand that, and they just assume we have dollars to go solve all the health issues.

DJ: I think one of the most important things that we can do, and I think both the Kansas Health Foundation and the Health Fund work on this, is bringing people together to convene Kansans to build a shared vision on how we're going to get from where we are now in terms of our health to leading the nation in health.

BSP: That's a great set-up for where we're going to go, I hope, with this conversation. I just want to reflect back on somebody, a mentor that we share in common. Marni Vliet who talked about that relationship you're talking about where you might envision charity as addressing the needs of individuals at the current time, right now, a short point in time, whereas strategic philanthropy has a very long-time horizon and maybe addresses populations, maybe not an individual face that you can recognize but whole groups of people over long periods of time. That is a very different framework for thinking about problem solving than elected officials or charity organizations, health care organizations. It's a tremendous asset for Kansas to have, and I'm excited to talk more about what you guys are up to.

The word "Health" is in the names of both of your organizations, but I think health is a very difficult thing to really get your arms around and understand. Talk to me a little bit about how you think about health and how you want Kansans to think about health.

DJ: I think as a starting point, we view health as being beyond the health care that's delivered in a doctor's office or a hospital. I mean, the technical term is probably like living a life without infirmities and disease, but I think we want to ensure that Kansans are healthy, but they're thriving. There's a high quality of life, high educational attainment, economic opportunity, ability to be healthy and active, and I think in order to achieve that, you need to look at a number of factors or social needs outside of the traditional health care system.

EO: I remember when I was in the legislature and I was at a coffee shop in Overland Park, and I was writing thank you notes to donors to my campaign. I got a phone call from the recruiting

firm that was doing the recruitment for the Kansas Leadership Center CEO position that the Kansas Health Foundation had created. I remember taking the call and listening to that recruiter talk about there's this opportunity that's related to Kansas Health Foundation, and we're wondering if you might be interested in it, and I wasn't because in my mind, health meant medical. It meant health care. I didn't have an expanded thinking of health. It was only through staying on that phone call and listening and eventually going down, and you were on that search committee if I remember correctly and meeting you and Marni Vliet who you just mentioned that I began to realize, "Wow, the Kansas Health Foundation and other foundations have a bigger definition of health." I found it very exciting.

The idea that—we all know, for example, the biggest determinant of your health is your economic status hands down. So, health has got to be bigger than health care. It's got to be bigger than what happens in a doctor's office. I know our foundations, the other foundations in the state, all share this broader kind of thinking. We talk about it at the Kansas Health Foundation now as "There's capital H Health and lower H health. Lower-H health is really, really important. It's a part of Capital-H health. Lower-H health is health care. Capital-H health is all the things that go into your ability to thrive. The foundations work on as many of those different topics as they can.

BSP: I remember practicing as a pediatrician, you'd see a kid come in the office with asthma or something, and you have a ten- or a fifteen-minute office visit, and then you're not going to see them again for several months probably, and you think of all of the things that that child encounters in their family, in their physical home, at school, in their neighborhood that influenced all the things that affect whether asthma is symptomatic or not, and that ten minutes in a physician office is very small compared to the overall impact of all of those other factors in their life and their health.

DJ: The complicating thing is that I think our jobs would actually be easier in some ways if we had a smaller definition of health. If we thought our only work was to work with the health care community to support innovations and initiatives inside the health care community, it would actually scope the work down quite a bit and might make it a heck of a lot easier. We certainly do a lot of that, but over the years, I think all of the foundations have realized it's actually a much more expansive playing field, and if we don't see that, we're not going to make a difference.

BSP: I know both of you are familiar with the way the World Health Organization has talked about health. Actually back in 1948, the original constitution of the WHO defined health, and I've heard you both say this—the World Health Organization defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. So, it really has very much of a positive, proactive, much more than being unsick, but sort of empowerment, the enablement that people have as individuals.

Thirty years later at an international health conference in Alma-Ata in the former Soviet Republic, there were some important contextual frameworks put around that original definition. They let that definition stand, but they said it needs some further explanation, and they added a

couple things. I want to just mention these. I'm going to ask you how you wrestle with them, and how people in positions of influence think about these sorts of issues.

But the first one, they outlined ten principles that supported that WHO definition, and again this is 1978. We're talking about fifty years ago. Health is a fundamental right. The declaration established that attaining the highest level of health is a fundamental human right. Health requires broad action. It's the condition that realizing the goal requires the action of many social and economic sectors outside of health, things like agriculture, housing, education. Social equity, again, 1978, highlighted gross inequities in health status between and within countries. These differences were politically, socially, economically unacceptable. This is an interesting one: right to participation. People should be empowered with the right and the duty to participate in the planning and implementation of their own health.

And it goes on. Those are the ones that I think are most germane. But, first, are those consistent with how you guys think about health? How are those concepts received by people in positions of influence?

