

Bob St. Peter: Hello, I'm Bob St. Peter, a pediatrician and the retired president and CEO of the Kansas Health Institute. Today is March 6, 2026, and I'm here to interview Tom Bell. Tom is a lawyer and was the president and CEO of the Kansas Hospital Association from 2005 to 2020. This interview is taking place at the Kansas Health Institute located across the street from the Kansas State Capitol. Tom, thanks for being with us here today.

Tom Bell: Sure, happy to be here. Thanks for having me.

BSP: This interview is part of the Kansas Oral History Project, a series exploring 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 Kansas State Representative Dave Heinemann. Tom, thanks again for being here.

TB: Happy to be here.

BSP: Tell me a little bit about you and where you came from and the early parts of your career.

TB: Sure. Thanks again for having me, really thanks to the Project for what they do. This is important in so many ways. I was born and raised in Holton, Kansas. a small-town kid. I went to Kansas State University, went to law school at Washburn, and actually clerked for Justice Herd, Harold Herd, for a couple of years after I got out of law school, which was fascinating.

BSP: The Kansas Supreme Court?

TB: Yes, the Kansas Supreme Court. I then started practicing law here in Topeka. Our law firm represented the Hospital Association. During one session, the KHA lobbyist I think quit like in the middle of the session. KHA, the Hospital Association did something that I would never do now. They went to our law firm and asked if there was somebody that maybe could fill in and do that. I don't know what the partners of that law firm were thinking, but they suggested me. I did that as kind of a contract with the law firm for a couple of years and then went to work for KHA after that and was there for I think thirty-five years, something like that. I married my high school sweetheart. We're still married. We've got two grown children, one who happens to be a surgeon. So, I get to talk to him about health care quite a bit. And we still live in Topeka. I've been retired now for four or five years and try to stay busy doing things like this.

BSP: That's awesome. Tell me a couple of things that kept you busy in high school.

TB: Trying to make sure that my girlfriend didn't break up with me was a lot of the time. I played sports. I guess in high school is where I really learned to love books and still read a lot. That's probably my favorite pastime now in retirement is reading. You know, just being with my friends and part of a small town. If you're from a small town, you recognize that little town kind of holds you. You get in trouble, but it never really lets you get in too much trouble, at least it didn't then.

BSP: The set of watchful eyes from community parents is pretty incredible.

TB: Exactly.

BSP: You spent a long time at the Kansas Hospital Association. For those of us who don't know, what is the Kansas Hospital Association? What does it do? How does it function?

TB: The Kansas Hospital Association is like many associations across our state and even across the nation. It's a trade association. The members are the hospitals in Kansas. That number has fluctuated over the years. Roughly about 120 or so are what you would consider to be community hospitals. It provides education and advocacy, the two main things. More recently, a lot of data compilation, but education and advocacy. For example, yesterday, I'm on the board at Stormont Vail Health Care here in Topeka.

BSP: As I am. We both serve on that board.

TB: I was at a trustee conference, a hospital board member conference sponsored by the Hospital Association. So, they do a lot of education, but the main thing is advocacy on both the state and the federal level.

BSP: Give us an idea a little bit of what that advocacy involves, both at the federal level and the state level.

TB: Gosh, Bob, that's probably one of the things that's changed a lot since I started. I remember when I first started, I had no idea what I was doing. I really didn't. There were a couple of mistakes that I made that probably would cost somebody their job now, but it was only by the grace of people like Dr. Bob Harder who would go to my boss and say, "You know, maybe you should be watching this a little closer" that I learned on the job.

But the Kansas Hospital Association from the federal level, its job really is to stay in touch with its Congressional delegation. That's kind of a finite universe. There are ways that they do that both in Washington and locally, but that's six people. The biggest advocacy job they have is in the state legislature, and that job I think has grown tremendously more difficult as the political climate has changed.

The other part of advocacy is regulatory advocacy, working with the different regulatory agencies. Right now, probably the main one for hospitals is the Department of Health and Environment, but kind of those areas.

BSP: As you think back, and I had a great conversation earlier in this series with Maynard Oliverius who talked a lot about federal health policy, as you think about state level health policy, what are some of the big issues that came up during your tenure at KHA?

TB: The big issues were I would say—I'd probably name three or four—one of the very first things that I was involved in when I started was Certificate of Need. I have thoughts about how that sort of played into—

BSP: Explain what that is.

