What Happened to Health in Kansas?

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Themes Contextualizing Why Health in Kansas Has Not Kept Pace With the United States

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Table of Contents

Executive Summary 1

Introduction 3

Conceptual Framework: The Flow of Health 4

Methods 4

- Study Design and Data Collection 4
- Human Participant Compliance Statement 4
- Data Analysis 4

Results 6

- Participant Characteristics 6
- Themes Contextualizing the Flow of Health in Kansas 6
  - Upstream: Structural Forces Fuel Downstream Turbulence 6
  - Midstream: Diverging Currents in the Flow of Health 7
  - Downstream: The Health System Caught in the Current 8

Discussion 10

- Strengths and Limitations 11
- Conclusion 11

Appendix A: Endnotes A-1

Executive Summary

Kansas has experienced one of the steepest long-term declines in health ranking in the nation. In 1991, Kansas ranked eighth in *America's Health Rankings*. By 2024, the state had fallen to 28th. This decline is evident in widening mortality gaps — between 1999 and 2023, Kansas' age-adjusted all-cause mortality rate rose by 90 deaths per 100,000 compared to the U.S. average.

To understand the drivers of this decline, the Kansas Health Institute conducted a statewide Delphi study from August 2024 to March 2025. More than 100 leaders and experts representing public health, health care, academia, advocacy, philanthropy, community organizations and government provided input across three rounds of surveys. Using the *Flow of Health* framework — which examines upstream, midstream and downstream determinants of health — the study identified how structural, cultural and system level forces shape health outcomes in Kansas.

Themes Contextualizing the Flow of Health in Kansas

- **Upstream: Structural Forces Fuel Downstream Turbulence:** Participants reported that Kansas lacks a coherent policy agenda to support health. They highlighted the absence of Medicaid expansion, chronic underfunding of public health and challenges in education and public assistance programs. Many described the political climate as highly partisan, making it difficult to advance solutions. Cultural values emphasizing personal responsibility were seen as limiting support for collective approaches, and several participants noted that structural racism, though often overlooked, continues to shape health inequities.

- **Midstream: Diverging Currents in the Flow of Health:** Economic strain, poverty and income inequality were described as key barriers to health, with disproportionate effects on Black, Hispanic and Indigenous Kansans. Participants also raised concerns about the safety and well-being of LGBTQ+ residents, especially under recent state policies. Rural communities were often portrayed as struggling with population loss and service erosion, while others described examples of thriving communities where inclusive leadership and innovation supported resilience.

- **Downstream: The Health System Caught in the Current:** Participants described the health care system as fragile, citing rural hospital closures, workforce shortages and mental health service gaps. Fragmentation and scope of practice restrictions also were viewed as limiting access. The public health system was characterized as underfunded, politically vulnerable and fragmented across many local health departments. Some noted that local boards often lacked the expertise needed to support public health effectively, and participants emphasized the need for stronger leadership and a clearer statewide vision.

Implications for Policy and Leadership

Kansas' health ranking decline is the result of a complex adaptive system where policy, cultural values and structural inequities reinforce one another. Technical fixes alone will not suffice. Reversing this trajectory will require **bold, collective leadership**, leadership that creates urgency, builds bipartisan coalitions, articulates a compelling vision and fosters inclusive collaboration across sectors. Systems thinking approaches, such as identifying high leverage points, can help disrupt entrenched patterns and move Kansas toward a healthier future.

Conclusion

Kansas' health ranking decline reflects deeply rooted structural and cultural dynamics, not simply individual behaviors or programmatic gaps. Turning the tide will require a fundamental shift in how health is prioritized and pursued. By cultivating adaptive leadership, fostering cross sector alignment and investing in systemic solutions, Kansas can chart a new path toward better health for all residents.

