

Nestled amidst north Urbana's large oak trees, the tan brick complex of Carle Hospital and Carle Clinic stands as symbols of the planning, money, and research that have combined over the past 75 years to create a cutting edge medical center. Behind the tan bricks, however, lie papers and papers outlining hospital policies on services, finances, and expansion. What appears to be a welcoming area with smiling doctors and state of the art technology is actually limited to a mere thirty percent of Central Illinois' population.

Located on University Avenue, Carle Foundation Hospital is the University of Illinois at Urbana-Champaign's primary teaching hospital and the two entities have a strong research relationship. Dr. Stephen Boppart, Associate Professor in the Department of Electrical and Computer Engineering, and his team of research scientists have developed a new approach to imaging that could help doctors detect tumors at the bedside. Dr. Michael Goldwasser of Carle Clinic and engineers at U of I have been working to create an artificial bone substitute, which allows physicians to create an artificial bone that stimulates the body to create new bone. In addition, Carle has teamed up with the U of I's National Center for Supercomputing Applications (NCSA) to develop an early-warning system for infectious disease and bioterrorism outbreaks (The Carle Foundation, 2006). Since the University is a public land-grant institution it has a responsibility to its surrounding community and that responsibility extends to the partnerships it makes. This means that U of I officials and the College of Medicine should be made aware of the access to health care crisis in Champaign County and what role the Carle Foundation and the Carle Clinic Association play in the problem.

Humble Roots

Before the arrival of the Illinois Central Railroads, the area of Urbana was barren frontier. Dr. John Saddler arrived to the area in 1839 with hopes to practice medicine. There weren't any established hospitals in the area at this time, but with widespread diseases like tuberculosis, medical facilities were necessary. Once the railroads were built in 1854, Champaign County began to greatly expand as the population quickly soared and the area became a center for agriculture.

Consequently, as the population increased, the need for medical care and facilities did as well. However, medical training at the time was poor and hard to come by. In fact, only 10% of physicians had graduated from medical school. The need for medical training in Champaign and Urbana was addressed, and different clinics began to arise. One leader in medical training was the Mayo Clinic in Minnesota. Although medical education increased in the area by 1915, many of the physicians were still in general practice. There were also limited hospital facilities so doctors weren't able to collaborate. The population still continued to increase through 1915. The University of Illinois had grown to 4,000 students, and there was only one general hospital with 100 beds. Mrs. Margaret Burt Carle Morris acknowledged the need for medical facilities and addressed the issue in her will. Mrs. Morris was the wife of a wealthy farmer, Albert G. Carle. Mr. Carle owned most of the land that is now the experimental farm at the University. He died in 1881, and Mrs. Carle then married James H. Morris (The Carle Foundation, 2006).

After her husband's death, Mrs. Morris called upon Henry Green, an Urbana attorney, to help write her will. She asked that \$40,000 be set aside for constructing a hospital. Her will stated that plans and a site for the hospital must be made within three

years of her death. If plans had not gone underway within the three years, then the money was to be divided among her nieces and nephews. She also made it clear that the hospital must be built in Urbana. Champaign had already begun their own hospital project, and Mrs. Morris didn't want Urbana to fall behind. Mrs. Morris died in 1918, and the money set aside for a hospital wasn't touched for two years. Henry Green was very interested in the idea of a new hospital, so he asked a few of his friends to make a committee and put the \$40,000 to good use. He chose Frank E. Williamson, also an Urbana attorney, to head the committee. The hospital committee chose the name the Urbana Memorial Hospital Association (U.M.H.A.). With only a year until the deadline for the \$40,000, the U.M.H.A. scrambled to find a location to begin building the hospital. Mrs. Gus Freeman, a committee member, said she would be willing to donate the land that her parents had previously owned. Work on the site began in August 1920, and the hospital was scheduled to open to the public by that fall. More money was needed to complete the project, so fund drives were used to raise money. The project was pushed back and it was then decided that the building would be first used as a sanitarium and would officially open in January 1921.