TB: Certificate of Need was part of the state's health planning process, and it was put in place to make sure that facilities that weren't needed didn't get built. There was a whole bureaucracy that you had to go through to get approval. I think that's probably one of the things that ultimately weighed it down. But one of the first things I was involved in was the doing away of that, getting rid of that, which was fairly controversial at that time, and I think over the years became much less controversial. I'm not sure there's any state that actually has it anymore. There may be a few.

Another issue that's sort of throughout my career at KHA was the idea of scope of practice of health care professionals. That sort of give-and-take, push-and-pull of the providers who had a large scope of practice who resisted giving part of that scope up to other providers who were working their way into the system.

BSP: So physicians maybe and nurse practitioners or podiatrists.

TB: Good example. Yes.

BSP: Those sorts of issues.

TB: Chiropractors, physical therapists, you name it. Whenever the scopes of practice intercede, there's always—people in those scopes are professionals, and they've been trained and have a strong feeling that they're the best at doing that job. When they see someone else wanting to sort of encroach on that, it does bring up a lot of difficult questions and hard feelings sometimes.

I would say another one was just the transformation of rural health care over the years and the pressures that have been put on states like Kansas who have such a high number of rural facilities and the difficulties that people in rural areas in our state have accessing health care. And with that, the change in health care employment or folks who go into health care, work force issues that have just gotten more and more difficult over the years, really probably one of the top two or three issues facing anybody in health care now is work force.

And then probably the one that defines that period as much as anything is Medicaid expansion and the opportunity that Kansas had that it never took advantage of and frankly, it looks like probably never will take advantage of, that it just kind of squandered, not for lack of trying by many people, but that issue, gosh, since the early part of this century has been an issue.

BSP: And you talked about Medicaid expansion. Talk a little more broadly about reimbursement issues in general and how they affect hospitals.

TB: That's an ongoing issue. I remember when I first started that one of the things that was happening was that payers, when you talk about payers in health care, in Kansas, you talk a lot about Blue Cross and Blue Shield, but in many ways, Medicare is the payer. It's the biggest payer in our state. So, the payers, especially Medicare were going to this process that they called

DRG's, Diagnosis-Related Groups, which were intended to bring a little more sense into the reimbursement system, that we would reimburse you for a certain type of episode. I remember that happening, and the people in health care were apoplectic. This was the worst thing that was going to happen. It was going to kill health care.

I think that shows a couple of things. #1, that people in health care are very good at lobbying their elected officials about issues that affect them, but also that the health care system is extremely resilient about how it responds. It will respond to the financial incentives that are provided to it, and that's what happened. The health care system learned to deal with this DRG issue, and since that time, there's been three or four things that happened, that every time it happened, that was the worst thing that was going to happen, and we just seemed to be able to deal with it.

I'm not saying that there's not legitimate reimbursement questions. That's a huge issue for health care providers, and when Medicare or Medicaid or Blue Cross does not reimburse you what the cost of actually providing that care is, obviously that's a situation that can't last. So, reimbursement is always at the top of the list of issues on the mind of health care providers.

BSP: It's interesting you talk about the sort of natural reluctance or resistance that the medical community has towards big changes. It was that way with the introduction of Medicare and Medicaid themselves back in the sixties. Now it's considered an integral part of the health care system, that reimbursement system as you said, the largest payer in the state of Kansas.

TB: Yes, I think Kansas is striving to be the Arizona of Medicaid. Arizona was the last state in the union to agree to do Medicaid, and Kansas wants to be the last state to agree to do Medicaid expansion.

BSP: Exactly. Reimbursement can affect different hospitals differently. Talk a little bit about how this issue plays out for large hospitals and medium hospitals and the smaller rural hospitals.

TB: One of the things that happened really in the course of the career that I had at the Hospital Association was a pretty major change in the way we reimbursed hospitals, and we, meaning the payers, the federal government and Medicare mostly, decided that we wanted to find a way to reimburse the smaller hospitals at a level that would allow them a better ability to stay afloat. In other words, those littler hospitals don't have the volume that the bigger hospitals have, which helps those bigger hospitals make up for some of the lack of reimbursement.

So what the federal government did essentially is say to the small hospitals, "You tell us what your costs are, and we'll reimburse you those costs." That definitely was helpful. I think that was kind of the impetus of the Critical Access Hospital Program, which is the program that the feds put in place to single out the smallest hospitals and say, "Tell us what your costs are, and we'll reimburse you."