Introduction

Kansas was once among the nation's healthiest states. In 1991, Kansas ranked eighth in *America's Health Rankings*, but by 2024, had fallen to 28th, reflecting the largest long-term decline of any state.[1] This is further reflected in widening mortality gaps, with Kansas' age-adjusted all-cause mortality rate increasing by 90 deaths per 100,000 relative to the national average between 1999 and 2023.[2] Together, this highlights a persistent trend. Indicator-based assessments, such as *America's Health Rankings*, provide a valuable snapshot of a state's health status. However, they lack the nuance needed to explain why health outcomes have developed as they have, or to identify the underlying leverage points for intervention.[3,4] "Wicked problems," such as Kansas' health ranking decline, require understanding the problem's complexity, including values, assumptions and viewpoints from multiple stakeholders.[5]

To address this issue, a statewide Delphi study engaged Kansas health experts and leaders in examining the factors contributing to the state's health ranking decline. Participants provided narrative input on the underlying forces shaping health in Kansas, alongside identifying and prioritizing key issues. This article focuses on the qualitative themes that emerged, providing context for how system-level dynamics have influenced Kansas' health trajectory.

Conceptual Framework: The Flow of Health

To support this analysis, the Flow of Health conceptual framework was developed by integrating elements from the World Health Organization's Conceptual Framework for Action on the Social Determinants of Health,[6] socio-ecological frameworks[7] and the widely used upstream-midstream-downstream model of health determinants.[8] The framework focuses the study on drivers of health across multiple levels while facilitating communication to diverse audiences. The framework organizes factors into upstream structural forces (policies, governance and cultural values, midstream factors (socioeconomic position and community characteristics) and downstream factors (health system). Leadership was incorporated as a cross-cutting influence, reflecting that Kansans, through collective action, have agency to shape the structures, policies and systems driving the flow of health (*Figure 1*, page 4).

Methods

Study Design and Data Collection

A statewide Delphi study was conducted from August 2024 to March 2025 to explore factors contributing to Kansas' health ranking decline. Data were collected through three sequential surveys with participants representing academia, advocacy, community organizations, foundations, health care, public health, state and local government and business. Qualitative data were collected in Rounds 1 and 2 only. Round 1 included open-ended questions on factors contributing to Kansas' health ranking decline, organized around laws and policies, social and economic factors, health behaviors and conditions, quality of care and services, leadership and governance, and other issues. In Round 2, participants could suggest additional issues, refine framing and identify top priorities and strategies for action.

Human Participant Compliance Statement

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 were kept confidential.

