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What Happened to Health in Kansas?

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Priorities for Reversing a Long-Term Decline in Health Ranking

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What Happened to Health in Kansas?

Priorities for Reversing a Long-Term Decline in Health Ranking

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Executive Summary

Kansas has experienced one of the steepest long-term declines in health ranking in the nation. Once ranked eighth in *America's Health Rankings* in 1991, the state had fallen to 28th by 2024. To identify actionable priorities for reversing this trajectory, a three-round Delphi study engaged 100 health experts and leaders across Kansas.

Methods

Participants from academia, public health, health care, advocacy, community organizations and other sectors identified and prioritized factors contributing to the state's health ranking decline. In Round 1, participants submitted open-ended responses. In Round 2, they rated the importance of issues. In Round 3, they allocated 100 points across the issues to simulate real world tradeoffs.

Participants

Most participants held advanced degrees, with 42 percent reporting a master's degree and 27 percent a doctoral or professional degree. Key sectors represented included public health (27 percent), advocacy (21 percent), academia/research (21 percent), and health care (12 percent). Participants primarily resided in the northeast (59 percent) and south central (17 percent) regions of Kansas. Participants were predominantly White (76 percent) and non-Hispanic (92 percent), with some racial and ethnic diversity.

Findings

From 52 identified issues, four emerged as the top issues of concern, making them the **highest priorities**:

1. Closure of rural hospitals and health care services
2. Lack of Medicaid expansion
3. Limited availability of mental health services
4. Low public health funding

Seven additional issues were identified as **high priorities**, including chronic disease, obesity, income and wealth inequality, rural workforce shortages, housing access, lack of a culture of health and system fragmentation.

Participants emphasized **structural and system-level drivers** of Kansas' health ranking decline, rather than individual behaviors. The findings underscore that policy decisions, underinvestment and infrastructure gaps are key contributors to the state's health outcomes.

Conclusion

Reversing Kansas' health ranking decline will require focused investment and policy reform. The priorities identified in this study — stabilizing rural health care, expanding Medicaid, strengthening mental health services and increasing public health funding — provide a starting point and roadmap to align resources and effort with the most critical drivers of population health in Kansas. This offers Kansas leaders a practical foundation for meaningful systems transformation.

Introduction

Kansas was once among the healthiest states in the nation. However, over the past three decades, the state's health status has declined substantially relative to the rest of the country. In 1991, Kansas ranked eighth in *America's Health Rankings*. By 2022, that rank had fallen to a low of 31st, and as of 2024, it sits at 28th.[1] In 2019, the *America's Health Rankings* reported that Kansas had experienced the steepest decline in rankings of any state since the inception of its rankings.[2]

America's Health Rankings provides a comprehensive view of population health in states. However, changes in these rankings can be difficult to interpret, as shifts may result from changes within Kansas or other states across any of the indicators. However, age-adjusted all-cause mortality rates in Kansas also have fallen behind. In 1999, Kansas' age-adjusted all-cause mortality rate was 27.5 deaths per 100,000 fewer than the national rate. By 2023, the state's rate exceeded the national average by 63.0 deaths per 100,000, a relative increase of approximately 90 deaths per 100,000. The widening gap has followed an almost linear trend, increasing by an average of 3.5 deaths per 100,000 annually, suggesting a sustained and systemic decline rather than short-term fluctuations.

Tools such as *America's Health Rankings* provide a useful snapshot of states' health status and can point out opportunities for improvement. Additionally, epidemiological studies quantify disease burden and policy, and program evaluations test the effect of interventions. But it was unclear if these methods would help to identify and prioritize system-level leverage points, as this data may lack the nuance needed to uncover root causes.[3,4]

To address these issues, a statewide Delphi study was conducted with Kansas health experts and leaders. The purpose was to explore why health in Kansas has not kept pace with the United States and to identify priorities for reversing this trajectory. This study generated both rich qualitative themes and quantitative priority rankings to address the research question. This article focuses on the quantitative priority rankings viewed by the participants as most critical to improving population health in Kansas.[5]

Methods

Kansas' health ranking decline may be considered a "wicked problem" — a complex issue that lacks clear-cut agreement on its drivers and importance.[5] To address this challenge, experts and leaders in Kansas' health were engaged to systematically explore the underlying causes and identify key priorities. Given the geographic dispersion and challenges associated with in-person group discussions, the Delphi technique was selected.

The Delphi method is a structured, consensus-building approach used to gather and refine expert input on complex issues lacking clear solutions.[6] Developed by the RAND Corporation,[7] it has been widely applied in strategic planning,[8,9] priority setting[10] and public health assessment.[11] Key features, such as anonymity, iterative rounds and structured feedback, help reduce bias, minimize the influence of dominant voices and support more reliable consensus than traditional group discussions.[12] These strengths make the Delphi method particularly appropriate for exploring wicked problems like Kansas' decline in health ranking, ensuring that diverse expert perspectives inform the identification of key contributing factors and strategic priorities.

This study used a three-round Delphi method to gather input from a purposefully selected group of experts and leaders in health-related fields across Kansas. Participants refined their responses across sequential survey rounds, with each round incorporating structured feedback from the previous one. This iterative process facilitated the integration of diverse perspectives, supporting the identification of shared priorities. Following the final round, data from all phases were synthesized to identify and rank key factors contributing to Kansas' health ranking decline, informing strategic recommendations for action planning (*Figure 1,* page 3).

Participants

Participants were drawn from sectors with expertise and influence in the health of Kansas. This included academia, advocacy, community organizations, foundations, health care, public health, state and local government, and business. The participants were identified through the research team's professional network and searching public directories.

