Hospitals are the centerpiece of U.S. healthcare. Hospitals are multipurpose healthcare institutions. They provide a place for physicians and other clinicians to treat patients, for special diagnostic and treatment services, and for emergency care services. They are important resources in times of crises, for aggregating healthcare assets to benefit the community, and major sources of employment and other economic benefits. Hospitals also often serve as focal points for the coalescing of people’s efforts to address the healthcare needs of communities.

Definitions
Hospitals are increasingly defined by the various organizations that license, regulate, and accredit them. As such, the technical definition of a hospital may vary widely across nations, states, and programs.

The World Health Organization (WHO), for example, broadly defines a hospital as an organization that is permanently staffed by at least one physician, can offer inpatient accommodations, and can provide active medical and nursing care.

The American Hospital Association (AHA) more narrowly defines a hospital as an organization that (a) has at least six inpatient beds that are continuously available for care; (b) is constructed to ensure patient safety; (c) has an identifiable governing authority responsible for running it, a chief executive who reports to the authority, a medical staff with licensed physicians, and at least one registered nurse supervisor and continuous nursing services; (d) admits patients only by a member of the organization’s medical staff; (e) maintains medical records; and (f) provides pharmacy services and patient food services, including special diets.

The National Center for Health Statistics (NCHS) defines a hospital, for the purpose of its surveys, as an organization with an average length of inpatient stay of less than 30 days (short stay) whose specialty is general (medical or surgical) services or that provides general medical care for children. NCHS excludes federal hospitals, hospital units of institutions, and hospitals with fewer than six beds staffed for patient use.

Classifications
Hospitals are classified in many ways, such as by their ownership, the services they provide, whether they are community hospitals, and whether they are members of a multihospital healthcare system.

In terms of ownership, hospitals are classified as being nongovernment not-for-profit institutions (i.e., church operated, or other), investor-owned (for profit) institutions, or government-owned institutions (i.e., federal, state, or local).

In terms of the services they provide, hospitals are classified as being general institutions (providing a wide array of patient services, diagnostic and therapeutic, for a variety of medical conditions), special institutions (providing services for patients with specific medical conditions), rehabilitation and chronic-disease institutions (providing services to handicapped or disabled individuals requiring restorative treatment), or psychiatric institutions (providing services for patients with psychiatric illnesses).

A very important distinction is whether an institution is a community hospital or not. The AHA defines
community hospitals as all nonfederal, short-term (having an average length of inpatient stay of less than 30 days), general and other special hospitals (e.g., children's hospitals, obstetrics and gynecology, rehabilitation hospitals) whose facilities and services are available to the public.

Hospitals can also be classified by whether they are members of a multihospital healthcare system (two or more hospitals owned, leased, sponsored, or contract managed by a central organization) or a single stand-alone institution.

**Hospitals in the United States**

In 2006, there were a total of 5,747 hospitals registered with the AHA in the United States. Of the total, the majority, 4,927, were community hospitals (85.7%). Most of the nation's community hospitals were nongovernment not-for-profit institutions (2,919 hospitals, or 59.2%), followed by state and local government institutions (1,119 hospitals, or 22.7%) and investor-owned institutions (889 hospitals, or 18.0%). Most community hospitals, 2,926 (59.4%), were located in urban areas, while 2,001 (40.6%) were in rural areas. And most community hospitals (2,755 or 55.9%) were members of a multihospital healthcare system.

In terms of noncommunity hospitals, there were 221 federal hospitals (e.g., Veterans Affairs, Public Health Service, and Department of Justice hospitals), 451 nonfederal psychiatric hospitals, 129 nonfederal long-term care hospitals, and 19 hospital units of institutions (e.g., prison hospitals and college infirmaries).

There were a total of 947,412 staffed hospital beds in the nation, with community hospitals accounting for 802,658 beds (84.7%). There were a total of 37,188,775 admissions to all hospitals, with 35,377,659 admissions to community hospitals (95.1%). The total expenses for all hospitals were $607,355,354,000, with community hospitals accounting for $551,835,328,000 (90.8%).

**Licensure, Regulation, and Accreditation**

Hospitals must meet the myriad standards created by various government regulatory bodies. Such standards include, among others, (a) state and local licensure requirements; (b) conditions of participation for federally funded payment programs (i.e., Medicare, Medicaid, and TRICARE, the Military Health System); (c) rules governing research, the use of controlled drugs, radiation safety, and patient rights; (d) patient privacy guidelines; (e) state and federal tax-exempt requirements (for not-for-profit hospitals); and (f) federal and state rules regarding assured access to emergency medical care.

The most direct independent force in molding the structure of contemporary hospitals has been the Joint Commission. The Joint Commission sets standards through which almost all nongovernmental hospitals and many other healthcare organizations are measured to attain accreditation approval. This accreditation is not only a means of asserting a quality status to the public at large but also serves as the surrogate approval mechanism for many other regulatory agencies and other state and federal certification. Approval may also be the key to being accepted by payers such as Medicare, Medicaid, and Blue Cross. While the accreditation process is voluntary, and hospitals are required to pay for participation, the link to certification, licensure, and payment makes it all but mandatory. Its impact on the structure of hospital medical staff is, as a result, unavoidable.