DJ: I think the whole debate on—well, one yes, I think those principles all resonate with me personally and with the Health Fund. I think the interesting thing is in the United States, we spend a lot of time on the first piece, whether or not health care is a right, and everyone has a right to health care. A lot of the energy in rooms are sucked up in terms of what is government's role in health care and what do individuals have a right to. I think the reality is 1) we do need to reconcile that, and health care should be a right, and everyone should have access to the highest qualities of health care. But in order to really improve health, you do need to focus on things like social capital. How can we make sure people have social connection? That has an inordinate amount of impact on health. How do we make sure spiritual and behavioral health are factored into this?

So, it's really interesting to hear about those factors and principles being talked about in 1978 because every ten or fifteen years, patient-centered care, things are being repackaged, but those I think are really great grounding points.

EO: I would love to get a copy of that, or maybe I could find that online. So, yes, it resonates 100 percent. It's shocking that's from 1978. I think sometimes I've felt maybe that there's been this journey the last twenty, twenty-five years of some of us in the health space that I now consider myself a part of, but it predates that clearly, 1978.

A couple of things popped in my mind as you were reading those. One of them was on that first one, it talks about health as a right, and I think you're right, David. What we're debating endlessly in our country implicitly or explicitly is whether health care is a right. I'm pretty sure it's health.

BSP: It's the highest possible level of health.

EO: And I think that gets to part of the problem, that we have so integrated health and health care in our thinking. Our inability to separate those things out, it's making it hard to have the type of

discourse that would be the most useful. I want to believe that we might, if we could get policy makers in our country to talk about "Should that statement be a right?" Health. That's a different argument or different discussion than "Should health care be a right?" I wonder if we could get folks on that, if it would lead to different outcomes in a better, maybe kind of conclusive way of thinking about what is the role of government going to be in health care in America or in Kansas, but I think that stuff resonates perfectly today like it did back in 1978.

DJ: I think you could even look at it though with being maybe a bit more pessimistic in that I think we started to see, for instance, like the health status of Kansans decline in the mid-1990s, and coincidentally all of the things that go into improving health, but we think about it as systems and policy levels are things that include other social safety nets: TANF, SNAP.

BSP: Give us the acronyms for people who are listening.

DJ: Okay, TANF [Temporary Assistance for Needy Families] which is essentially cash assistance or welfare, SNAP, the food assistance program, [Supplemental Nutritional Assistance Program] childcare assistance, all of these safety net programs or work support programs became politicized in the mid-nineties. And all of those are key factors in health. It's not just access to health care. So, you layer in whether or not folks should have access to those safety nets and supports. Those things are politicized, too. I do think we need to try to depoliticize whether or not it's these programs or supports, and just find ways to get everyone to participate at the highest level.

BSP: That's really interesting, and I want to continue this conversation a little bit but let me ask a question before we dive into that. Do you think most people in Kansas think that the United States has the best health care system in the world? And do you think that? Does the United States have the best health care system in the world?

DJ: I think this is where you need to unravel health and health care and what we're measuring when we say best. Do we have the most cutting-edge technologies and better access to more of those technologies? The answer is probably yes. Do we have better access to cutting-edge pharmaceuticals? The answer is probably yes. But the reality is it costs a lot more. Not everybody has access to it, and we certainly have a more complicated system that produces some of the not-as-good outcomes. So, it's tough to say it's the best if what we really should be measuring is health outcomes.

DJ: And I just, being a student of you, Bob, I've followed you long enough and learned from you long enough to know the answer to the latter part of your question. The United States lags behind on health from a number of other countries, which shouldn't be the case. It shouldn't be the case in some ways. There shouldn't be—we're the wealthiest country that's ever existed on the planet, and for an individual, we know that the biggest determinant of an individual's health is their economic status. That's not the same for a country, which is interesting to think about.

BSP: Yes. I think you're right. You mentioned earlier sort of efficiency. If the system that you have is trying to produce health and you have the right mix of inputs into that system, and you have an efficient system, then you should have the outcome, the output that you're striving for.

But it does seem that in the US, we haven't quite hit that correctly. Just to throw out a couple more numbers there, we spend more in the US per capita than any other country and more than a factor of 2, more than most developed countries. Yet, most metrics of health we don't do as well, life expectancy being a very simple one. In the United States, life expectancy is 79 years. In comparable countries, it's 82.7 years. So, they're spending half as much per person and as a proportion of their overall economic output, yet they're getting better outcomes. That's just one metric. There are many, many—infant mortality rates, lots of other things we could talk about.