The Busey house, the house previously owned by Mrs. Freeman's parents, was remodeled and became quite popular. The number of beds was increased to 15, and more nurses continued to be brought in. The building was called the Busey Hospital by the public, despite the requests in Mrs. Morris' will that it be called the Carle Hospital. Patient demands began to increase and additional beds were moved into the halls to accommodate the growing numbers. It was quickly decided that an expansion was in need. Another fund drive took place in July 1921, but only \$15,000 was raised. Despite

the failure of the first attempt, more fund drives took place. Eventually \$80,000 was raised, but plans for expansion increased as well at the amount of money needed to carry out the plans. Expansion began in December 1924, despite the lack of money. Soon after, construction was stopped because they could not afford to finish the building. The U.M.H.A. put their heads together and decided to rename the hospital. By renaming it the Eastern Illinois Memorial Sanitarium (E.I.M.S.), they believed they could draw more donations from people outside of the Urbana area. Unfortunately, their funds only increased slightly. Supportive citizens ran more traditional fund drives such as bake sales to finance the rest of the expansion. Using this amount of scrapped together money, they were able to complete most of the planned expansion by March 1927. Some Urbana families even donated furniture for use in the sanitarium. The E.I.M.S. was up and running fairly smoothly but was also very much in debt. Plans for yet another fund drive were made to pull the sanitarium out of debt, and this time their goal was \$100,000.

Another Roadblock

In October 1929, two major problems occurred that made this goal impossible. First, on a national front, the stock market collapsed. Then, the Urbana Banking Company failed. As the leading bank in Urbana, it was where many major investors held their accounts. Also, Burnham and Mercy Hospitals were favored by physicians, so the E.I.M.S. was rarely needed by them. It was clear that the hospital would not be able to continue operation, and was forced to close its doors on June 30, 1930.

A Dream Fulfilled

Olin L. Browder, an Urbana attorney and E.I.M.S. supporter, wrote a letter to his friend Dr. George Higgins in September 1930. In this letter, Browder described the

situation of the sanitarium and asked Higgins if he had any interest in using it since he was an experimental biologist at the Mayo Clinic. Higgins didn't have any interest but passed the letter on to one of his colleagues, J.C. Thomas Rogers. Rogers contemplated the idea of starting a clinic at the sanitarium, but was fairly resistant. During Thanksgiving of that year, Rogers and his wife were driving to visit relatives in Indiana. His wife persuaded him to visit the sanitarium building on their way. He resisted at first, but finally gave in. After touring the building, Rogers was very enthusiastic. The idea of starting a clinic became a reality, and Rogers began searching for an associate. Many of his colleagues had major debts from medical school and were not willing to willing to take the risk of putting their careers on the line to start a clinic. When it was looking hopeless, Rogers finally ran into Dr. Hugh Davison. Davison had originally asked Rogers to come to Texas and set up a clinic with him, but when Rogers explained about the abandoned sanitarium, Davison quickly jumped on board the project. The Rogers-Davison clinic was now formed. However, the E.I.M.S. was still in debt, but Henry Green came back into the picture with an idea. A new corporation, The Carle Memorial Hospital, Inc., would operate the hospital under a lease from the E.I.M.S. The Rogers-Davison clinic could then rent out office space, and could work there rent free for the first six months. The hospital was then renamed as the Carle Memorial Hospital, as Mrs. Morris had originally requested in her will (Rogers, 1978).

One Name, Two Separate Businesses

There are two legal entities that make up the Carle system. The first is the Carle Clinic association, which is physician owned. This is a for profit entity owned by approximately 315 physicians. These physicians work as associates, and therefore each

own a piece of the clinic. The clinic also owns Health Alliance Medical Plan, but since it is such a large organization, the clinic views it as separate. Since the clinic owns the HMOs they can make patients go to them or to Carle hospital for services.

The second piece of the system is the Carle Foundation. The Foundation itself only employs about six to seven people for management purposes and is a non-profit organization. The Foundation acts as an umbrella organization in that there are several different components involved with it. The main component is the Carle Foundation Hospital, a 300 bed licensed facility. Another part of the Foundation is the home health services organization, which include a hospice and home care. The Foundation also includes ten retail pharmacies and a medical supply company with three locations.

(Personal Interview 1, 2006)

Many patients find themselves in trouble when they don't know the difference between the Carle Foundation Hospital and the Carle Clinic Association. It's difficult because they market themselves as one organization. They use the same logo and also share a website which makes it easy to mistake them as one. "Carle markets itself and promotes itself as one seamless institution or system of care. The logo is exactly the same, they share the same website, their bills look similar...and this causes some problems," said a member of the Champaign County Health Care Consumers (CCHCC).