Data Analysis

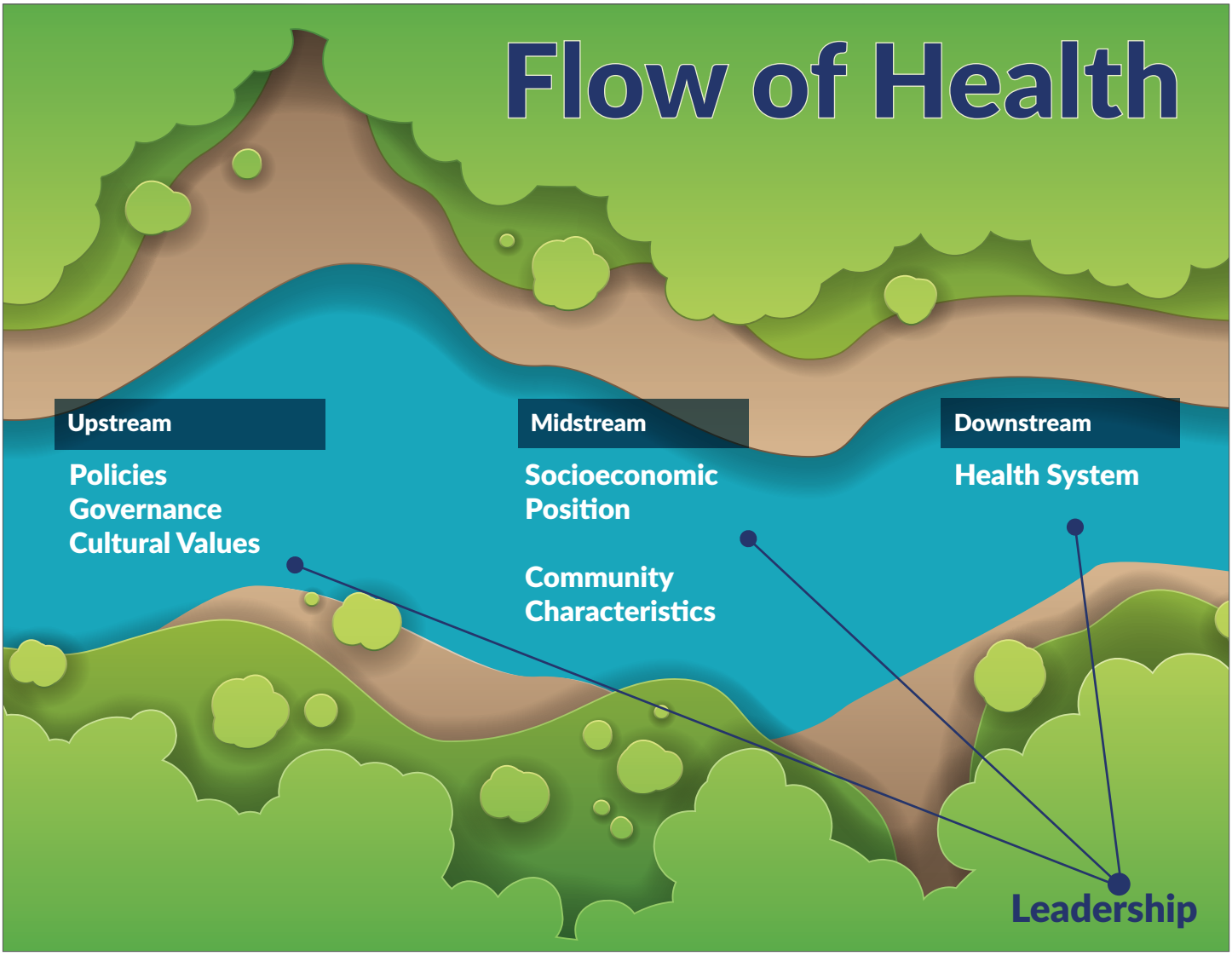
Qualitative data analysis followed applied interpretive approaches, drawing on frameworks such as Sort and Sift, Think and Shift[9] and the Qualitative Analysis Guide of Leuven,[10] which emphasize iterative engagement with full narratives, balancing data organization and interpretive synthesis to develop coherent, policy-relevant themes. Analysis was conducted by a single researcher, with periodic feedback from the

research team. Atlas.ti version 25 software was used to code and organize the data.[11]

The researcher first familiarized themself with the full dataset. Text segments with explanatory depth were then coded as "power quotes," intentionally avoiding initial interpretation. Power quotes were then organized into domains aligned with the Flow of Health framework using Atlas.ti's network mapping function. Within each domain, descriptive or in-vivo codes were applied to reflect participants' language and provide dimensionality across domains.[12] Codes were further refined to support the development of higher-level themes, with coding and network mapping used primarily for data organization and retrieval.

Interpretive synthesis occurred through repeated engagement with full quotations during analytic writing. Themes were iteratively refined through this process. Findings are anchored in participants' own words across upstream, midstream and downstream determinants of health.

Figure 1: **The Flow of Health Conceptual Framework**



Note: The Flow of Health conceptual framework was developed by the Kansas Health Institute based on a synthesis of socio-ecological frameworks developed by the World Health Organization[6], Bronfenbrenner,[7] and Castrucci and Auerbach.[8]

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.

Results

Participant Characteristics

The study included 50 participants in Round 1, 67 in Round 2 and 60 in Round 3, primarily representing public health, health care, advocacy, academia and community organizations. Most participants held graduate degrees. The majority were based in northeast and south central Kansas, with all regions represented. Participants predominantly identified as White and non-Hispanic (*Figure 2*, page 5).