In 2013, the Institute of Medicine put out a report called "US Health: An International Perspective: Shorter Lives, Poorer Health." Steve Woolf was the main author of that report. Many, many large work groups within the Institute of Medicine and National Academy of Sciences that worked on this. I want to read a paragraph from the preface to that report: "The United States spends much more money on health care than any other country. Yet, Americans die sooner and experience more illness than residents in many other countries. While the length of life has improved in the United States, other countries have gained life years even faster, and our relative standing in the world has fallen over the past half century." So, spending more, getting less in terms of outcomes. Again, how do you process that? How do you think a typical Kansan that you run into, I doubt they think about it much, but how might that be important to them to understand?

EO: I think you're right. The typical Kansan doesn't understand that. I think the typical Kansan would be surprised at some of that data. From my perspective, I know I don't have enough influence to influence what's happening in our country. I think I have enough influence working with partners around the state to influence how our state is doing our part inside that broader kind of system that is the United States, and how do we at least mitigate what we can in Kansas. Are we mitigating what we can in Kansas relative to other states? It's a big national issue, and the context is—

BSP: And it's an important one. This is 18 percent of our economic output as a country going into health or health care, and we're maybe not getting out of it what we would expect.

DJ: I think most Kansans are concerned about the costs that they face personally. I think the biggest concern in Kansas and nationally right now is the cost of health care. I think they feel like they're paying a lot of money, and then they're either faced with out-of-pocket cost or getting fragmented care. I think the challenging piece is that health care is one of the largest economic drivers in Kansas, and the conversation about health care also becomes a financial one. So goes the hospital, so goes the community, like many rural hospitals and rural schools. I think there is—how do we preserve what we have versus improve. I think that's the challenge. The status quo becomes the default versus dreaming about what could be.

EO: The system, like the health care system, is so complicated and so big. You said 18 percent of the economy.

BSP: Of the economy, GDP.

EO: That's really hard to change something that's that big.

DJ: Those financial incentives.

EO: All the financial incentives are aligned to keep producing the results that we're currently getting. So, change is really hard, which just makes this whole thing kind of maddening.

BSP: You mentioned cost, and individuals in Kansas worry about that. It's still true that medical bankruptcy is the most common cause of personal bankruptcy in our state, in our country, which is again hard to fully understand.

DJ: Yes. I know that others have brought up just Medicaid expansion. I think this is where it's so tough because Kansans would like—what opportunities are there to change the system and make a big impact? And Kansas is one of the remaining nine or ten states that hasn't expanded eligibility to Medicaid up to 138 percent of the federal poverty level. We know that expanding Medicaid would bring down costs for 150,000 Kansans. We know that it would reduce medical debt. We know that it would not just improve health, but it would improve family finances. I think to the extent that we think about how can Kansans improve health, that's why the conversation goes to Medicaid expansion because there really is the opportunity to have a significant impact on families' budgets, on the sustainability of health care providers like rural hospitals, and also on economic opportunity. But we know it's more complicated of a topic than just expanding Medicaid.

BSP: I heard you both say earlier that while it may be extremely helpful, may be necessary but not sufficient to really impact health at the higher level as we want to achieve as a state.

EO: I think it would impact health. It's not the—we haven't gotten to the health rankings yet. Expanding Medicaid isn't going to all of a sudden take us from currently we're at 27 in the nation in the American health rankings to 1st. It's going to be really hard to climb the rankings significantly without something like either expanded Medicaid or some other transformative large-scale solution to dramatically increase the number of Kansans who have quality health coverage. It's going to be really hard to climb the rankings but for something like that.

The one other thing I want to mention about the Medicaid expansion discussion, too, though is the number of Kansans at the poverty level, my recollection of the data has stayed pretty consistent for the last several decades. The number of Kansans who are below what is now called the ALICE threshold—so, ALICE stands for Asset Limited, Income Constrained, Employed. This is a new data set that the United Way all across the country is preparing state by state. The number of Kansans that are below the ALICE threshold, which is like a survival budget for a family, keeps growing. It is now 40 percent, around 40 percent. That number keeps going up. So, when we don't do something like expand Medicaid, the working families that are struggling are having a harder and harder time getting by, and we've got to come up with some kind of solution, and it's getting worse and worse for the families in Kansas.

DJ: Sort of building on what Ed said, the reality is we look at health rankings, which I think are a good way to have a conversation about how do we strategically improve health is that expanding Medicaid is, as Ed said, not going to put us at #1. But no state that has not expanded Medicaid is

in the top 17. There's two pieces of this conversation. One is what Ed just talked about really eloquently is that Medicaid expansion is going to help improve health outcomes, and it's going to help close the gap in terms of the lack of support that these working families have. But the other piece of it is resources for the state. In the early 2000s, Kansas ranked 23rd in terms of the amount of federal dollars we're bringing into the state. And whether we like it or not, dollars help fund critical services.