They don't reimburse every single cost that you might give to them, but that wasn't the point. And then the larger hospitals theoretically were left to still be able to negotiate with insurance companies because of the volume that they have.

BSP: And Kansas is sort of uniquely engaged in that program of critical access hospitals that you talked about. We've got more critical access hospitals than any state in the country. That's on an absolute basis, not adjusted for population. Talk a little bit about that and the role of the Hospital Association.

TB: The increase in the number of critical access hospitals really happened about the time I started working at KHA, and in the beginning, they set up this system that I'm going to not say exactly correctly what the rules were, but essentially if you are further than a certain mileage from another hospital—I think it was thirty-five miles—then you can be a critical access hospital. In other words, if there's no other hospital that close to you, you're kind of on an island, and we're going to let you have that status. But when they did that at the very beginning, they said in states, "You have"—I can't remember how long, maybe a year—"You have a year or so to let other hospitals who might be within that mileage, you can designate them as critical access hospitals," and Kansas did a tremendous job of doing that to the point where, like you said, we have more than any other state. Most of our hospitals by a large majority are critical access hospitals in our state.

That has created kind of a system of different tiers of critical access hospitals. You have some that are very, very tiny, and then you have other critical access hospitals that are in what would be considered in Kansas to be larger cities like Emporia for example, Atchison.

BSP: How has that program worked over the long run? I read about the dire situation that rural hospitals are in, one report saying that fifty-nine rural hospitals in Kansas are at risk of closure, and twenty-eight of those at imminent risk of closure. How has it worked or not worked?

TB: I don't want to get off track. I never understand those articles that say that. They will never specify what hospitals exactly they're talking about. I think there's a lot of hospital leadership that would tell you that their hospital is at risk of closure for lack of them doing something about it. I would say the critical access hospital program saved a lot of rural hospitals in our state because it allowed them to get reimbursed close to what the cost of providing care was.

BSP: What do you see happening in the next twenty years with the situation with rural hospitals, the reimbursement challenges, staffing, costs, all of those sorts of challenges? What are we headed for? What are we looking for in Kansas in places like Holton?

TB: If I could answer that question—

BSP: You wouldn't be here.

TB: I would be somewhere else probably, but I don't think there's anything that's happened in the health care system over the last twenty years that suggests to us that it's going to be easier for the next twenty years, and that's across the board. That's the biggest hospitals, and that's the smallest hospitals. Those pressures are going to grow. The people that pay for health care do not want to pay more money understandably. The system puts pressures on the people that work in it that sometimes make it not as desirable for those who are thinking about going into the practice

of health care. You talk to many, many physicians who are retirement age, and they'll—I hate this, but many of them will say, "Don't ever go to medical school." It's kind of like teachers who tell people—if there are professions in our society that we should be encouraging people to go into; it's health care and education.

The point is, those pressures are going to continue to grow, and I think what's needed, I don't know if that is what's happening, and I think there are places where it's trying to happen, I think what's needed is a real coordinated discussion about "What are the needs of our health care system?" but more importantly, "What are the needs of the people served by that health care system?" We'll see. I think there are some places that that's trying to happen. I know the Hospital Association has been involved in some of those. I know the Health Foundations have been involved in some of those. I know the Health Institute has been at the forefront of some of those discussions, but those are really, really hard discussions to have.

BSP: You mentioned sort of the incentives or disincentives to go into health care. We're not talking just about physicians.

TB: Right.

BSP: We're talking about all sorts of health care professionals, nurses, pharmacists, technicians in the hospitals, all of those.

TB: It's an interesting situation. If you go into health care, you're always going to have a job. You get out of nursing school; you're going to be employed, no question about it, or almost any other health care situation. You're probably going to make a pretty decent wage. So, there are lots of reasons to go into that system, and one of the things I learned fairly quickly when I started working at the Hospital Association is, in my opinion, the best people in the world are in health care, delivering health care. They're the sorts of people that run toward a problem as opposed to people like me who run away from those problems. There's so many good things about working within the health care system, but the pressures that we have put on it as a society; we want it to do everything for us, but we don't want to give it the resources that it needs to do all of those things.

BSP: I want to come back a little bit later to talk about a unique period of time where those pressures were intense, around the pandemic. We'll go back and talk about that. Thinking again of the Hospital Association, you've got small hospitals with an average census of maybe two or three patients a day. You've got behemoths, whether it's Stormont Vail or KU or in Wichita, any of the systems there. How do you balance the different and maybe sometimes competing interests of those different groups of members to the association?