Round 1: Exploring Factors Contributing to Kansas' Health Ranking Decline

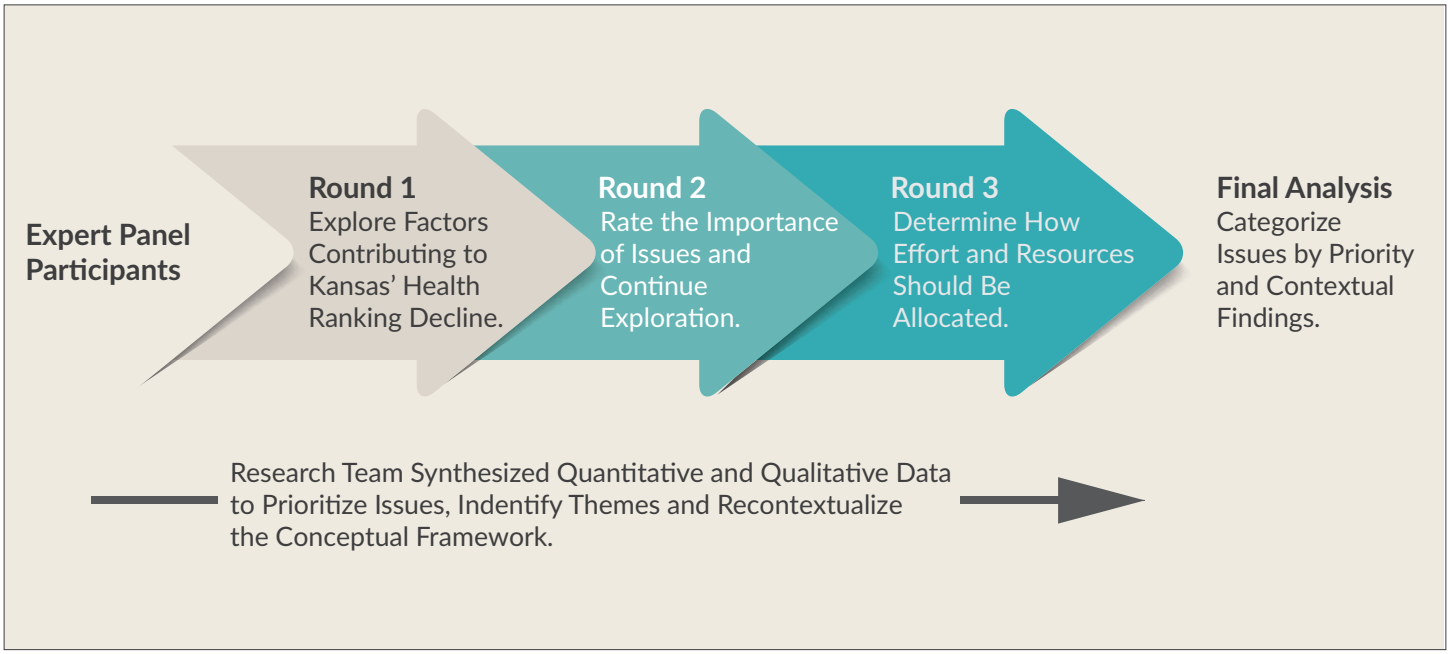
The first survey sought to identify key factors contributing to Kansas' health ranking decline. Participants received background on the decline in Kansas' health status, including its rank in *America's Health Rankings*. Participants were asked to respond to open-ended questions within five domains aligned with the World Health Organization's *Conceptual Framework for Action on the Social Determinants of Health*[13] and upstream, mid-stream and downstream determinants of health.[14] Domain names were simplified to be accessible by all audiences and included:

- Laws and policies
- Social and economic factors
- Health behaviors and conditions
- Quality of health care, public health and social services
- Leadership and governance for health

Participants were encouraged to provide specific details and contextual details to support their responses. After responding to these domains, participants also were provided an opportunity to contribute other ideas that did not fall within the previous domains.

Qualitative data analysis procedures were used to identify issues emerging from participants' input. A single researcher familiarized themself with the data, conducted an initial descriptive coding and organized the codes into thematic categories using Atlas.ti's network feature.[15] Following this, the researcher developed issue statements to represent each of the distinct issues. Issue statements were written as a brief title of the issue and a two to three sentence description of the issue. Feedback on the issue statements was sought from the full research team. Each statement was presented with supporting quotations and a rationale for its development. Final issues and statements were then refined and agreed upon through team deliberation.

Figure 1: **Three-Round Delphi Study Design**



Note: Overview of the study design. A panel of Kansas experts and leaders completed three anonymous surveys: (Round 1) elicit factors contributing to the state's health ranking decline; (Round 2) rate importance and refine items; and (Round 3) indicate how effort/resources should be allocated. After each round, controlled feedback was provided; quantitative summaries and thematic coding were integrated to prioritize issues and contextualize findings.

Round 2: Rating the Importance of Issues and Continued Exploration

The second survey assessed the perceived importance of each issue and provided participants with an opportunity to offer feedback on the issue list, including whether any issues were missing or if they disagreed with how issues were framed. Participants were presented with a randomized list of the issue statements derived from the first round. Each statement was rated on a four-point Likert-type scale, from extremely important to not at all important. An option for "I don't know" also was included.

Quantitative data were analyzed using SAS 9.4 software.[16] Response options were assigned numeric values (4 to 1, with 0 for "I don't know"). Rank sums were calculated to determine the relative importance and scores were normalized to a 1–100 scale to produce a comparable priority score . Responses to the open-ended questions were analyzed and used to modify the final round.

Round 3: Determining How Effort and Resources Should Be Allocated

In the final survey, participants were asked how Kansas' collective effort and resources should be allocated to the issues. A constant sum method was used in which each participant was given 100 points to distribute across the issues.[17] This mirrored real-world resource allocation, requiring participants to weigh tradeoffs. The revised list of issue statements was provided in order of their importance, based on their priority score from Round 2. New issues identified from Round 2 were included at the end. Data from the constant sum exercise were analyzed to produce the mean investment score and the percent of participants who assigned any points for each issue.