When we were near 9 [#8] in the country in health rankings, we were spending a lot more money on upstream interventions through public health. Right now, we rank 40th in the country in public health funding on a per capita basis. That's because the dollars that we have in our state budget to dedicate towards health are dealing with uninsured. That could be paid for if we expanded Medicaid with a 90-10 federal match. The dollars that we have at the state level for health are going to pay for behavioral health services of which we could cover a third of the services through Medicaid services for a third of the uninsured people. So, we're constraining the resources as a state that we have to address the broader health issues by not expanding Medicaid. I think that resource conversation is a really important one as we think about what we want to do to improve health and improve the lives of Kansans.

BSP: Great. I want to follow up on that insurance issue a little bit because a lot of people that saw this Institute of Medicine study that ranked the US, that said the outcomes weren't as good as other countries thought, "Well, it's because we have so many more uninsured in our country." If we just address that, we would get up there. The IOM [International Organization for Migration] group found that not to be true. As you said, it's an important component, but the higher uninsured rate alone did not explain the difference between the US and other countries.

Similarly, people have said, "Maybe it's the racial and ethnic diversity that we have in the US compared to a lot of Scandinavian or Asian countries." They looked at that in detail, and that also does not explain the difference in outcomes in the US. You can adjust for all of those things. Surprisingly, even if you look at well-to-do Americans who don't smoke and are not overweight and you look at their outcomes, even that group doesn't have as good of health outcomes as similar people in other countries.

So, there's something broader and more systemic than any one of those individual situations. We have higher rates of chronic disease and mortality rates in adults. We have higher rates of early death and injury in children than all of these other developed countries. So, there's something there. Again, that report was thirteen years ago and caused quite a buzz at one point in time, but these are very difficult issues to grasp and to deal with from a policy and societal perspective. They're unlikely to go away though until we do.

EO: The meta issues are unlikely to go away. The best we can do here in Kansas is think, "How do we best organize ourselves to mitigate those issues as much as possible here?" That's a tricky conversation also.

DJ: While not addressing the point you made, which I think is really provocative, it's interesting, I was reading an article a few weeks ago. A lot of time and energy is spent on "How do we reorient the health care delivery system to bring down cost and deliver care in a more patient-

centered way?" thinking we're going to get better outcomes. And that's just not coming to fruition. This is just a drip, drip, drip, drip, and really radical incrementalism that just isn't bearing fruit.

But what is bearing fruit is states that have passed sin taxes on things like tobacco in the last five years. The health outcomes in those states have really increased, if you look at states like New York and New Jersey that have put significant taxes on tobacco. You've seen significant gains in health outcomes. I know you were looking data of non-smokers that you referenced, but I think that's something really to think about—not only are you generating revenue, but you're really seeing a benefit in terms of health. Again, this is multifaceted.

BSP: You're getting at that point of "What's the mix of inputs going into this function of producing health to get the outcomes you want?" Maybe that mix of inputs going in isn't ideal to get the outcomes that you're striving for. And I've heard you both say in other settings that this isn't that the American health care system isn't great. It's phenomenal. It's miraculous in many ways, what our health care system can do when somebody is sick and has an acute event, when a baby is born weighing 500 grams and needs intensive support. We do very, very well in those sorts of outcomes.

The issue is "Why are we seeing such pressure upstream to have higher rates of those coming down the pipe to our health care system?" and it just overwhelms the numbers when you have—low birth weight is a great example. If you look at babies born a certain weight, the survival rate in the United States for those babies is better than other countries, but we have so many more low-weight, very low birth-weight babies that the numbers get overwhelmed by the larger numbers coming down the pipe. So, it's not a criticism of the health care system.

EO: Here's what I think about it. We cannot health care our way out of the bottom half of America's health rankings. We've got to have amazing health care. Health care is not what's going to help us climb. It's the social structural supports. It's these policy changes. It's changing the system dynamics. Frankly, if we did that, it will actually ease the burden on the health care community that have to kind of catch all those sick babies. If we could reduce that burden on them, the health care sector would probably be stronger, too, but we can't health care our way up the rankings.

DJ: As a health foundation, oddly enough, one of our three strategic areas of funding is thriving children. We look at that as three different buckets. One is "How do we make sure that Mom and baby have the healthiest start in life?" There's a lot of traditional health care measures: prenatal services, strong labor and delivery, home visiting programs, but then the biggest bucket really is safe and stable families. The best way to measure that in the case of children and moms is the PRAMs report where there's the number of self-reported days of stress in a month. It's like, "If we want that mother and baby and family to be healthy, how do we reduce those stressors?" like paying for the heating bill, putting food on the table, making sure that there's money to pay for childcare. All of those stressors are impacting both the family unit and the child. So, we need to reduce those stressors because those impacts result in spikes in cortisol levels, which are going to impact the health of that person throughout their life spectrum. So, it really is that, "How do we make sure we can support safe and stable families?" that I think is going to be critical.