Although they are legally separate entities, the two collaborate all the time. For example, the Hospital owns land and can lease it out to the clinic for a lower price. If the clinic were to buy from an outside source, the price would be greatly increased. It's virtually impossible to tell whether the clinic or the hospital owns the land just by looking at it. The hospital is also very dependent on the physicians in the clinic in order to

operate, and therefore the hospital's growth is very dependent on the clinic as well. The two are very much intertwined, which is cause for the common confusion of their separate identities. The clinic and the hospital use this to their advantage. They want to be regarded as both separate and individual depending on the situation. The two can structure things financially to their advantage, such as tax breaks for the non-profit entity and putting revenue-producing functions in the for profit entity.

One of the major problems with having two organizations working so closely is that they are able to slap patients with a bill from the hospital as well as a bill from the clinic. Many lower income community members come to the hospital for primary care in the emergency room. This is because they can't afford doctor visits, which may have been able to prevent their illness or condition. For example, many lower income community members are first diagnosed with diabetes, high blood pressure, heart conditions, etc. in the emergency room, because they weren't able to see doctors regularly. The patient is treated but then is presented with two medical bills: one from the hospital and one from the clinic. The hospital bill covers the use of space and medical equipment such as x-rays or sonograms. The clinic bill covers the physician services such as reading the x-ray or performing a surgery.

Because many don't realize that the clinic and the hospital are separate, they are overwhelmed when receiving two bills. The bills usually end up being for the same amount, and patients can have the hospital bill paid for by the charity care program, which looks at patient income and insurance to decide how much a patient should pay—it can sometimes waive 100 percent of the hospital bill. However, the clinic does not have a charity care program, so they offer no financial relief for the bill and collect the money

very aggressively. Sometimes a payment plan can be arranged between the patient and the clinic, but the clinic isn't very lenient. They want the bill paid off in about ten months. Many lower income patients can only spare 30-40 dollars a month, but the clinic won't agree. If they are not able to come up with a payment plan, then the clinic usually can sue the patient or send them to collection agencies. The clinic can also cut a patient off from all current and future services if they are unable to pay the bill (CCHCC Interview 3, 2006).

Another problem with primary care in the Urbana-Champaign area is that 90% of the doctors are divided into two main clinics. Carle Clinic and Christie Clinic are the two dominating providers of care, and that is why there is such a huge problem in this area in regards to health care. In other communities, there are generally several group practices that have about 6-13 physicians in each. Patients can choose which practice they prefer or which practice takes their form of insurance. Many of these practices will take different combinations of Medicare and Medicaid. For the community members of Urbana-Champaign, they are left with only a couple of options, and the community is very vulnerable to the policies of the clinics.

An Invisible Crisis

According to the CCHCC, Carle is a big player in the access to health care crisis in Champaign County. They note that the healthcare crisis in the county is a result of four factors:

1. Carle Clinic and Christie Clinic maintain policies that refuse or limit appointments to Medicaid patients, uninsured patients, or they price health care appointments and procedures out of reach for uninsured patients.
2. Ninety percent of the county's doctors are concentrated at one of the two major clinics, resulting in more than 20,000 Medicaid patients having to seek care among the minority of physicians

3. France Nelson Community Health Center (a public clinic) lacks the capacity to serve both the Medicaid and uninsured population, which totals to about 70,000 people.
4. Illinois state policy has provided low and often delayed Medicaid reimbursement to health care providers, creating a disincentive to serve Medicaid patients.

These factors have escalated the issue to a crisis stage partly due to aggressive practices the clinics employ in collecting unpaid medical bills. This legal tactic of arresting a debtor who fails to appear for a court hearing—referred to as “body attachment”—is so extreme that some of the country’s biggest commercial creditors say they never use it. Major corporations like Sears, Roebuck & Co and Ford Motor Credit Co., explicitly prohibit their collection agents from asking judges to issue arrest warrants against no-show debtors, yet Carle Clinic continually used this method to punish debtors in 2001 and 2002 (DemocracyNow!, 2004).

Until an article in the Wall Street Journal exposed Carle’s practices to the nation, the Clinic continually went after uninsured patients. In 2001, Carle obtained an arrest warrant for an uninsured single mother who missed two court hearings on a \$1,678 debt she had after a miscarriage. She was briefly jailed before posting a \$100 bail payment. In another case, a patient was hospitalized after a suicide attempt and missed a hearing on his \$7,718 hospital bill, and he was sent to jail for several hours.