**History**

Specially organized places where individuals sought relief from illness or injury, places to receive care in the process of dying, and places to go for birthing have existed in many forms for thousands of years.
The ancient Greeks, Egyptians, and Romans established temples where rites were performed to cure the sick.

Perhaps the oldest highly organized institution specifically dedicated to the care of the sick was established in Mihintale, Sri Lanka, sometime around the 4th century BCE. Archeological evidence appears to show that the well-constructed hospital had a waiting room, a dispensary, examining rooms, residential rooms for patients, and a bath where patients would be immersed in medicinal herbal water or oil.

In Europe, hospitals were typically created by various religious orders. Hospitals were also established as hospices along the major pilgrimage routes. The name hospital comes from the Latin hospes, referring to either a visitor or the host who receives the visitor. From hospes came the Latin hospitalia, an apartment for strangers or guests, and the Medieval Latin hospitale and the Old French hospital. In England, in the 15th century, the name shifted to mean a home for the elderly or infirm or a home for the down-and-out. Hospital only took on its modern meaning as an institution where the sick or injured are given medical or surgical care in the 16th century. Other terms related to hospital include hospice, hospitality, hospitable, host, hostel, and hotel.

In the New World, the Spanish conquistador Hernando Cortez built the first hospital in 1524 in Mexico City. The Hospital of the Immaculate Conception (which in 1663 became the Hospital of Jesus of Nazareth) is today the oldest continuously operating hospital in America. Throughout the Spanish settlement of America, various Catholic orders established a number of hospitals.

As other Europeans settled in what would become the United States, they also established hospitals. As the population of the new country expanded, more hospitals were created. Specifically, hospitals were established for a number of reasons. Religious orders created hospitals in response to local needs. Some communities created hospitals to expand their almshouses and prisons in order to house the insane, the poor, and others who did not have a home in which to receive care, whereas other communities created hospitals to contain patients who were contagious or who were in some other way undesirable. Physicians also created hospitals to have a place to support patient care. Some communities built hospitals as a place to support training of physicians and other professionals to meet their healthcare needs and/or as a place to support research and the development of new medical technology. In addition, individuals and corporations created hospitals as profit-making ventures to fill specific market niches.

**Technology and the Modern Hospital**

Today's modern hospital emerged in the latter half of the 19th century. Although a number of factors were responsible for its emergence, arguably, the two most important factors were the development of anesthesia and the germ theory of disease and antisepsis techniques.

While American surgeons had much of the knowledge needed to conduct major surgical procedures by the 19th century, because the surgeons lacked anesthesia, they had to operate quickly, patients suffered great pain and torture, and postoperative infection rates were high and often deadly. It was not until the mid-19th century with the introduction of anesthesia, such as nitrous oxide, ether, and chloroform, making possible the systematic application of surgery, that the growth of hospital services began. As a result, surgeons became the professional leadership in the formalization of hospital organizations well into the 20th century.

https://search.credoreference.com/content/topic/hospital
In the mid-19th century, individuals such as Oliver Wendell Holmes, Ignatz Semmelweis, Louis Pasteur, Joseph Lister, Robert Koch, and others advanced the germ theory of disease and demonstrated effective measures that could reduce the rate of disease, methods of immunization, and ways to prevent the raging infectious disease death rates in hospitals. With the reduction of diseases such as puerperal fever, a deadly disease of women giving birth, the public no longer viewed the hospital as a place to die; instead, it was a place to be cured. New antisepsis techniques developed by Lister lowered the infection rates from surgery. Previously, almost all wounds became infected, and mortality rates from surgery were as high as 90%.

Today, technologic innovations and medical advances continue to take place in hospitals. For example, recent surgical innovations include minimally invasive surgery, various endoscopic procedures, and the use of surgical robots that allow delicate microprocedures to be performed. In addition, advances in physiology and the monitoring technology of anesthesia have extended surgical procedures to older and sicker patients. Interventional instruments such as the laparoscope and balloon catheters continue to radically change hospital care, while advances in the development of radiation therapy have expanded the treatment options for many diseases. New imaging instruments such as ultrasonography equipment, thermal imaging equipment, high-speed computerized tomography (CT) scanners, magnetic resonance imaging (MRI) equipment, and positron emission tomography (PET) scanners are opening a new world of early and noninvasive diagnostic techniques.

The Hospital Medical Staff

As hospitals evolved through the 19th century, the role of physicians remained as that of independent caregivers and entrepreneurs. Their relationship with the hospitals of their time was as individuals and, for the most part, was neither organizational nor economic. The concept of mutual benefit had mostly to do with the perceived need for a place to keep those patients who could not be treated at home. The physicians performed surgery and attended to their patients, but there was little demonstration of an organized role in the governance or oversight of medical care as a whole.