Final Analysis: Categorizing Issues by Priority

Priority categories were established using a combination of the mean investment score (constant sum) and the proportion of participants who allocated any points to each issue in Round 3, alongside importance ratings (rank sum) from Round 2. This approach allowed for a more robust prioritization by incorporating both the intensity and breadth of perceived importance and investment. The following priority categories were applied.

1. **Highest Priorities:** Issues ranked in the top quintile for mean investment, assigned points by a majority of participants, and received a priority score of moderately or extremely important.

2. **High Priorities:** Issues ranked in the top quintile for mean investment and receiving a priority score of moderately or extremely important, but were not assigned points by a majority of participants.

3. **Moderate Priorities:** Issues ranked in the second highest quintile for mean investment or receiving a priority score of moderately or extremely important and not assigned points by a majority of participants.

4. **Low Priorities:** Issues ranked in the bottom three quintiles for mean investment, not assigned points by a majority of participants, and that receive a priority score less than moderately or extremely important.

Ethical Considerations

This study was reviewed by the Stormont Vail Health System's Institutional Review Board and determined not to involve human subjects research under 45 CFR 46. Participants provided informed consent prior to participation and all data was kept confidential.

Results

Participant Characteristics

A total of 100 individuals participated in the study: 50 completed Round 1, 67 completed Round 2, and 60 completed Round 3, with participants completing an average of 1.8 rounds. Participants were purposefully selected based on their expertise and leadership in health-related fields in Kansas. Most held either a master's degree (42.0 percent)

Figure 2: **Participant Characteristics**

Participant Characteristics	Round 1	Round 2	Round 3	Total
	N (%)	N (%)	N (%)	N (%)
Total Number of Participants	**50**	**67**	**60**	**100**
Education				
Associate's Degree	2 (4.1%)	2 (3.0%)	5 (8.3%)	5 (5.0%)
Bachelor's Degree	9 (18.4%)	16 (23.9%)	13 (21.7%)	24 (24.0%)
Master's Degree	20 (40.8%)	27 (40.3%)	29 (48.3%)	42 (42.0%)
Doctorate, M.D., D.O., or J.D.	18 (36.7%)	20 (29.9%)	12 (20.0%)	27 (27.0%)
Missing	1 (2.0%)	2 (3.0%)	1 (1.7%)	2 (2.0%)
Sector				
Academic/Research	15 (30.0%)	13 (19.4%)	14 (23.3%)	21 (21.0%)
Advocacy	12 (24.0%)	13 (19.4%)	13 (21.7%)	21 (21.0%)
Community-Based Organizations	4 (8.0%)	5 (7.5%)	6 (10.0%)	8 (8.0%)
Foundations	4 (8.0%)	2 (3.0%)	4 (6.7%)	6 (6.0%)
Government Other Than Public Health	1 (2.0%)	3 (4.5%)	1 (1.7%)	4 (4.0%)
Health Care	3 (6.0%)	12 (17.9%)	7 (11.7%)	12 (12.0%)
Public Health	11 (22.0%)	19 (28.4%)	14 (23.3%)	27 (27.0%)
Business	0 (0.0%)	0 (0.0%)	1 (1.7%)	1 (1.0%)
Geographic Location				
Northeast Region	32 (64.0%)	41 (61.2%)	33 (55.0%)	59 (59.0%)
Southeast Region	1 (2.0%)	3 (4.5%)	4 (6.7%)	6 (6.0%)
North Central Region	3 (6.0%)	6 (9.0%)	6 (10.0%)	8 (8.0%)
South Central Region	11 (22.0%)	11 (16.4%)	10 (16.7%)	17 (17.0%)
Northwest Region	0 (0.0%)	2 (3.0%)	1 (1.7%)	2 (2.0%)
Southwest Region	3 (6.0%)	4 (6.0%)	5 (8.3%)	7 (7.0%)
Outside of Kansas	0 (0.0%)	0 (0.0%)	1 (1.7%)	1 (1.0%)
Race				
American Indian, Alaska Native	0 (0.0%)	0 (0.0%)	1 (1.7%)	1 (1.0%)
Asian	2 (4.0%)	2 (4.0%)	2 (3.3%)	3 (3.0%)
Black or African American	2 (4.0%)	2 (4.0%)	4 (6.7%)	6 (6.0%)
Multi-Racial	1 (2.0%)	1 (2.0%)	2 (3.3%)	3 (3.0%)
White	42 (84.0%)	42 (84.0%)	45 (75.0%)	76 (76.0%)
Other	1 (2.0%)	1 (2.0%)	2 (3.3%)	3 (3.0%)
Prefer Not to Say/Not Provided	2 (4.0%)	2 (4.0%)	4 (6.7%)	8 (8.0%)
Ethnicity				
Spanish, Hispanic or Latino Origin	3 (6.0%)	4 (6.0%)	5 (8.3%)	8 (8.0%)
Not Spanish, Hispanic or Latino	47 (94.0%)	63 (94.0%)	55 (91.7%)	92 (92.0%)

Source: Kansas Health Institute analysis of data from the three-round Delphi study used for this project.

or a doctoral degree (27.0 percent) and represented sectors including academia and research (21.0 percent), advocacy (21.0 percent), public health (27.0 percent), and health care (12.0 percent). Although individuals from the business sector were invited, only one participated and only in a single round. Participants were primarily from the northeast (59.0 percent) and south central (17.0 percent) regions, with all regions of Kansas represented. The majority identified as White (76.0 percent) and non-Hispanic (92.0 percent), though some racial and ethnic diversity was present (*Figure 2,* page 5).

Priorities

Based on participant input across all three rounds, the research team identified 52 distinct issues contributing to Kansas' health ranking decline. The full list of issue statements is provided in Appendix A (*page A-1*). These issues spanned the full range of the conceptual framework: 14 addressed upstream socioeconomic and political context; 13 reflected midstream factors related to individual socioeconomic position and community characteristics; 27 focused on downstream impacts on the health system and health outcomes; and 2 were cross-cutting, encompassing both upstream and midstream dimensions.