The American Hospital Association issued a memo urging its 4,800 members to look at their bill-collection practices and ensure that their collection agencies and lawyers treat patients with dignity and respect. Even Congress has launched an investigation into the practice of charging uninsured patients more than the discounted rates offered to patients with insurance. The state of Illinois is holding hearings to address these issues, but enough progress has not been made (Lagnado, 2003).

The problem lies in the fact that many uninsured and low income patients do not have the means to have a primary care physician. When these people have a small problem, like a cold or knee pain, they tend to live with it and do not visit a physician for a check-up. In some cases, these medical issues get worse and a low income patient will only seek care once they absolutely have to—in most cases this means when an accident lands them in the emergency room.

“Both hospitals in our community have seen their emergency room activity increase in the number of uninsured and Medicaid patients who have to come to the emergency room for essentially primary care. Care delivered through the emergency room is the costliest and least effective,” said a member of CCHCC.

CCHCC has seen numerous cases where patients needed a small surgery, like a hernia operation, and they were unable to get the services because they had prior medical debt and no insurance. In one severe case, a woman developed tumors but could not have a biopsy to see if it was cancer and was instead given painkillers from the emergency room. It turned out she had cervical cancer and she had gone without medical attention for almost a year and a half until CCHCC begged the hospital to do something.

It’s necessary to note that Carle and other private clinics are not the only ones to blame for the health care crisis. Medicaid, the government’s health care program for low-income people, is being used by more and more people as the government is taking longer and longer to pay the bills. As of April 2006, the state of Illinois was taking at least three months to pay the Clinic’s Medicaid claims. Already, Illinois owes doctors and other medical service providers nearly \$2 billion in unpaid claims, \$1.6 million

which is owed to Carle Clinic in particular. Carle Clinic loses about \$10 million dollars a year serving Medicaid patients (Pressey, 2006).

Finding Other Options

There are few alternatives for low-income and uninsured patients in Champaign County. Frances Nelson Health Center is one option, as it serves mostly Medicaid and uninsured patients. However, Frances Nelson doesn't have the resources to deal with all the patients the other two clinics can't accommodate. Frances Nelson can have 20,000 patient visits a year; the average patient visits the doctor four times a year, so the health center can only realistically accommodate 5,000 patients. There's also the Christian Health Center, but it only has the capacity to serve a few hundred patients a year. These are necessary strides, but are not sufficient. Even with these two health centers, there are still over 50,000 people without primary care.

The Clinic tries to defend itself by stating that they are a for-profit clinic and that they need to pay their own bills. This isn't made clear to the vast majority of health care recipients in the area, as the not-for-profit hospital and the for-profit clinic share the same name, giving an impression of a seamless umbrella of care. When criticism is targeted at Carle Clinic, the Foundation goes out of their way to say that they are two separate entities and aside from the name, they are not tied to each other. On the other hand, the Foundation leases land to the Clinic, the Foundation shares doctors with the Clinic, and the two work in tandem to provide services to their patients, so if one is not serving the community well, the other should be concerned.

In October 2006, Provena Covenant Medical Center located a block away from Carle Foundation Hospital was stripped of its tax-exempt status by the governor's

cabinet. The Illinois Department of Revenue pointed out that the amount of discounted medical care Provena provided to uninsured patients was insufficient and did not justify a property tax exemption that is given to not-for-profit hospitals. The Champaign County Board of Revenue has also recommended that Carle lose its tax-exempt status, but no ruling has been made as yet. Despite its recent strides, Carle hasn't been doing enough for the community's access to healthcare. According to the hospital's IRS 990 report, the hospital had a \$42 million revenue surplus at the end of fiscal year 2005, meaning that Carle has the means to invest time and money in figuring out how to make their services more accessible.

Aggressive Expansion

“Over the years smart administrators have purchased additional land as it became available... our approach is not overly aggressive in that, when the opportunities arise we take advantage of them, and that makes us good neighbors,” said one Carle Foundation employee (Carle Foundation Interview 2, 2006).

While Carle states that it does not aggressively expand, recent announcements prove the contrary. In the last two years, Carle has constructed a Spine Institute, broke ground on the Mills Breast Cancer Institute, and announced plans to construct two new out patient clinics, add five stories to the hospital, and last week announced plans to construct a rehab clinic. There is no urgent need in the community for any of these facilities.