Themes Contextualizing the Flow of Health in Kansas

Upstream: Structural Forces Fuel Downstream Turbulence

Policies — Policies in Kansas Are Not Aligned With Health

Participants described Kansas as lacking a coherent policy agenda to support health, with multiple policies setting the state apart from peers with stronger outcomes. Medicaid expansion emerged as the most prominent example. One participant noted, "*Kansas is one of only 10 states that have not expanded Medicaid, and not surprisingly, nine of those 10 states fall in the bottom half of the rankings.*" Others emphasized that failure to expand Medicaid limited working-class Kansans access to care: "*The working poor don't have the option of employer-based health insurance or can't afford it.*" Participants also viewed the absence of expansion as a threat to providers' financial viability: "*The hospital or clinic eats the cost of that service… If enough uninsured patients cannot pay, providers are looking at possibly closing down.*"

Chronic underfunding of public health also was cited. One participant explained, "*Per capita public health funding in Kansas was among the lowest in the nation.*" They continued, "*This means we do not have the person power to implement programs, especially in smaller rural counties.*" Participants described a boom-and-bust funding cycle: "*Funding comes in… for emergencies but is eliminated after the emergency. This is insufficient for infrastructure.*" Grant funding also was described as stagnant: "*Grant funding stays flat despite raises and the costs of benefits increasing, forcing us to leave positions open.*"

Participants also pointed to the broader policy landscape. Educational funding and quality were viewed as harming health. One participant noted that "*the quality of education in Kansas has faced challenges, with underfunded schools and disparities between urban and rural areas.*" They emphasized long-term health consequences: "*Individuals with lower levels of education are more likely to experience poverty, have limited access to health care and suffer from chronic health conditions.*" Cuts to public assistance programs, such as the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), were viewed as further restricting Kansans' ability to meet basic needs.

Governance in Kansas — Solutions Blocked Due to Conflict with Political Ideology

Participants said Kansas' political environment has blocked policies that support health. One participant stated, "*It is no surprise that Kansas was failing as a state … because the majority party has neglected public health for the better part of 30 years.*" Others noted that solutions are often blocked because "*they conflict with the ideology that disparities result from shortcomings of those left out.*"

Partisanship was described as a core barrier: "*Everything is so partisan, it's hard to get anything done.*" Some expressed hope for bipartisan commitment: "*It would be great to see the leaders of both parties jointly commit to a plan for a healthy Kansas.*" But many described political maneuvering that blocks progress: "*Given what appears to be majority support… legislative leaders who are opposed to expanding Medicaid cannot (and do not) allow bills that could be amended to incorporate Medicaid expansion to reach the floor.*"

Culture and Values — Personal Responsibility, Empathy Gaps and Hidden Racism Limit Health

Participants also linked Kansas' policy environment to cultural norms shaping attitudes toward government intervention and collective responsibility. Personal

responsibility was described as a dominant value: "*Kansans, in general, tend to have an independent nature that can lead to the attitude that asking for help is morally wrong.*" Others described how this worldview blames individuals, not systems, for health disparities: "*There's a whole ideology built around the idea that people's circumstances are the direct result of their behavior, their choices and their fundamental goodness or badness.*"

This culture also limits empathy: "*I wish there was a way for individuals to understand that because I'm not afflicted by a condition… that doesn't mean I should limit [support] to others.*"

Structural racism was identified as an underrecognized but pervasive force. "*Racism is a key driver of health disparities,*" particularly affecting rural Hispanic and Indigenous communities, "*where geographic isolation compounds inequities in education, employment and health care access.*" Others emphasized that racism is often dismissed: "*Many will say that because we have a relatively small population of racial and minority communities…the problem doesn't exist. Yet, it is everywhere.*"

Midstream: Diverging Currents in the Flow of Health

Socioeconomic Position — Disparities in Access, Risk and Opportunities for Health

Participants emphasized that health in Kansas is shaped by inequities across income, race, ethnicity, geography and identity, creating unequal opportunities for health.