Perceived importance was assessed in Round 2 using a scaled rank sum, with values ranging from 50.4 to 90.3. Of the 52 issues, 24 received a scaled rank sum of 75 or higher and were classified as moderately or extremely important. In Round 3, participants allocated 100 points across all issues using a constant sum method, simulating real-world tradeoffs. Mean investment scores ranged from 0.1 to 11.1, with top quintile scores averaging 5.3 points. Only four issues received investment points from more than half of participants.

Figure 3, page 7, presents the full list of issues categorized by priority level, based on three indicators: (1) mean investment score quintile, (2) percentage of participants assigning points and (3) scaled rank sum from Round 2.

Four issues met the criteria to be classified as the highest priorities to resolve:

1. The closure of rural hospitals and health care services
2. Lack of Medicaid expansion
3. Limited availability of mental health services
4. Low public health funding

Seven additional issues met the criteria to be classified as high priorities:

5. Chronic diseases
6. Overweight and obesity
7. Income and wealth inequality
8. Rural health care workforce shortages
9. Lack of a culture that prioritizes health
10. Limited access to affordable and safe housing
11. Fragmentation across health care and public programs

This tiered classification provides a structured view of where participants saw both urgent need and the strongest potential return on investment for reversing the state's health ranking decline.

Discussion

This study identified a focused set of system-level priorities that participants viewed as most critical to reversing Kansas' health ranking decline. Of the 52 issues identified, four met all the criteria to be classified as the highest priorities to resolve. This included closure of rural hospitals and health care services, lack of Medicaid expansion, limited availability of mental health services and low public health funding. Seven additional issues were classified as high priorities, including chronic disease, overweight and obesity, income and wealth inequality, rural workforce shortages, lack of a culture that prioritizes health, limited access to affordable and safe housing, and fragmentation across health care and public programs.

Notably, systemic and structural challenges were prioritized over more downstream factors, such as health behaviors or disease specific interventions. All the highest priorities were either upstream or

Figure 3: **Issues and Priority Classification**

Issue	Causal Position	Round 3		Round 2
		Mean Investment Score (Quintile)	% of Participants Assigning Points (Yes>50%; No≤50%)	Scaled Rank Sum (Moderate Importance)
Highest Priorities				
Closing of Rural Hospitals and Health Care Services	D	11.1 (1)	66.7% (Yes)	90.3% (Yes)
Medicaid Expansion	U	11.0 (1)	61.7% (Yes)	89.2% (Yes)
Mental Health	D	7.8 (1)	61.7% (Yes)	89.9% (Yes)
Public Health Funding	U	5.9 (1)	55.0% (Yes)	89.2% (Yes)
High Priorities				
Chronic Disease	D	4.1 (1)	40.0% (No)	84.7% (Yes)
Overweight/Obesity	D	3.5 (1)	36.7% (No)	85.1% (Yes)
Income/Wealth Gap	M	3.4 (1)	33.3% (No)	85.8% (Yes)
Rural Health Care Workforce Shortages	D	3.4 (1)	38.3% (No)	86.2% (Yes)
Culture of Health	U	3.0 (1)	28.3% (No)	86.9% (Yes)
Housing	M	2.6 (1)	33.3% (No)	84.0% (Yes)
Fragmentation	D	2.4 (1)	28.3% (No)	86.2% (Yes)
Moderate Priorities				
Political Climate	U	2.3 (2)	33.3% (No)	83.2% (Yes)
Adverse Childhood Experiences (ACEs)	D	2.3 (2)	30.0% (No)	80.6% (Yes)
Public Health Policy Infrastructure	D	2.3 (2)	21.7% (No)	72.8% (No)
Maternal/Child Health	D	2.2 (2)	28.3% (No)	N/A
Food Insecurity	M	2.0 (2)	31.7% (No)	82.5% (Yes)
Vaccine Misinformation and Hesitancy	D	1.9 (2)	33.3% (No)	74.3% (No)
Out-of-Pocket Costs	D	1.9 (2)	25.0% (No)	88.8% (Yes)
Transportation	M	1.6 (2)	30.0% (No)	77.6% (Yes)
Governance and Legal Oversight in Public Health	U	1.5 (2)	21.7% (No)	73.5% (No)
Vision for the Public Health System	D	1.5 (2)	16.7% (No)	73.1% (No)
Child Care	M	1.3 (3)	28.3% (No)	81.3% (Yes)
Respect for Public Health	D	1.3 (3)	20.0% (No)	76.9% (Yes)
Education Funding	U	1.1 (3)	21.7% (No)	76.9% (Yes)
Profit Motive in Health Care Investments	U	1.1 (3)	25.0% (No)	76.9% (Yes)
Population Dynamics	M	0.6 (4)	18.3% (No)	81.3% (Yes)
Public Assistance	U	0.4 (5)	13.3% (No)	78.0% (Yes)
Medicaid Benefits	U	0.4 (5)	11.7% (No)	76.1% (Yes)
Employer-Based Health Insurance Coverage Gaps	U	0.3 (5)	10.0% (No)	79.9% (Yes)

Figure continued on next page.