Carle's continued expansion shows that Carle is not devoting enough attention to the needs of the community. In effort to maximize revenues, Carle is constructing new outpatient clinics in both southwest Champaign and southeast Urbana. Aside from

parking problems on University Avenue, there is no need to move primary care activities into two new clinics. Carle's total number of patients is only growing by about two to four percent a year. However, Clinic officials argue that many of the clinic's patients are aging and can be expected to come to the doctor more frequently in years to come. According to Carle Clinic Chief Executive Dr. Bruce Wellman said the decision to build the new clinics was made after taking a look at doctors' current and long-term space needs (Monson, 2006).

With the new out-patient clinics, Carle plans to shift most of its primary care services—adult medicine, family medicine, and pediatrics—out of its south clinic building on University Avenue. The Carle Clinic Association is investing 45 million dollars in the new developments.

Enterprise Zone Developments

In addition, in a move to expand at a discount, Carle is constructing new facilities in north Champaign under an Enterprise Zone justification. The 71 acre lot, located west of Mattis avenue and north of the I-74 and I-57 junction, would become home to a second Carle campus, the first being the University Avenue main branch. Enterprise Zones are meant to encourage development in blighted neighborhoods by offering entrepreneurs and investors tax and regulatory relief if they start businesses in the area. The fact that there has been hesitancy in the Champaign City Council over whether this region fits the requirements of an enterprise zone is indication enough that this area is not in desperate need of development and the subsequent tax breaks are not necessary. In addition, the county board's Environment and Land Use Committee was to consider the enterprise zone issue but a quorum of the committee failed to show up.

Dr. James Leonard, President and CEO of the Carle Foundation told the News-Gazette that this stretch of land could accommodate up to 700,000 square feet of building space over the next 20 to 25 years. He added that, financially, it makes sense for Carle to purchase the land now while the price of the land is still within reach (Wood, 2006).

CCHCC argues that this expansion, especially under an Enterprise Zone justification is a blow to the underprivileged in the community. “It [Enterprise Zones] gives them tax abatements so they pay less than they would have had to pay in property taxes; and what do property taxes do? Well, through the county, it helps to fund programs like the child dental access program, things like that. They’re getting a tax break of two million dollars a year for five years,” said a member of CCHCC (CCHCC Interview 3, 2006).

They added: “All the growth and the expansion, everyone loves to see new buildings and new equipment and stuff like that but if you’re in the 40 percent who can’t get care, what difference does it make?”

Leaving Their Mark

“Good leaders always plan ahead... we have had consultants for years that are experts in land use planning and campus planning so that we maximize the property, or the foot print, and we don’t want to spread out unless it is necessary,” said one Carle Foundation employee (Carle Foundation Interview 2, 2006).

Despite these statements, Carle Foundation and the Carle Clinic Association continue to draft plans to expand and exert their influence in the region through the development of more facilities. The Foundation says that it conducts market surveys to assess the need for these facilities, but these studies are not made public. Because of the

private nature of patients' needs, it's difficult for outsiders to gauge how high demand is for the new developments. One thing is clear, though, and that is that the tan bricks associated with Carle's buildings have emerged in all corners of Central Illinois. There's no disputing that their presence is here to stay, no matter what is said about their policies and practices.

Looking to the future

Not enough is being done to bring community hospitals and clinics to the examination room. Healthcare policies in this community need to be re-evaluated and money needs to be allocated more wisely. There is not a lack of funds in the community; the problem is how those funds are being spent. City planners need to do more to make public what goes into deciding if a new facility will be built and the County board must keep a close eye on the not-for-profit nature of the hospitals and ensure that they are using their property tax exemptions properly, by investing in the community—and not just the insured community.

In addition, the Clinics need to at their surpluses and realize that ultimately they should be working for the health of community and this can only be done if they revise their financial policies. They will need to do it one step at a time, but they can start by allowing low-income patients to pay bills in installments. If the Carle Clinic makes it their goal to acquire a certain number of new low-income patients per year, they will eventually reach the point where they will have provided care to everyone who needs. Health care is a right, not a privilege, and it's essential that those in power do what they can to ensure that.

Healthcare in Central Illinois is like a gated community: All the buildings, facilities, state-of-the-art equipment, and infrastructure are there. There are more than enough doctors to care of this community, but more than half of the community is completely locked out of the healthcare system, and it's because they are locked out of primary care at local for-profit clinics.

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