Poverty and the widening wealth gap were consistently identified as core barriers. Financial strain undermines access to health care, housing, food and transportation. One participant observed, "*Not only are there fewer services available, but for people with transportation issues, inflexible work schedules, lower knowledge about available resources, etc., it has become increasingly difficult… to manage chronic conditions and maintain a reasonable level of health.*"

Participants described how these economic pressures intersect with racial and ethnic inequities, particularly for Black, Hispanic and Indigenous communities in rural areas where racism and isolation compound barriers. As one participant explained, "*Racism is a key driver of health disparities, particularly affecting rural Hispanic and Indigenous populations, [who face] limited access to quality education, employment and health care.*"

Disparities also were identified for LGBTQ+ Kansans, especially transgender individuals. Participants said the care and safety of transgender individuals are undermined by the enactment of policies such as the *Women's Bill of Rights* and laws that restrict gender-affirming care, which "*contributes to a hostile environment and reinforces social norms that enable violence.*"

Community Conditions — The Impact of Struggling and Thriving Communities on Health

Participants emphasized that while many Kansas communities are struggling, others are finding ways to thrive. Rural areas often were described as facing cycles of population loss, economic divestment and service erosion. One participant explained, "*As people leave, the economic base and need for services decrease. So, businesses and services close and leave. And so on.*" Another noted, "*rural economies continue to face boom and bust cycles,*" with broader forces like globalization and inequality reflected in worsening health outcomes.

Participants said that these trends have led to closures of hospitals, grocery stores and essential services, with limited health care access constraining growth. As one participant explained, "*Access to affordable, proximal, quality health care for children and mothers is a rate-limiting step for economic growth in Kansas,*" noting that businesses hesitate to locate in communities lacking core infrastructure.

Participants also described shifting demographics and social fragmentation contributing to disconnection. Some communities experience low "*community self-esteem,*" where residents ask, "*why would anyone want to live here?*" Others described a "*vicious cycle of not feeling represented, apathy and lack of political and social will to address upstream causes.*" Weakening social ties further compound these struggles: "*Without knowing your neighbors*

and having a sense of community, people may be more likely to cause harm and less likely to support a neighbor or notice when things are out of the usual."

In contrast, participants described thriving communities where inclusive and innovative leaders foster resilience. As one participant explained, "*Communities that are more inclusive and welcoming are the ones coming up with creative solutions.*" Leadership was consistently identified as a key factor, with thriving communities led by "*creative thinkers*" and "*good collaborators*" who "*bring others together and drive collective efforts to improve quality of life.*" Participants pointed to programs, such as Engage Kansas, that cultivate civic capacity, and to examples like north central Kansas where they "*have [transportation] issues figured out… with the OCCK and their grant from the Department of Transportation,*" demonstrating how local innovation can address critical needs.

Downstream: The Health System Caught in the Current

The Health Care System — Fragile, Fragmented and Ready for Solutions

Participants described Kansas' strained health care system, shaped by rural hospital closures, workforce shortages, mental health gaps, fragmentation and scope of practice restrictions.

Rural hospital closures and workforce shortages were recurring concerns as financial pressures limit services. One participant explained, "*If there is no margin, [hospitals] cannot… keep their organization afloat.*" Recruiting providers to rural areas was described as a persistent challenge: "*Kansas has many rural and frontier areas that have not been able to attract providers.*" With low Medicaid rates, "*Kansas remains a less attractive state for clinicians.*" Add-on payments for rural areas were viewed as "*a commonsense approach… to ensure that the system is supporting [rural hospitals].*"

Participants stressed the consequences of losing clinicians to out-of-state residencies: "*A medical student is more likely to stay where they practice residency and not where they go to medical school.*" Additionally, scope of practice restrictions were seen as limiting access, especially in underserved areas. "*Our medical providers… are territorial and create barriers for other practitioners to work within their scope of practice.*" Participants called for team-based models leveraging the full workforce: "*If we're not making more docs, we need to be more innovative.*"