BSP: I'm so tempted to go down a rabbit hole on this, but I do have to at least comment on that. The question that existed in this whole social determinants of health kind of research for decades has been, "How do these factors, these societal factors, get under the skin?" so to speak. How do they actually affect physiology? And we've learned a ton in the last twenty-five years about what you just said, how chronic stress, commonly called "toxic stress," actually changes the way your brain and other organs in your body produce chemicals and hormones, and it even has been shown more recently to affect the genetic support structures around the genes, which we've always talked about sort of the multigenerational aspects of some of these challenges. But I think that we've learned a lot about how these toxic stressors are introduced to the body and manifest in chronic disease but also in lots of the other challenges that you talked about.

DJ: I think it really is important that you recognize that. There's clearly, and you referenced this earlier, significant disparities that exist between, for instance—Black mothers in Kansas face many more challenges, and we have higher levels of maternal morbidity among Black women in Kansas than we do among White women. But there's just important recognition of like generational challenges as it relates to how toxic stress impacts not just your health but the health of future generations. There's a really great examination of that as they were talking about a few years ago, we were looking at Black Wall Street and the generational trauma that was created through that.

BSP: In Tulsa, are you talking about?

DJ: In Tulsa.

EO: So, just to knit a few of these things together. If the science is now telling us that toxic stress produces a physical reaction that makes health less likely might be a way of putting it. And what we also know from the research is that more and more Kansans year by year are struggling to fund the survival budget for a basic family. These are often working families. These are fammilies often with Moms and Dads with more than one job, right? And they're struggling to survive on that budget. So, you can imagine what's happening to their stress.

So, that number keeps going up. So, the number of Kansans struggling to have a survival budget keeps increasing. Logic tells us everything is going to be harder in Kansas, like health outcomes are going to keep getting worse, economic outcomes. How do you be a strong functioning employee if you are suffering from toxic stress because you're not sure how to feed your family? Everything is going to get worse in Kansas if we don't turn this around and find a way to help people value capital-H Health, broad health, and understand what goes into it.

BSP: And if adults are more stressed, they may be less effective and productive at work.

EO: Right.

BSP: There may be more accidents related to workplace injuries, those sorts of things.

EO: It's all connected.

BSP: I want to just talk about one more thing before we switch to Kansas, talk about it at a national level. You guys have touched on this but let me put a couple of numbers to it and get your thoughts. In the US for about every $1.00 that we spend on health care, we spend about $0.56 on broader social services. So, $1.00 for health care, we spend about $0.56 on other social services. Comparable countries around the world that spend $1.00 on health care spend a $1.70 on other social services. When they've looked at sort of where the differences are, the big differences are in the spending on working-age families, early childhood, and parental leave. Those last couple, we spend about a third of what other countries spend on those things.

Where does the US spend more? We spend more on older populations around income support and residential support services. So, $1.00 to $0.56 in the US, $1.00 to $1.70 in other developed countries and less on working-age families, kids, some of the community supports, more on older ages. Those are tough political conversations to have.

EO: They are, and what those data points tell me is we're spending more money downstream. Health care is usually downstream. There's some preventative health care, but most health care expenditures are you're already sick, and then you're getting health care. So, we're spending more money downstream and less money upstream. Those other countries are spending more money upstream and less money downstream, and they're getting the better results.

DJ: I think the other piece, which is counterintuitive, is that those investments, which is one of the reasons why we would consider ourselves also an early childhood funder, not childcare, but social-emotional development, evidence-based interventions is because you look at the return on investment for investing in those first thousand days of life—for every $1.00 invested, there's a $13.00 return on investment.

BSP: The Nobel Prize awarded in economics to the person who developed a lot of those theories.

DJ: So, the evidence is there. The constituency isn't always there, politically, as you think about making the case. I think if you're looking for an upstream place to invest with a great return on investment, both in terms of long-term health outcomes, long-term economic opportunity, long-term educational attainment, it's investing in those first thousand days of life.

BSP: And I want to put a caveat on some of those numbers, which is that those are government spending numbers, which reflect a lot of priorities. There's a lot of private spending. What people don't understand about our system in the US is there's a lot of private spending in health care and in those other areas that supplement the governmental spending. That's just on governmental spending.

DJ: Absolutely. And I think the other piece is largely the population with children under the age of five would fall into that bucket of working families, but more working poor. Eighty percent of families that have children under the age of five have incomes below 200 percent of the poverty level. I think that is a place where we could be strategic.

BSP: Yes, and hitting some of those stressor points that lead to the kinds of challenges that we know we're facing.

DJ: Yes.

BSP: We've talked a lot about the US and health broadly, let's talk about Kansas for a little bit. Both of your organizations have become really focused on the recent change in the health rankings of Kansas compared to other states according to America's health rankings put out by United Health Foundation. Tell me what got your attention focused on those issues, and what you see as the challenge that is present in those numbers.