TB: It's not easy, obviously. I don't know that I would say that I ever really did much to balance it. I think our members balanced it. I think the large hospitals realized and continue to realize that the small hospitals in our state play a critical role in our health care system, and those smaller hospitals recognize that we've got to have the major facilities for trauma and so many other kinds of things. So, the interdependence I think was something that our members at least, the

hospitals, always did a really good job of recognizing and not letting the differences that they might have get in the way of that.

BSP: What about over the last twenty-five years or so, the evolution of more for-profit medicine, including on the insurance side, on the hospital, on the provider side, even on the physician side, the larger investor-owned types of organizations?

TB: I don't think you can look at the system over that period of time and not recognize that there are differences between for-profit and nonprofit. Nonprofit, for example, is required to put any money that it makes back into the system. And the for-profit system is by design, they're for shareholders. So, I don't think you can deny that there are different ideals maybe at work. That's probably not the greatest word because I know there are many, many people who work in for-profit facilities who have just as much of an interest in the common good as people in nonprofit.

But the other thing I would say is that, going back to what I said earlier, this system responds to the financial incentives that it's given. So, if it's presented with a situation, in many ways, a nonprofit facility and a for-profit facility are going to react the same way. So, yes, there's differences, but I don't know that I would say that is a major issue that I felt like was one of the biggest problems in our system.

BSP: One of the benefits of being a not-for-profit hospital is not being taxed, having federal taxation. Part of the ACA was a requirement that community or nonprofit hospitals report what they're doing to justify that nonprofit and tax-exempt status. How has that played out? Has that helped us understand a little more of what role community hospitals are really playing in serving the public, the greater good?

TB: I don't know. I really don't. I know that the thought there was good. The purpose was good. I personally have always thought that for any nonprofit who is tax exempt, we should say to them, "You show us how much benefit you provide, and if the benefit you receive is above that, you're going to get taxed on that difference." That will never happen, and it's probably something I couldn't have said when I was working at the Hospital Association, but I just think this is not just true in health care, but the entities that provide health care are so big in many instances that you need to make sure that they're providing the community benefit at least to the point of what they're receiving back from not paying taxes.

BSP: It can sometimes be difficult to measure.

TB: There's no question about that. For example, should the difference between what you charge and what Medicaid pays you be a community benefit? I don't know the answer to that, but that's a pretty big gulf.

BSP: Yes. Just following that through a little bit more, years ago, hospitals were places people went to die. Over time, the innovation and development of technology, new procedures, new medications have made hospitals just incredibly high tech, innovative, industrial complexes really. Now there's been a conversation about "What's the broader role of the hospital in the

health of the community?” That has been quite a stretch for hospitals to start to think about. Talk to me a little bit about that.

TB: It's true, everything you've just said, and I've kind of witnessed it. But you know what's true with so many institutions in our society? Look at public libraries. They're not even close to what they used to be. When I was a kid, you went to the library and checked books out, or you went and sat in the corner and read. Now they're community centers, and they kind of have to be. That's happened with hospitals as well.

I think hospitals who are thinking about the future are thinking about “How can we serve the community?” Not that they haven't in the past, but they really are now. It's a good thing that they've been put in that sort of position. I think that's only going to continue. The question for a hospital is “Are there financial incentives that are helping me to do that?” and right now there's not that many.

We talked about going to a system where we would reimburse providers based on what they call population health or take a big group of people and we'll give you this much money, and if you do a really good job keeping them healthy, you can keep the difference. If not, you have to pay for their hospitalization. And we just haven't done that much of that. If we truly had a system like that, it would really provide an incentive to do more community.

BSP: The idea is a good one, many people would argue but coming up with the methodology to actually reimburse the system with that is extremely difficult.

TB: Exactly.

BSP: One of the themes that we're talking about in all the interviews in this series is the health of our state as a whole. I know you've heard many, many times the state health rankings, America's health rankings that come out from the United Health Foundation, and back in the early nineties, Kansas at one point was the 8th healthiest state in the country based on the criteria of that ranking. And we've fallen to where now in the last year, Kansas ranked 27th. I always want to point out that it's not that health in Kansas has gotten worse. In most measures of health, we're doing better than we used to, but we're not gaining as much as quickly as other states. So, our relative position has fallen. What do you think about that? What role has hospitals played in that or can they play in trying to get us back up to a higher ranking?