Mental health gaps were described as severe, with high suicide and overdose rates signaling crisis: "*The high rates of opioid overdose deaths and suicides in [rural counties] illustrate the severity of the mental health crisis in Kansas.*" The closure of state facilities left many Kansans "*on the street, homeless and without medication.*"

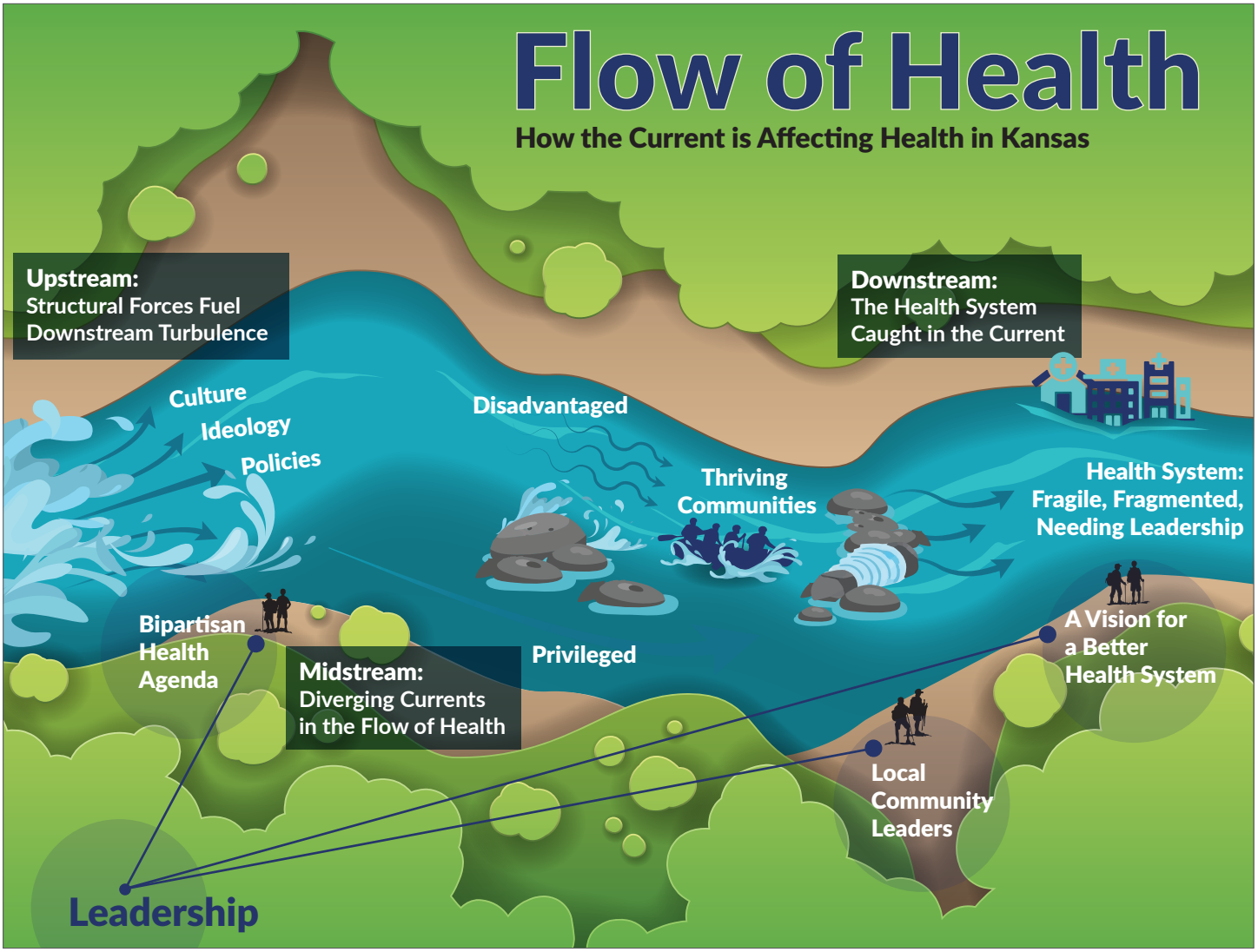
Participants described frustration with customer service systems that fail to resolve time-sensitive requests. "*Connecting with the representatives that you really need to talk to… is nearly impossible.*" Some suggested embedding agency staff in hospitals to expedite applications and services. Others criticized insurance practices that block care: "*Appeals are lengthy when care is urgent. If providers don't have the capacity to appeal, it's left up to the patient, who has little knowledge on how to navigate the system.*"