EO: I think from my perspective, I've been involved in Kansas civic life for a long time now, and I would, every once in a while, hear about that ranking and would notice it going down, but I noticed that there wasn't a lot of conversation about it. That was from my experience. Four years ago, we hit #31. Kansas used to be one of the healthiest states. The high point was 1991. We were #8. No state has fallen further in terms of the number of slots in the last thirty-five years than Kansas, fell all the way to 31. Most states, as I started digging into it, most states are kind of where they are. New Hampshire is always #1, #2, #3. Mississippi is always in the bottom, #48, #49, #50.

What happened with Kansas is just different. It's just there aren't other examples of a state falling precipitously like that over such a long period of time. When we were at #31, I happened to come to the Kansas Health Foundation, and we were in the middle of developing a new strategic framework. We felt that anchoring our strategy around the ranking was a—the hypothesis was, and still is, that it's a good way to try and change the conversation about health. There's something about a ranking that can catch people's attention.

That's why we've focused on it so much. We think the ranking's good. It's not perfect. I can poke holes in it, but for the most part, fifty-three different measures inside that ranking, we've gotten to know the team of people who do it through the United Health Foundation. They're good, smart people. We think it's a pretty darn good measurement of health, the broad determinants of health.

BSP: It doesn't measure just the doctor's office, medical health.

EO: The lower age health—the health care stuff is in there, but so are these broader social issues that we've been talking about. And again, it's not perfect. If I could undo a few things, I might. But for the most part, it's good. What we're finding is it's a useful tool to get a different type of conversation going on about health. And our thinking is, we need a different kind of conversation. We might not know how to go from that low point, which was 31, to #1, but I'm quite confident that if we just keep having the same kind of conversation we've been having, we weren't going to do that. So, that was what was in our thought process for why we find ourselves now talking about the ranking all the time.

DJ: I think likewise. We tried to help stimulate discussions on the future of health in Kansas. When we started having conversations in rural communities in particular, we added this slide in

terms of just looking at our health rankings over the last thirty years to this deck because it's noteworthy that we've fallen so much. I think if we want to build a healthier future, we need to think differently than just preserving the status quo. That's not going to be enough, just keeping the doors of that critical access hospital open, keeping the doctor in town, and keep doing the same tobacco cessation program. So, I think it's really a way to drive the conversation in a different way.

EO: Another thing I like about it, it's relative. Health has gotten better in Kansas.

BSP: Right.

EO: But other states have been able to make their health be even better. So, it's relative.

BSP: And that's reflected in the international comparisons as well.

EO: Exactly. There's a lot we should be proud of that happened in Kansas in the last several decades on health. We should celebrate those things. And other states have also had wins and victories and even more. So, it's a useful tool in that regard as well, I think.

BSP: So, you're digging into this issue. Have there been any insights into—most of the people that I've interviewed in this series, including the three of us, have all been in this world working on health over this period of time. Any insights as to why we've slipped?

DJ: I think we have to look at the changing policies and systems that exist in Kansas. I know I referenced it earlier, but I do think we have seen the state try to do more with less, and I think you see the impact over time as we've stopped taking advantage of federal dollars to support not just things like Medicaid expansion relatively to other states, but for those other supports around family stressors, the food, the cash assistance, the child care assistance. I think all of those are having an impact on health, but they're also having an impact on the dollars available in the state budget to support families. I think we have seen that change over time, both in like the state budget but also the amount of dollars we take down from the federal government. I think our policy environment has changed since the mid-nineties, and we're starting to see some of the impacts of those policies and systems.

EO: I agree with all that. Just to add a few additional things to the mix. I think it's really hard to pinpoint why. I've learned you ask a hundred different people who've been involved, and they'll have a hundred different takes on it, and that's okay. It's a complicated system. There's not going to be an easy explanation for why we fell, nor is there going to be an easy solution to climb the rankings.

But just a few other things to add into the mix: We are an aging state. Demographically, we are getting older and older. It's harder to be healthier as we're older. Now, that's not an excuse because there are other states in America's health rankings who have similar demographic challenges—Iowa, Nebraska—and they're much further ahead than us in the rankings. But that factor is on my mind a little bit, too.

I think there's also—all of us have been heavily involved, and I think it's important that we all—this happened on my watch. I got involved not too long after, and I've been involved in Kansas ever since. I'm not saying it's completely my fault, but I probably bear some responsibility like a lot of people do. Specifically what I'm playing with here is I think the way in which we have tried to work some health issues, looking back, might not always have been the most helpful. I'll give an example here. Some of this just is "How do we learn and not beat ourselves up, but learn from the past?"

A great movement years ago around county health rankings, helping people look at the rank of your county's health compared to the other counties in Kansas. That spurred a lot of conversation. That spurred tremendous work.