However, it was in this period that the functional and economic basis for cooperation among physicians grew. Acceptance by a group of colleagues, willingness by those colleagues to refer patients to the member for service, and willingness to see a colleague’s patients when he or she was not available were all valuable resources for a physician. As these benefits became more important, the notion of limiting who could join the medical staff of the hospital and share its benefits became more important. Being selective about who may join the hospital medical staff has been a powerful tool for improving and maintaining healthcare quality, but it also has been responsive to economic incentives.

The role of gatekeeper has sometimes been an appropriate one for the hospital medical staff, and sometimes it has been abused. In addition to helping staff focus on maintaining quality, it has also been closely related to economic factors and the success of the staff physicians.

Today's hospital/hospital medical staff partnership is constructed in an environment of regulation more intense than at any other time. But these recommendations and requirements have emerged slowly, over a period of many years, as the concepts of clinical science, technology, and ethical responsibility have grown more complex.

Hospital medical staffs originally began as social organizations that facilitated an orderly referral of patients from one member to another, controlled the growth of the medical staff, and helped nurture
the addition of new members deemed desirable. The mutuality of operating and economic interest among staff members and the hospital in which they operated was the powerful glue that held them together, and the choices made in that mutuality would benefit the patient, whose best interest was served by the increasing availability of medical services.

This was convenient and economically productive at a time when the majority of care was on a fee-for-service basis. The economic basis for this exclusivity was also the basis for attacks on it by excluded physicians.

While the courts in the 1970s and 1980s forced hospital medical staff to become less exclusive and opened staff privileges to any qualified physician, the legitimate need to control access to staff had to be recognized and a new way had to be found to serve that need. There was, in part, as a response, a significant increase in externally imposed regulation on the hospital. This created many more complex responsibilities for the medical staff and its elected officers. Organizing and monitoring to ensure the quality of care became a substantial task. Later, there emerged complex reimbursement methodologies that required even more staff involvement in oversight, regulation, and assurance of fairness to the patient.

**Hospital Management**

Over the course of the past century, as hospitals increased in size and complexity, and the financing of care moved from self-pay to a third-party reimbursement system, healthcare administration as a profession evolved to meet these new challenges. Early hospital administrators were called superintendents, and they typically had little formal educational training for their jobs—many were nurses who had taken on administrative responsibilities. For example, more than half of the superintendents who were members of the AHA in 1916 were graduate nurses. Other hospital superintendents were physicians, laypersons, and Catholic nuns.

The first degree-granting program in hospital administration was established at Marquette University in Wisconsin. In 1927, two students, both women, received their degrees, but in 1928, the program, with no other graduates, failed.

In 1934, Michael M. Davis, a pioneer researcher in the economics, quality, and organization of medical care, developed the first graduate program in hospital administration at the University of Chicago. Davis recognized that most hospital superintendents of the time lacked proper training in business. The new program was placed in the university's business school. Davis developed the curriculum, which included 1 year of academic course work in accounting, statistics, and management and a hospital residency. With the success of the program, other universities established hospital administration programs based on Davis's model.

Before the founding of the first graduate program in hospital administration, a group of practicing hospital superintendents came together in 1933 and formed the American College of Hospital Administrators (now the American College of Healthcare Executives [ACHE]), the first professional association for hospital administrators. And while both clinically trained and lay administrators could join the college, the emphasis was clearly on the lay administrator. Among the 106 charter fellows of the college, only 32 were physicians. Over the years, the college has grown; and today it is an international professional society of more than 30,000 healthcare administrators who lead hospitals, healthcare systems, and other healthcare organizations.
While hospitals have continued to evolve, the field of healthcare administration continues to sustain three primary objectives. First, healthcare administrators are responsible for the business and financial aspects of hospitals, clinics, and other health services organizations, and they are focused on increasing efficiency and financial stability. Their roles include human resources management, financial management, cost accounting, data collection and analysis, strategic planning, marketing, and the various maintenance functions of the organization. Second, healthcare administrators are responsible for providing the most basic social service: the care of dependent people at the most vulnerable points in their lives. Third, healthcare administrators are responsible for maintaining the moral and social order of their organizations, serving as advocates for patients, arbitrators in situations where there are competing values, and intermediaries for the various professional groups that practice within the organization.

The challenges faced by the healthcare administrators of hospitals are many. Shortages of nurses and other healthcare workers, concerns for the safety and quality of healthcare services, rising costs, the growing number of uninsured Americans, an aging population, and the rapidly changing medical technology and practice make managing hospitals a complex and challenging task.

See also
Academic Medical Centers, Access to Healthcare, American College of Healthcare Executives (ACHE), American Hospital Association (AHA), Health Insurance, Hospital Closures, Joint Commission, Multihospital Healthcare Systems

Web Sites
American Hospital Association (AHA): http://www.aha.org
Center for Studying Health System Change (HSC): http://www.hschange.com
Healthcare Financial Management Association (HFMA): http://www.hfma.org
Joint Commission: http://www.jointcommission.org
National Center for Health Statistics (NCHS): http://www.cdc.gov/nchs

Further Readings

Greenspan, Benn J.