The Public Health System — Under Attack, Fragmented and Needing Leadership

Participants described Kansas' public health system as persistently underfunded, fragmented, politically vulnerable and lacking the leadership and structure for long-term success. One participant noted the public health system has been "*under attack since before COVID in terms of reduced funding and lack of public confidence.*" The pandemic further intensified tensions, with one participant saying: "*I don't think the public health system has recovered from attacks on their expertise and credibility during COVID.*"

Participants described political efforts to strip authority from local health departments: "*Legislators and local elected officials … believe the system should be changed to give [themselves authority] instead,*" replacing local expertise with political decision-making. Others stressed the need to rebuild trust: "*It would take bringing elected and local officials together to chart the map to mutual assurance, keeping the health of community members as the priority.*"

Figure 3: **The Flow of Health Contextualized to Kansas' Experience**



Note: The Flow of Health Contextualized to Kansas' Experience was developed by the Kansas Health Institute by mapping themes identified through qualitative data analysis from the study onto the Flow of Health conceptual framework developed by the Kansas Health Institute based on a synthesis of socio-ecological frameworks developed by the World Health Organization,[6] Bronfenbrenner,[7] and Castrucci and Auerbach.[8]

There were also concerns about unprepared boards of health. "*County commissioners are making decisions about public health without understanding what public health is,*" one participant stated. Another added, "*They don't own their role because they don't understand what the role should be.*" Without expertise, some commissioners "*actively undermine their administrators… block funding, question science-based recommendations and politicize routine decisions.*"

Participants said resource constraints compounded these governance challenges. "*Underfunded agencies result in minimal provision of public health functions… when compared to peer states.*" The decentralized system was described as too fragmented: "*A decentralized system with 100 local health departments cannot and will not ever assure a basic standard of public health services for all people in this state.*"

Finally, participants identified a broader leadership vacuum: "*We lack the leadership needed to frame up a coherent path forward to build an effective case for a strong public health system.*" Others called for comprehensive leadership development, including policy development and advocacy, with one participant saying: "*Leadership training for public health should include a significant policy*

development component, not just a few hours but a deeper investment in skill-building for advocacy." Themes contextualizing the flow of health in Kansas are presented in *Figure 3*, page 9.

Discussion

The findings illustrate that Kansas' health ranking decline is not the result of isolated policy missteps or programmatic gaps, but the outcome of a complex adaptive system[13] with interdependencies and reinforcing feedback loops contributing to a sustained erosion of health outcomes compared to the U.S. Kansas' decision not to expand Medicaid illustrates how upstream policy choices can cascade through the system. This decision limits access to care for low-income residents, which reinforces health disparities and places financial strain on rural health care systems — and when hospitals close, local economies feel the impact.[14] This functions as a vicious cycle with each step fueling the next.[13]

However, Kansas' health ranking decline predates the Medicaid expansion debate and likely reflects a broader set of systemic issues. Participants described similar patterns in relation to public health funding and system organization, ongoing tensions between expanding scope of practice and protecting professional boundaries, and conflicting values between emphasizing personal responsibility and building a more integrated system that eases access to services. While each of these issues may appear distinct, they reflect a common set of dynamics in which political ideology, cultural values and self-interest may be prioritized over the health of all Kansans. These dynamics reflect the often-cited observation that *"every system is perfectly designed to get the results it gets,"*[15] as one participant noted bluntly, *"It was no surprise that Kansas was failing."*