BSP: At the local level.

EO: At the local level. In some ways, that was amazing, a great kind of local effort in southeast Kansas. Wyandotte County dove deep into it for years. And what I've thought about in more recent time is the challenges affecting health, for example, in Wyandotte County, the economic and social issues that are contributing to health, Wyandotte County controls very little of that. So, like if we focus on the county health rankings as our kind of lens we're looking through and try to figure out, "How do we improve health?" it's almost like—it's not like fighting with one hand behind your back, you fight with two hands behind your back because Wyandotte County is in a broader economic system, that is the state of Kansas—that is the Kansas City metro, the decisions being made in Topeka are probably having more impact on the health of Wyandotte County than any of the decisions in the unified government.

So, some of this is, "What's the nexus of the problem? How do we bring the right people together to understand their role in the problem?" I'm not saying there's not a role for locals. There's a role for everything. But how we've tried to work some of the problems, I think we're going to have to keep learning from and that's a factor as well.

BSP: I think one of the more valuable aspects is just to point out the differences. You say, "Okay, well, Wyandotte, here's your health ranking. Adjacent counties or similar counties in other parts of the country have substantially better rankings than you do." It does help understand what's possible and achievable.

DJ: Yes. It does, but it also—the people of Kansas needs to understand that any counties that are having a low ranking—the county health ranking—we're all responsible for, and we're all impacting in the way I'm thinking.

BSP: That's true.

DJ: So, I think some of this is like "How do we learn from past debates and past experiences and make sure the next debates or the next experiences are improved based on those learnings?"

EO: I think it speaks to the impact that statewide policies and system building have on county-level impact. I agree with both of you. I do think that that statewide system needs to be addressed

because we're not going to solve any one county's problems just within the borders of that county. It has to do with funding. It has to do with policies. It has to do with incentives. But, on the other hand, we can't ignore the fact that the biggest indicator of health sometimes is your zip code, which factors into your economic status, is directly tied to it, when you talk about health outcomes.

A few other things that I think might be part of the interpretation for the slide. Big, big things happened like Menninger's leaving Kansas. That was 1999, I think, when Menninger's left for Baylor.

Commented [DJ1]: This says DJ but I think Ed is making that pointI

BSP: Around then.

I was working for Governor Graves at the time. I was a young staffer. I wasn't in any of the important meetings. Sometimes I was on the periphery of them. That I think was a major blow. Looking back, that was a major blow, losing that organization, but also just all the kind of adjacent infrastructure. Twenty years later, we had some of the lowest mental health rankings in the country. But I don't remember massive conversations in the state about "Oh, my gosh, we're losing Menninger's." People didn't want them to leave, but I don't remember—maybe there were. I wasn't aware. But I don't remember massive conversations about "How do we have an intervention to counterbalance the loss of Menninger's?"

Commented [DJ2]: This was Ed not me.

Other big efforts like the Kansas Health Policy Authority was a massive push to rework things. Medicaid expansion has been a massive push, but I don't know if we've had the type of ongoing strategic collective across political faction discourse about "How do we create a healthier Kansas?" that I think we're going to need more and more.

BSP: That has been pointed out by other people that I've interviewed in this series. There used to be ongoing conversations. Maybe they weren't as broad as they could have been, but they were at least broadly addressing a set of issues. Now we may have very specific groups looking at one question, one issue, but where is that collective, high-level, strategic conversation about improving health in the state? Did we really use to have more of those years ago than we do now? If that's true, what changed over that period of time? Is it just more difficult to have those kinds of conversations? Or are we looking through rose-colored glasses and maybe we didn't really have them back then?

DJ: I think there's probably a lot to unpack there. I do think that, for better or for worse, a lot of the discussion around health in Kansas was consumed by the debate over Medicaid expansion.

BSP: That's been twelve years now.

DJ: Fifteen, probably.

BSP: Implementation was in fourteen, but passage was before that.

DJ: Before that. I think you're looking at the last ten to fifteen years the legislature wasn't able to discuss any other issues because they were afraid that Medicaid expansion would come up, the

politics of it. I think that was to the detriment of Kansas. Maybe there is some rose-colored glasses perspective here. I think there is also different government structures that exist—this isn't all about government by any means, but I do think the Health Policy Authority was probably a good venue. There might have been a more integrated driver within government to think about what health is, but I don't think it's just health.

I think the capacity of state government as a convener to execute programs was significantly diminished during the Brownback administration due to what happened as a result of the tax cuts and the lack of resources going into state government and also the lack of federal dollars being drawn down by Kansas. We rank 48th in the country in terms of the federal dollars that make up our state budget. So, we have less capacity as a state to have those conversations, not just health care, child welfare, human services. That's a factor. And I think it's probably a challenge to us in health philanthropy to restart and catalyze a new discussion on the future health of Kansas.