Figure 3 (continued): **Issues and Priority Classification**

Issue	Causal Position	Round 3		Round 2
		Mean Investment Score (Quintile)	% of Participants Assigning Points (Yes>50%; No≤50%)	Scaled Rank Sum (Moderate Importance)
Low Priorities				
Substance Use Disorder	D	1.4 (3)	21.7% (No)	N/A
Structural Racism and Discrimination	M/U	1.3 (3)	23.3% (No)	74.3% (No)
Public Health Leadership	D	1.2 (3)	16.7% (No)	70.9% (No)
Community Cohesion	M	1.2 (3)	23.3% (No)	71.3% (No)
Health Literacy	D	1.0 (3)	20.0% (No)	N/A
Small Local Health Departments	D	0.9 (3)	16.7% (No)	74.6% (No)
Public Health Data	D	0.8 (4)	16.7% (No)	70.1% (No)
Culturally Competent Care	D	0.8 (4)	15.0% (No)	69.8% (No)
School of Public Health	D	0.7 (4)	6.7% (No)	56.0% (No)
Medical Residency Positions	D	0.7 (4)	8.3% (No)	N/A
New Technologies	M	0.7 (4)	10.0% (No)	N/A
Food Standards	U	0.7 (4)	11.7% (No)	62.3% (No)
Climate Change	M/U	0.6 (4)	13.3% (No)	64.9% (No)
Tobacco/Vaping	D	0.6 (4)	15.0% (No)	69.4% (No)
Environmental Health	M	0.5 (4)	13.3% (No)	67.5% (No)
Violence	D	0.5 (5)	13.3% (No)	63.8% (No)
Agricultural Incentives for Fruits and Vegetables	U	0.5 (5)	13.3% (No)	61.2% (No)
Built Environment	M	0.5 (5)	16.7% (No)	72.4% (No)
School Health	D	0.5 (5)	15.0% (No)	72.0% (No)
LGBTQ+ Safety	M	0.3 (5)	10.0% (No)	59.7% (No)
Practice Scope	D	0.3 (5)	5.0% (No)	55.6% (No)
Sexually Transmitted Infections	D	0.3 (5)	6.7% (No)	N/A
HIV/AIDS	D	0.1 (5)	1.7% (No)	50.4% (No)

Note: Causal position refers to the upstream (U), midstream (M) and downstream (D) position of the issues as determined by the research team. Priority classifications were defined as: 1. Highest Priorities: Issues ranked in the top quintile for mean investment, assigned points by a majority of participants, and received a priority score of moderately or extremely important. 2. High Priorities: Issues ranked in the top quintile for mean investment and receiving a priority score of moderately or extremely important, but were not assigned points by a majority of participants. 3. Moderate Priorities: Issues ranked in the second highest quintile for mean investment or receiving a priority score of moderately or extremely important and not assigned points by a majority of participants. 4. Low Priorities: Issues ranked in the bottom three quintiles for mean investment, not assigned points by a majority of participants, and that receive a priority score less than moderately or extremely important.
Source: Kansas Health Institute analysis of data from the three-round Delphi study used for this project.

health system issues, and only two of the seven high priorities were related to downstream health behaviors or conditions. This suggests that while clinical and behavioral factors remain important, stakeholders perceived Kansas' health ranking decline to be primarily driven by policy decisions misaligned with health, inadequate investment and structural gaps in access and infrastructure. Existing evidence supports the role of the highest priority issues in Kansas' health ranking decline. The

closure of rural hospitals and health care services emerged as the highest priority to resolve, with rural health care workforce shortages also ranked among the high priorities to resolve. According to the Center for Healthcare Quality & Payment Reform, 10 rural inpatient hospitals in Kansas have closed since 2005. Among the 99 remaining, 89 percent have lost services, 64 percent are at risk of closure, and 26 percent are considered at immediate risk.[18] Kansas leads the nation in the proportion of rural hospitals operating at a financial loss. Although losses associated with Medicaid reimbursement rates and uninsured patients contribute to this financial strain, the Center for Healthcare Quality & Payment Reform states that the largest operating losses result from underpayments by private insurance.[18] However, the extent to which this national trend applies to Kansas specifically remains uncertain and may reflect differences in the state's policy and payer mix.

Medicaid expansion was the second highest priority. Multiple studies have documented the relationship between Medicaid expansion and improvements in access to care, preventive services, health care quality, reductions in emergency department use, maternal mortality and all-cause mortality rates.[19–24] Kansas' continued non-expansion status places it among a shrinking number of states that have not adopted this policy, which will likely have negative impacts on various indicators of health status.

The severity of mental health conditions and lack of access to mental health services was the third highest priority. This is consistent with recent national rankings that have placed Kansas among the lowest performing states for mental health access and workforce availability.[25,26] While recent investments have improved Kansas' ranking, participants in this study continued to view mental health service availability as a critical gap requiring sustained attention.[25]

The underfunding of the public health system in Kansas was the fourth highest priority. This mirrors and exceeds national patterns of limited investment in public health infrastructure,[27] despite evidence linking public health spending to improved population health outcomes.[28–30] Previous studies have demonstrated associations between state and local public health investment and reductions in mortality, preventable disease and health disparities. Previous research also has documented uneven public health system performance across jurisdictions, with lower levels of performance and innovation often observed in small-population areas, such as many found in Kansas.[31–34]

Systems Implications of the Priorities

The results from this study highlight the extent to which Kansas' health ranking decline is rooted in structural and system-level vulnerabilities rather than in individual behaviors and personal responsibility. The highest-ranked priorities — stabilizing rural health care, expanding Medicaid, strengthening mental health services, and increasing public health funding — reflect core elements of the state's health care and public health infrastructure that directly shape population health outcomes. These findings are consistent with systems-level frameworks that emphasize the role of policy, governance and financing in driving state-level variation in health trajectories.[13,35]

While downstream conditions such as chronic disease, obesity and related risk factors were rated as important, participants placed greater emphasis on the upstream and midstream policy and infrastructure conditions that influence these outcomes. This suggests that stakeholders perceive many of Kansas' downstream health challenges as symptoms of broader systemic issues, particularly insufficient access to care, underinvestment in public health capacity and fragmentation across sectors.

The structured prioritization approach used in this study further underscores the importance of explicitly balancing both the magnitude of issues and their feasibility for targeted investment. By requiring participants to allocate finite resources through the constant sum method, the process surfaced a sharper view of the tradeoffs policymakers may face in addressing Kansas' population health challenges. These results offer a data-informed foundation for directing future investment and reform efforts toward the most pressing and potentially impactful leverage points within the state's health system.