TB: Well, I don't think it's good that we've fallen, but that's about as much of an answer as anybody can give you, I think, then going to their opinions about it. It's a really, really difficult question. I think part of it is: What are those rankings? How legit are they? But other states are measured by them as well.

I feel like I said earlier, one of the first things that happened when I came to KHA was the dismantling of the CON system --certificate need. In many ways, that needed to be done. It had kind of become burdensome, cumbersome, but I think that was the beginning of us as a state abandoning the idea that we could ever have a state or a coordinated health care policy. You've

seen us over the years. We kind of tried to do it, but we failed. We once had an agency that really had all the health care issues in it, SRS, Social and Rehabilitation Services.

BSP: I thought you were going to go to the Kansas Health Policy Authority.

TB: Well, that agency was for a long time run by the same person. He worked for both Republicans and Democrats, Dr. Bob Harder. There was a semblance of a policy there because they were so involved, and we had some other policy planning things going on. But we divided that agency up, and there's several agencies that have what SRS used to do. I don't know if that's a good thing or not.

Then we came up with this idea of a Kansas Health Policy Authority, which would be a policy body that would kind of be in charge of our state health planning our state health policy, we couldn't agree on that. At the beginning, it was a good idea, and then it wasn't, and maybe it was again, and then it wasn't, and we abandoned that. You look at over the years; there's just never been any appetite to create a statewide plan. I think there are people who maybe would argue that there's some of that going on, but it's not in a coordinated way across different kinds of sectors. So, we've created this nonsystem which is bifurcated. It has hundreds of different parts to it. It has parts that are fairly well funded. It has parts that are tragically underfunded. It has parts that don't talk to each other, and I can't help but think that that has played into it. There are obviously other things that have gone on in terms of our society and how we've dealt with things.

So, in terms of the people of our state, I don't necessarily feel like we as a society have done any worse job than any other state. I'm not saying we've done a good job because we're overweight. We do things that aren't good for our bodies. We're too stressed. You can go on and on.

But at the same point in time, we as a state have not shown that we have an appetite to try to work together. That kind of goes with the political system—any sort of planning that's not good anymore, any kind of government involvement, that's a bad thing. It's one of the sort of sad things that I think has happened over the last twenty-five years, that we've decided that government really can't do much for us. I think that's true in some cases, in many cases, but I think that has caused us to throw out the areas where it really could be helpful.

BSP: Some states are known for being a little more proactive and coordinated at the state level with doing health policy planning, but you wouldn't put Kansas in that category.

TB: I don't think so. I don't think we even have the apparatus to do that anymore.

BSP: You mentioned one of the roles that the Hospital Association got more and more involved in over time, and that's making data available to have a system and understand how your system is operating and how the changes you're making are affecting the system requires good data. I don't know how interesting some people may find this, but I want to talk just for a minute about data. I remember the early days when I came back to Kansas, there was a group that was trying to coordinate data issues in the state, and the doctors and the hospitals were absolutely adamant that no data should be released and provided. We don't want comparisons and all that.

Where are we now in that? My dad needed to have a surgical procedure. We were all trying to figure out what was the best hospital to send him to. This was a few years ago, but not that long ago. It can be hard.

TB: What a difficult question. I'm one of those people that's really not that interested in data. I know you know more about data in Kansas than most of us have forgotten, but what I would say is that it's a great example of the way the system works. I think it's changed, and I'll mention that in a minute, but that providers or sectors feel threatened sometimes by those sorts of things, and they push back against it. I think what you explained was a perfect example of that, which I think is interesting because people in health care, especially physicians, are science-based. Give them facts and they will act on it. Give them the evidence. That's what they want.

I think we've become much more comfortable with providing that evidence, having that evidence, acting on the evidence. Maybe the health care system has been forced into that a little bit because of the explosion of electronic information, electronic health records in health care and the advent of AI, which we're kind of in the middle of, and who knows where that's going to go. But I feel like that's an issue that probably if we've haven't gotten over the hump on it, we're close.

BSP: And the opportunities to improve health with the use of large data in ways that might make people uncomfortable, but what they don't realize is that largely, it's already being done.

TB: No question.

BSP: Just by maybe not their hospital, but by their social network provider, something like that.