EO: I don't know if I'm smart enough to know if we had all this great cross-party dialogue, discourse coordination in the past. Maybe we did. Maybe that's just rose-colored glasses. I don't know. I know we need it going forward. We need it. We need a high quality, collaborative discourse. I do think there are some recent examples of promising efforts that the Kansas Health Institute was heavily involved with the behavioral health modernization effort. The way that was organized, the number of different parties involved was a really kind of beautiful example of bringing the right people together and a prolonged discourse over a period of time to craft a set of solutions. It was really, really amazing.

I think there's one underway right now that time will tell, history will tell how effective it is. The Rural Health Transformation program right now—David, you're involved with it at a deep level. I'm involved with it to some degree. I think that KDHE and KDADs are doing a good job organizing this, bringing lots of different people into this conversation. I believe that type of collaboration and alignment is going to get better results.

So, we're seeing some great examples of collaboration alignment, which is different than sometimes in the past, we're debating one faction's preferred solution to improve health, and there's a place for that, but I think right now in Kansas, we're in a place where we need factions coming together to figure out what are we going to do to improve health, not coming with their lead suggestion.

BSP: We're ending on a bit of an upbeat message in that. What other roles do you see philanthropy playing in our state in helping us work our way through these challenges?

DJ: I think philanthropy can play a really powerful role in driving change. I know Ed and his team are working on a number of different initiatives, both in capital-H and lower-case h. I think we have the ability to look at innovative ideas that are working in other states, and the innovation is the place here in Kansas. We can bring those innovative ideas here as philanthropy. We can fund or seed the money needed for demonstrations, and then we can work alongside to show one proof of concept but then two to start to think about how we make this sustainable, find payment structures and payment policies to do that.

Over the last few years, there's a lot of opportunity in the health care work force space, and I think we need that innovation, whether or not it's community health workers, doulas—

BSP: That's an area where the health ranking in Kansas is particularly low, the supply of mental health and oral health professionals.

DJ: I think we have the opportunity in philanthropy to stimulate those discussions, fund the demonstration projects, do the evaluation to show proof of concept, and then work alongside industry and government and commercial payers to make sure it's reimbursable and sustainable.

BSP: That used to be the model in national philanthropy, funding those demonstrations and evaluations, and then helping bringing them to scale. The national philanthropy world sort of moved away from that thirty years ago.

DJ: And I think it's still important for us to do it at the state level, and I know we're doing some innovation, innovative work together. Food as medicine, that's another example where it's not work force, but it's an evidence-based intervention. It can really make an impact on health. How do we make sure that the seed money is available? Try different ways to do it. Do it through a charitable food system. Do it through private industry, through rural grocers, but how do we make sure it's sustainable? I think that's a role for philanthropy to be willing to take those risks, invest in those models, and then work alongside to problem solve and establish the mechanisms for sustainability.

EO: I agree with it all. I think—a few things I would add, philanthropy can shine a light on issues that need more attention. There's something about when you're an organization that gives away money, people will pay attention to what you're pointing at. That can be good and bad sometimes. But to use that power wisely, related to improving health in Kansas, so philanthropy can shine a light on issues that need more attention.

I also think a key role for philanthropy in this journey of climbing the health rankings is to fund process work. Fund the right people being at the table. Fund engagements where those people are able to really wrestle together. We all know the quality of outcome is almost always related to the quality of input. We're not going to get our way out of this health slide by just jumping to solutions. We've got to work together. We've got to bring the right people together. You all have done a lot related to helping organizations and individuals have voice who need to be at the table who traditionally haven't. We have as well, made our largest investment in our history in racial equity, a thirty-million-dollar investment, trying to help organizations who need to be in these conversations because they have experience and perspectives that are needed to be able to be at the table. So, we've got to fund process components to make sure the right debates, the right discussions, the right people are working together across difference for the greater good.

BSP: And the timeframe that you have as foundations to work may allow that. This isn't quick work, right? This is long, difficult work.

EO: Yes. I don't think anybody except health foundations could anchor around an idea like "Let's lead the nation in health," or "Let's get back in the top 10 in health rankings." It takes too

long. It's bigger than any gubernatorial administration. It's bigger than any one cabinet secretary's tenure. I think it's a unique role for organizations like ours to hold a longer-term vision that's a ten, fifteen type of year vision. That's another unique role that we've got to play.

DJ: I agree. I think that's one of the strengths that we have in philanthropy is that we can commit to the long term.

BSP: That's awesome. Well, I'm energized. I'm thinking about coming out of retirement now.

EO: Come on! We need everybody!

BSP: Thank you very much for this really interesting conversation.

EO: Thank you, Bob.

DJ: Thank you, Bob. Great job.

[End of File]