Policy and Practice Implications

The application of the Delphi method in this study represents an innovative approach to statewide health assessment and improvement planning. Rather than relying solely on traditional indicator-based assessments, which often describe health status but offer limited strategic guidance, this process systematically engaged a diverse group of Kansas health leaders and experts to identify upstream, system-level drivers of health ranking decline and prioritize actionable leverage points for system improvement. The structured nature of the process allowed participants to deliberate independently, reducing the influence of dominant voices often seen in face-to-face discussions, and minimizing groupthink that can occur in consensus-building exercises where power dynamics or organizational interests shape outcomes.

Importantly, this approach provides policymakers with a refined set of priorities derived not only from expert opinion but through an iterative and replicable process that combined both qualitative and quantitative elements. The incorporation of multiple dimensions — investment scores, importance ratings and majority support — generated a more robust and nuanced prioritization framework than reliance on a single metric alone. As a result, the findings offer practical utility for health system leaders tasked with allocating limited resources across competing needs.

In addition, this approach directly supports public health accreditation standards by strengthening community health assessment and improvement planning processes. The structured Delphi method provides a transparent and defensible process for identifying strategic priorities, helping state and local partners move beyond indicator-driven assessments toward actionable system-level goals that align with PHAB requirements for prioritization, stakeholder engagement and data-informed decision-making.

For states like Kansas, where health performance has eroded over multiple decades, the value of such a prioritization process lies not only in identifying which issues matter most, but in helping to create a more strategic, transparent and defensible basis for guiding investment, policy reform and system alignment efforts. The Delphi method may serve as a replicable model for other states seeking to move beyond descriptive health assessments toward more actionable system-level planning.

Strengths and Limitations

This study has several strengths that contribute to its relevance for health system planning and policy. The use of a structured, multi-round Delphi process allowed for systematic input from a broad range of experts and leaders across Kansas' health system. The iterative design reduced the influence of dominant voices and encouraged participants to consider multiple dimensions of importance, investment and feasibility. The integration of both importance ratings and resource allocation exercises generated a more robust and nuanced prioritization than would have been possible using a single ranking approach. This structure offers practical utility for decision-makers tasked with allocating limited resources across a complex set of competing needs.

The composition of the participants provided a broad range of perspectives from public health, health care, academia, advocacy, and state and local agencies. However, participation from certain sectors, such as elected officials, business leaders and some community groups, was limited, which may have affected the breadth of perspectives captured. Additionally, the demographic composition of the participants lacked full racial, ethnic and geographic diversity, with most participants identifying as White and non-Hispanic.

While the Delphi process successfully engaged a diverse set of experts, it reflects informed opinion rather than representative views of the broader Kansas population. Some issues that scored lower in the quantitative prioritization may still represent significant concerns for specific subpopulations or stakeholder groups not fully represented among the participants. Finally, as with any prioritization exercise, the identified rankings reflect the knowledge and perspectives of participants at a specific point in time and may evolve as Kansas' health system and policy environment continue to change.

Conclusion

Reversing Kansas' health ranking decline will require bold, targeted and sustained action to address the system-level drivers identified through this prioritization process. The expert-informed priorities — stabilizing rural health care, expanding Medicaid, strengthening mental health services and increasing public health funding — represent actionable areas where focused investment and policy reform could yield substantial improvements in population health. This structured, transparent approach offers a model for states to move beyond descriptive assessments and toward strategic alignment of resources with the issues most critical to reversing long-term health ranking declines. Leaders across Kansas' health system now have a set of data-derived priorities to guide decision-making and catalyze meaningful system transformation.

Appendix A:

Full List of Issue Statements Emerging From the Study Organized by Priority Status

1. **Closing of Rural Hospitals and Health Care Services:** Hospital and health care service closures in rural communities limit access to care for Kansas residents.

2. **Mental Health:** Limited availability of mental health services, especially in rural areas, leaves many disorders untreated.

3. **Medicaid Expansion:** The lack of Medicaid expansion in Kansas limits access to health services for low-income residents, affecting overall health outcomes.

4. **Public Health Funding:** Kansas is among states with the lowest public health funding, which restricts resources for essential public health services.

5. **Out-of-Pocket Costs:** Rising health insurance costs increase financial barriers to care.

6. **Culture of Health:** A culture that prioritizes investments in health, including its social and economic drivers, is lacking.

7. **Rural Health Care Workforce Shortages:** There are shortages of physicians and other health care workers in rural communities, which limit access to care.

8. **Fragmentation:** Fragmentation in the health care system and public programs (e.g., KanCare, Social Security) reduces efficiency and effectiveness in health care delivery.

9. **Income/Wealth Gap:** Income and wealth disparities along racial, ethnic, gender and social class lines create health inequities.

10. **Overweight/Obesity:** Rising rates of overweight and obesity contribute to various health complications.

11. **Chronic Disease:** Efforts for chronic disease prevention and management are insufficient, contributing to high rates of chronic illness.

12. **Housing:** Limited access to safe, quality and affordable housing is a barrier to health and well-being.

13. **Political Climate:** The current political climate in Kansas limits opportunities for needed health solutions.

14. **Food Insecurity:** Food prices and grocery store closures contribute to food insecurity.

15. **Child Care:** Limited access to affordable child care reduces economic stability and impacts health.

16. **Population Dynamics:** Declining rural populations and an aging demographic place pressure on sustaining local economies and providing essential services.

17. **Adverse Childhood Experiences (ACEs):** ACEs contribute to lasting physical and mental health challenges in adulthood. Access to protective factors, such as strong social support, quality health care, and economic stability can help offset their impact. Addressing ACEs and the resources that promote resilience is important to improve health outcomes.