TB: One of the things I think I've observed over time was that hospitals at least came to recognize the people that pay me have all that data—Medicare, Blue Cross. They have all that data, and they're acting on it. So, maybe I ought to become more familiar with it and embrace it as opposed to pushing back against it.

BSP: I totally agree with your assessment as to where we are in the policy planning level in the state and the need of data to support that. So, hopefully, as the cost pressures and the supply of provider pressures increase, maybe we'll see some action there.

TB: That would be good.

BSP: Stepping back a little bit, when I think of hospitals in communities, they're unique entities at the community level. They're a large part of the community's identity. They're a large employer in the community. They're an economic engine in the community. What kind of accountability or responsibility does that create for a hospital and for its executives back towards the community?

TB: I think any hospital who recognizes their role and is really thinking about their role has to have that at the forefront. We're responsible to our community. Many, if not most of the

hospitals in our state are government owned or government run. So, that creates some accountability right there.

BSP: You're talking about at the county level, not necessarily at the state level.

TB: County or city or district. And most of the rest of them are nonprofit. That creates some accountability there, too. But I think almost any hospital in the state would tell you, "We're a community hospital." By definition, if you're a community hospital, you should be accountable to the community, and I think—I've seen a lot of growth in that from hospitals across the state. Maybe there are some that aren't as much as people would like in some instances, but by and large, I think they've embraced that role.

BSP: Good. I mentioned that I'd come back to the pandemic issue and lots of issues we could touch on around there. It had a profound impact on the health care system and hospitals and the staff in hospitals in particular. You were around at the beginning of that. Tell me a little bit about what you heard from your members and how that stressed the system. Then I want to ask about what we've learned from that and how we build going forward.

TB: I retired in the middle of the pandemic.

BSP: I was thinking of the timing, yes.

TB: It was really the best time to retire. There couldn't be any large gatherings or any functions where you had to get up in front of people, and they would talk about things that you had done. I remember reading during the pandemic when we were all forced to stay at home and not being able to gather, somebody said, "I've been practicing this my whole life." That's kind of the way I feel. I'm a lot more comfortable being at home reading a book.

But I think that's a really good point, and in some ways, I think you could argue that maybe—certainly there were health care work force pressures before then, but I think you could argue that that really exacerbated it. We all saw the videos of just the terrible situations in some hospitals and the pressure it was putting on providers, especially nurses, and the stress that they were under, and I think that probably helped create a narrative that this is a system that maybe I want to think twice about going into.

BSP: Yes. As a profession, as a career.

TB: As a profession. You don't have any choice about going into it as a patient sometimes.

BSP: Yes, although there's some evidence of people avoiding going into the hospital at that period of time had some bad outcomes as well.

TB: Yes. We've learned so many things about how we handled that. I don't want this to sound wrong. We maybe overreacted a bit in terms of not allowing ourselves to get together, some of those sorts of things. It put a tremendous amount of pressure on the health care system, especially those secondary and tertiary facilities that had ICUs, for example. There wasn't

enough room. Families couldn't talk to their loved ones who were in the hospital. I feel like we would really try to handle it differently.

I'm leaving the political climate out of this because I'm not sure the political climate is really equipped to deal with something like that. Again, I think it kind of proved that in the first instance, it really wasn't, but as a health care system, I think we would really, really try hard to avoid some of those more difficult things that happened during the pandemic.

But I would say the other thing that I think that came out of the pandemic that I think is terribly unfortunate is it undermined our public health system in a tremendous way. That was a system that was already underfunded in our state, and it made our public health officers out to be the bad guys in many ways when they did not deserve it. So, I think we're still recovering from that.

BSP: One of the things as a physician that I was really bothered by during that process is the whole concept of "Well, do your own research." People who are trying to make critical decisions about what to do or not to do somehow being able to come up with better information than thousands of scientists around the world who have committed their lives to this. I worry just more broadly about the impact of that on the relationship between patients and their physicians and their hospital and where the authority is going to come from in really important health care decisions.

TB: I share your concern. I'm one of those people that likes to do research on things that I might think I have. I always get to the worst possible thing out there. The Internet will always give you that. But I'm really careful when I talk to my doctor about making sure that she knows that this is just me asking you questions. I think docs, as docs get younger, they embrace that kind of a dialogue with their patients.

BSP: They should.