Strong leadership is necessary to reverse Kansas' health ranking decline. But this is not leadership as authority or position, it is leadership as practice focused on engaging others to co-create change through action, learning and shared meaning making.[16] Drawing on Dr. John Kotter's 8-Step Framework for Leading Change, this kind of leadership involves creating a sense of urgency, building guiding coalitions, articulating a compelling vision and enabling broad-based action.[17,18] Meanwhile, systems thinking, as described in Peter Senge's book, *The Fifth Discipline – The Art and Practice of the Learning Organization*, reminds readers that effective leadership requires seeing patterns, understanding feedback loops and challenging underlying mental models.[19] Such leadership is especially critical in adaptive challenges like Kansas' health ranking decline, where the answers are not known in advance, solutions must be discovered through experimentation, and progress depends on shifting values, narratives and relationships, not simply implementing new programs.

To translate these principles into practice, leaders in Kansas will need to engage in a specific set of actions that help shift the system's trajectory. Creating a sense of urgency can be supported by articulating the risks of maintaining the status quo, while also offering a credible and hopeful vision for successful transformation.[17,20] Systems thinking archetypes also can be used to see interconnections, patterns, feedback loops and tensions that sustain this health ranking decline.[13,19] Dr. Donella Meadows' work also highlights the need to identify and act on high-leverage points; areas in the system where small shifts can create significant improvements.[21]

Participants in this study identified several potential leverage points. One leverage point included fostering inclusive and creative community leaders to address local challenges. Another key leverage point was developing a compelling, shared vision for the future of the public health system in Kansas, one that can guide coordinated action and highlight public health leaders' openness to modeling change. Participants also emphasized the importance of bringing together stakeholders across the political spectrum and across sectors to establish a bipartisan agenda for health in the state. Perhaps the most powerful, yet most difficult, leverage point was cultivating a statewide culture that genuinely values health, respects people from diverse circumstances and remains open to innovative solutions, even when they challenge existing beliefs or ideologies.

Taken together, these findings suggest that reversing Kansas' health ranking decline will require more than technical solutions or isolated policy reforms. It will require a fundamental shift in how health is prioritized, communicated and pursued. By identifying systemic leverage points and emphasizing leadership as a collective and adaptive practice,

this study offers insights for engaging stakeholders, realigning structures and cultivating the cultural and political conditions necessary for lasting change.

Strengths and Limitations

This study had several strengths, including its use of the Flow of Health model to guide a purposeful examination of upstream, midstream and downstream factors. The participant panel included a broad range of health leaders and experts from across the state, offering insights that may be difficult to capture through other methods. This diversity of professional experience contributed to the richness of the findings. The qualitative analysis followed a structured interpretive approach aligned with established models for qualitative data analysis.[9,10]

Several limitations should be noted. While the panel included many respected leaders, it lacked strong representation from elected officials, business leaders and racially and ethnically diverse communities, despite intentional recruitment efforts. Additionally, qualitative coding was conducted by a single primary researcher; although supported by an audit trail and peer feedback, this approach reflects one interpretation of the data. Finally, as with all qualitative research, the findings reflect the subjective insights of participants and should not be interpreted as objective truth, but rather as grounded perspectives shaped by lived experience and professional context.

Conclusion

Kansas' declining health trajectory reflects deeply rooted structural, cultural and policy-level dynamics that require more than incremental solutions. This study identifies key leverage points, such as building inclusive local leadership, fostering cross-sector collaboration and cultivating a shared vision for health, that can support systemic change. Addressing these complex challenges will require sustained, collective leadership that engages diverse stakeholders, challenges entrenched assumptions and centers health as a shared public value. These findings can inform future strategy, policy development and cross-sector initiatives aimed at strengthening the conditions for health in Kansas and other states facing similar declines.

Appendix A:

Endnotes

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What Happened to Health in Kansas?

Themes Contextualizing Why Health in Kansas Has Not Kept Pace With the United States