18. **Employer-Based Health Insurance Coverage Gaps:** Certain provisions enable some employers to bypass providing health insurance coverage, reducing access to health insurance for some individuals.

19. **Public Assistance:** Public assistance programs are insufficient to meet basic health and well-being needs.

20. **Transportation:** Transportation challenges limit residents' ability to access health care services.

21. **Profit Motive in Health Care Investments:** Financial gains often take precedence over addressing the service needs of underserved communities.

22. **Education Funding:** Underfunding K-12 and higher leads to disparities in educational attainment, a social determinant of health.

23. **Respect for Public Health:** Low public confidence and lack of political respect for public health institutions weaken support for health initiatives.

24. **Medicaid Benefits:** Medicaid coverage in Kansas does not cover sufficient health care services for beneficiaries.

25. **Small Local Health Departments:** Small health departments lack the economies of scale needed to deliver essential public health services effectively.

26. **Vaccine Misinformation & Hesitancy:** Misinformation and vaccine hesitancy have contributed to reduced immunization rates.

27. **Structural Racism and Discrimination:** Racism and discrimination drive health inequities, limiting opportunities for good health.

28. **Governance and Legal Oversight in Public Health:** Outdated laws and limited preparation for county boards of health impact public health governance.

29. **Vision for the Public Health System:** A compelling, shared vision for the future of Kansas' public health system is lacking. Strengthening this vision can help coordinate action, investment and efforts to improve public health statewide.

30. **Public Health Policy Infrastructure:** There is a lack of infrastructure for public health policy engagement, which limits effective policy development and engagement.

31. **Built Environment:** Inadequate sidewalks, roads, parks and other infrastructure limit opportunities for physical activity and social engagement.

32. **School Health:** Limited physical activity opportunities and limited access to healthy foods in schools impact children's health.

33. **Community Cohesion:** Declining community bonds and trust make it challenging to address collective health concerns.

34. **Public Health Leadership:** There is a shortage of skilled public health leaders to address health challenges.

35. **Public Health Data:** Restrictions on data collection and sharing hinder data-driven decision-making.

36. **Culturally Competent Care:** There is insufficient culturally competent care, which limits effective service delivery for diverse populations.

37. **Tobacco/Vaping:** Tobacco use and vaping remain significant public health concerns.

38. **Environmental Health:** Insufficient environmental standards expose residents to health risks from pollutants.

39. **Climate Change:** Climate change results in more extreme weather, economic impacts and health effects.

40. **Violence:** Violence and safety concerns negatively affect community health.

41. **Food Standards:** Existing food standards are insufficient to support peoples' health.

42. **Agricultural Incentives for Fruits and Vegetables:** There are limited incentives for farmers to grow fruits and vegetables, impacting the availability of nutritious foods.

43. **LGBTQ+ Safety:** LGBTQ+ communities face safety challenges, including physical violence, discrimination and social exclusion that impact physical and mental health.

44. **School of Public Health:** Kansas lacks a full School of Public Health, limiting the state's capacity for advanced training, research and workforce development. While public health programs exist at the bachelor's and master's level, they do not provide the multidisciplinary scope, autonomy or doctoral-level training of a full School of Public Health.

45. **Practice Scope:** Restrictions prevent some health care providers from practicing to the full extent of their training and expertise.

46. **HIV/AIDS:** There is insufficient education and resources for HIV/AIDS prevention and treatment.

47. **Medical Residency Positions:** There are insufficient medical residency positions available in Kansas which affects the recruitment and retention of physicians.

48. **Health Literacy:** Health literacy is insufficient in Kansas to understand how to stay healthy and how to navigate the health care system.

49. **Maternal/Child Health:** Maternal and child health is inadequate, including maternal health care deserts, racial disparities and overall infant health outcomes.

50. **Substance Use Disorder:** Issues like the opioid epidemic, binge drinking and other substance use issues affect health in Kansas.

51. **Sexually Transmitted Infections:** Chlamydia, gonorrhea and congenital syphilis pose a growing public health challenge in Kansas.

52. **New Technologies:** New technologies like social media and artificial intelligence are having effects on mental and physical health, as well as social determinants of health.

Appendix B:

Endnotes

1. *America's Health Rankings*. State Summaries: Kansas. 2024 Annual Report. Published 2024. Accessed June 8, 2025. https://www.americashealthrankings.org/learn/reports/2024-annual-report/state-summaries-kansas

2. *America's Health Rankings*. 2019 Annual Report: Executive Summary. Published 2019. Accessed January 22, 2024. https://www.americashealthrankings.org/learn/reports/2019-annual-report/executive-summary

3. Laskowski RJ. *Does being "first" matter? Thoughts on ranking, health and public policy*. Delaware Journal of Public Health. 2019;5(5). doi:10.32481/djph.2019.12.013

4. Erwin PC, Myers CR, Myers GM, Daugherty LM. *State responses to America's health rankings: the search for meaning, utility, and value*. J Public Health Manag Pract. 2011;17(5):406-412. doi:10.1097/PHH.0b013e318211b49f

5. Head BW, Alford J. *Wicked problems: implications for public policy and management*. Adm Soc. 2015;47(6):711-739. doi:10.1177/0095399713481601

6. Linstone HA, Turoff M, eds. *The Delphi Method: Techniques and Applications*. Newark, NJ: New Jersey Institute of Technology; 2002.

7. RAND Corporation. *Delphi Method*. Accessed Feb. 12, 2025. https://www.rand.org/topics/delphi-method.html

8. Rikkonen P, Kaivo-Oja J, Aakkula J. *Delphi expert panels in the scenario-based strategic planning of agriculture*. Foresight. 2006;8(1):66-81. doi:10.1108/14636680610647156

9. Kovach KA, Lutgen CB, Callen EF, Hester CM. *Informing the American Academy of Family Physicians' health equity strategy: an environmental scan using the Delphi technique*. Int J Equity Health. 2019;18(1). doi:10.1186/s12939-019-1007-1

10. Evans K, Battersby C, Boardman JP, et al. National priority setting partnership using a Delphi consensus process to develop neonatal research questions suitable for practice-changing randomised trials in the UK. Arch Dis Child Fetal Neonatal Ed. 2023;108(6):569-574. doi:10.1136/archdischild-2023-325504

11. Bain SF, Weiss RE, Munoz SA. *Giving voice to rural communities' mental health needs through the Delphi method*. Rural Mental Health. 2011;11(1):XX-XX.