TB: But if you look at it, who do you—and you're a patient in the system, who do you want to get your advice from? And usually you're going to answer, "From my physician." If that's the case, is there not a better place to look for advice than a large group of physicians like the American Medical Society or the Pediatrics Association? There are dozens of those, and they all have evidence. So, why would we not rely on them?

I'm with you. I don't understand it. I think it's kind of like journalism. We can all be a journalist now. In some ways, we can all be a doctor, I guess. With the advent of AI, you can plug your stuff into AI. It won't be long before AI will be writing you prescriptions, I suspect. I don't know. That's another one of those scope-of-practice discussions that will happen.

BSP: I hadn't thought of that one. You spent a lot of years in our state engaged in the health policy discussion, really involved with hospitals and the challenges they're facing. If you had to make a list of the top issues that you think we as a state need to be addressing right now for the well-being of hospitals and therefore that they can provide all the community benefit that we've been talking about, what's the set of issues now that we've got a few years between you and your role?

TB: I don't claim to know. What I would say, work force is right at the top of the list. Reimbursement is always going to be there. And then I would add to those, "How do we serve our community?" I think that this kind of goes back to what I was saying a little bit earlier. I think that the discussion we need to be having in many parts of our state is not "How do we save the bricks and mortar of our hospital?" but "How do we save health care access in our community? What is the best way for our community to access the best level of health care that we can?"

In some instances, that means we need to upgrade our hospital. We need to add a wing. We need to provide more services. In some instances, it might mean our hospital, our building should be more of an emergency room, a clinic, a community center-type place. That's a really hard discussion to have on a community level, and I get it. If I'm in a small community, and somebody from Topeka is telling me that I should close my hospital, my response is "Who are you to tell me how I should spend my property tax dollars?"

BSP: Yes.

TB: But I also think that that's the right discussion to be having, and the best way for it to happen is for the people in the community to make the decision about what's best for them. If they decide they want to build a brand-new hospital, then that's up to them. It's just a discussion that needs to happen more often.

BSP: They're difficult conversations, as you said.

TB: Absolutely.

BSP: You're a lawyer.

TB: Barely.

BSP: You have background as a lawyer. Kansas has an interesting approach to malpractice issues. Just talk a little bit about that.

TB: I probably should have listed that as one of the biggest issues I was involved in. As I look back, I don't necessarily—it is a health care issue, but it's sort of beyond that. It has to do with the way our tort system is set up. It has to do with the courts and access by plaintiffs and defendants. But that was a huge issue in our state. There was a lot of evidence that, again, when I first started, and this was in the early eighties, mid-eighties, that medical malpractice insurance premiums had grown to a level that it was keeping people from going into the health care system, and it was keeping our state from recruiting physicians.

BSP: Certain specialties in particular.

TB: Yes, who might, for example, deliver babies. There were numerous examples of hospitals that decided they weren't going to deliver babies anymore because of the malpractice insurance

premium. So, our legislators were very responsive. This was a really difficult issue for many of our legislators who were really conflicted, I guess, or had trouble weighing the balance between the rights of a person to access the court system and to be reimbursed for wrongs that are done to them versus the needs of our society to access health care. We passed some laws that tended to limit non-economic damages that a number of states—we were probably one of the first states that did it, but a number of states followed suit. I think there was immediate help from those laws, but that system's changed a lot over the years. I don't know that people would say it's the same kind of crisis that it was back then.

BSP: Did you serve or are you serving now on the oversight work for that?

TB: Not anymore.

BSP: But you did at one point.

TB: At one point in time, I did. That's a good example of—

BSP: Being proactive in policy development.

TB: Exactly, of the state stepping in and providing what was essentially an insurance company that would provide a level of insurance that just wasn't available at that point in time. I think there's a question now about whether, given where the system is, do we need the state to be involved in providing malpractice insurance anymore? I'll probably get in trouble for saying that, but I think that's a legitimate question. Can the private market handle the entire levels of malpractice insurance needs?

BSP: It's hard to imagine talking about health in Kansas and how healthy we are as a state without bringing in the hospital perspective, and I really appreciate you taking the time to be here.

TB: I'm happy to do it. I think one of the things that I—it became clear to me as I worked for hospitals is that the hospital perspective should be the perspective of health care in a given community. We've talked about this. I think more and more hospitals are getting to that place. So what's good for a hospital ought to be what's good for a particular community.

BSP: Awesome. Well, thank you, Tom.

TB: Sure. Happy to be here. Thanks for having me.

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