12. Powell C. *The Delphi technique: myths and realities*. J Adv Nurs. 2003;41(4):376-382. doi:10.1046/j.1365-2648.2003.02537.x

13. World Health Organization. *A Conceptual Framework for Action on the Social Determinants of Health*. Geneva, Switzerland: World Health Organization; 2010. Accessed Sept. 29, 2016. http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

14. Castrucci BC, Auerbach J. *Meeting individual social needs falls short of addressing social determinants of health*. Health Affairs Forefront. Published Jan. 17, 2019. doi:10.1377/forefront.20190115.234942

15. ATLAS.ti Scientific Software Development GmbH. ATLAS.ti. Version 24.1.1. Berlin, Germany; 2024.

16. SAS Institute Inc. SAS. Version 9.4M9. Cary, NC; 2025.

17. Hirschhorn F. *Reflections on the application of the Delphi method: lessons from a case in public transport research*. Int J Soc Res Methodol. 2019;22(3):309-322. doi:10.1080/13645579.2018.1543841

18. Center for Healthcare Quality & Payment Reform. *Rural Hospitals at Risk of Closing*. Published 2025. Accessed May 22, 2025. https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

19. Eliason EL. *Adoption of Medicaid expansion is associated with lower maternal mortality*. Womens Health Issues. 2020;30(3):147-152. doi:10.1016/j.whi.2020.01.005

20. Lee BP, Dodge JL, Terrault NA. *Medicaid expansion and variability in mortality in the USA: a national, observational cohort study*. Lancet Public Health. 2022;7(1):e48-e55. doi:10.1016/S2468-2667(21)00252-8

21. Jiang GY, Urwin JW, Wasfy JH. *Medicaid expansion under the Affordable Care Act and association with cardiac care: a systematic review*. Circ Cardiovasc Qual Outcomes. 2023;16(6):e009753. doi:10.1161/CIRCOUTCOMES.122.009753

22. Hotca A, Bloom JR, Runnels J, et al. *The impact of Medicaid expansion on patients with cancer in the United States: a review*. Curr Oncol. 2023;30(7):6362-6373. doi:10.3390/curroncol30070469

23. Bellerose M, Collin L, Daw JR. *The ACA Medicaid expansion and perinatal insurance, health care use, and health outcomes: a systematic review*. Health Aff. 2022;41(1):60-68. doi:10.1377/hlthaff.2021.01150

24. Guth M, Garfield R, Rudowitz R. *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*. San Francisco, CA: Kaiser Family Foundation; 2020.

25. Reinert M, Fritze D, Nguyen T. *The State of Mental Health in America 2024*. Alexandria, VA: Mental Health America; 2024. Accessed May 22, 2025. https://mhanational.org/wp-content/uploads/2024/12/2024-State-of-Mental-Health-in-America-Report.pdf

26. Reinert M, Fritze D, Nguyen T. *The State of Mental Health in America 2023*. Alexandria, VA: Mental Health America; 2022. Accessed May 22, 2025. https://mhanational.org/wp-content/uploads/2024/12/2023-State-of-Mental-Health-in-America-Report.pdf

27. Commonwealth Fund. State-Based Public Health Spending per Resident. Accessed July 30, 2025. https://www.commonwealthfund.org/datacenter/public-health-funding

28. DeSalvo K, Benjamin G. *Public Health 3.0: a blueprint for the future of public health*. Health Affairs Blog. Nov. 21, 2016. Accessed July 15, 2017. http://healthaffairs.org/blog/2016/11/21/public-health-3-0-a-blueprint-for-the-future-of-public-health/

29. DeSalvo KB, O'Carroll PW, Koo D, Auerbach JM, Monroe JA. *Public health 3.0: time for an upgrade*. Am J Public Health. 2016;106(4):621-622. doi:10.2105/AJPH.2016.303063

30. Public Health Leadership Forum. *The High Achieving Governmental Health Department in 2020 as the Community Chief Health Strategist*. Washington, DC; 2014. http://www.resolv.org/site-healthleadershipforum/files/2014/05/The-High-Achieving-Governmental-Health-Department-as-the-Chief-Health-Strategist-by-2020-Final1.pdf

31. Erwin PC. *The performance of local health departments: review of the literature*. J Public Health Manag Pract. 2008;14(2):E9-E18.

32. Kovach KA, Lipnicky A. *An analysis of how characteristics of local health department jurisdictions influence involvement in PHAB accreditation: implications for health equity*. J Public Health Manag Pract. 2021;27(5):449-458. doi:10.1097/PHH.0000000000001248

33. Kovach KA, Welter CR, Seweryn SM, Torres G. *Perceived benefits of collaboration between local health departments and schools and programs of public health: a mixed-methods study*. J Public Health Manag Pract. 2019;25(2). doi:10.1097/PHH.0000000000000823

34. Kovach KA, Welter CR, Seweryn SM, Torres G. *Barriers and facilitators to collaboration between local health departments and schools and programs of public health: a mixed-methods study*. Collaborations: A Journal of Community-Based Research and Practice. 2019;2(2):1-11. doi:10.33596/coll.38

35. Booske BC, Athens JK, Kindig DA, Remington PL. *Different Perspectives for Assigning Weights to Determinants of Health*. County Health Rankings Working Paper. Madison, WI: University of Wisconsin Population Health Institute; 2010

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