Hospital Closures: The Sociospatial Restructuring of Labor and Health Care

Caitlin Henry

Department of Geography, University of Toronto

Since 2003, more than twenty hospitals in New York City have closed because of debt and a state-driven downsizing program. During this same time period, the labor market for nurses has tightened substantially, shifting from an overall nurse shortage since the 1980s to a job shortage since the mid-2000s. Drawing on an analysis of media and government publications on hospital closures since 2003 and interviews with nurses working in the metropolitan area, I argue that hospital closures and the new job shortage are intertwined. By pushing an austerity agenda in the wake of the 2008 economic crisis, New York City and state government agencies as well as private health care institutions are actively restructuring—or "rightsizing"—the health care sector. Ultimately, this is a downsizing of care provisions by another name. Capitalism's continued devaluation of social reproduction manifests in New York City as a restructuring of the spaces and work of health care. Hospital closures are central to this restructuring that involves the mutually constituted transformations in the built environment, health care provisioning, and the nursing profession. In conclusion, this process risks making good health and good jobs less accessible. *Key Words: built environment, health, labor, restructuring, social reproduction.*

2003年以降，纽约市已有二十馀家医院，因债务和州政府所主导的缩编计画而关闭。于此同时，护士的劳动市场大幅紧缩，使得1980年以来普遍的护士短缺，转变成2000年中叶开始的工作匮乏。我分析自2003年以来，媒体和政府有关医院倒闭的出版文献，并访谈在大都会地区工作的护士，主张医院倒闭和新发生的工作匮乏是相互交织的。藉由在2008年经济危机之际推出撙节政策，纽约市和州政府单位，以及私人健康照护机构，积极地再结构健康照料部门——或"矫正其规模"。最终，这仍然是缩减照护供给的别名。资本主义对社会再生产的持续贬抑，在纽约呈现为健康照护空间及工作的再结构。医院倒闭是此般再结构的核心，并涉及建成环境、健康照护供给以及护士专业之间互相构成的转变。最终，此般过程是以更难以获得良好的健康及工作为风险。 *关键词： 建成环境，健康，劳动，再结构，社会再生产。*

Desde 2003 han cerrado más de veinte hospitales en la Ciudad de Nueva York debido a deudas y a un programa de recortes de personal orientado por el estado. Durante el mismo período, el mercado laboral de enfermeras se ha tensionado sustancialmente, pasando de una escasez de enfermeras en general desde los años 1980 a una contracción del empleo a partir de mediados de la década del 2000. Con base en un análisis de publicaciones del gobierno y de los medios sobre el cierre de hospitales desde 2003 y entrevistas con enfermeras que trabajan en el área metropolitana, sostengo que los cierres de hospitales y la nueva escasez de empleo están entrelazados. Promoviendo una agenda de austeridad a la luz de la crisis económica de 2008, la Ciudad de Nueva York y las agencias gubernamentales del estado, y también las instituciones privadas de la salud, están reestructurando activamente—o "enderezando"—el sector de la salud. En últimas, de lo que se trata es de recortes en las provisiones de cuidado de la salud pública, con otro nombre. La continuada devaluación de reproducción social por el capitalismo se manifiesta en la Ciudad de Nueva York en una reestructuración de los espacios y del trabajo en salud. Los cierres de hospitales son centrales en esta reestructuración que implica las transformaciones constituidas de manera mutua en el medio ambiente construido, la provisión del cuidad de la salud y la profesión de la enfermería. En conclusión, este proceso arriesga la accesibilidad a la buena salud y a los buenos empleos. *Palabras clave: medio ambiente construido, salud, trabajo, reestructuración, reproducción social.*

St. Vincent's plight has been portrayed by public officials and the media as a story of misfortune—a community losing a vital piece of its infrastructure and a centerpiece of its identity to a combination of mismanagement, the recession, and bad luck. The truth, though, is considerably more alarming. St. Vincent's collapse is only the most visible symptom of an ongoing financial emergency facing the city's five dozen remaining hospitals and threatening those they serve. In a sense, St Vincent's is the Lehman Brothers of the local hospital industry: an institution whose dramatic disappearance, once unthinkable, raises dire questions about the viability of the entire system.

—Levine (2010)

Annals of the Association of American Geographers, 105(5) 2015, pp. 1094–1110 © 2015 by Association of American Geographers
Initial submission, August 2014; revised submission, February 2015; final acceptance, February 2015
Published by Taylor & Francis, LLC.

In 2010, St. Vincent's Hospital in Manhattan's West Village closed its doors after 161 years in operation. Politicians, community members, nurses, staff, and doctors all rallied in the year prior to save the hospital but, after slipping into $1 billion in debt, New York State opted not to bail out the facility but to let it close (Hartocollis 2010; Levine 2010). This was not, however, an isolated case; the twenty other hospital closures in New York City in the past decade signal a comprehensive restructuring to health care in New York.

This article investigates New York City's hospital closures and their implications for nurses and the neighboring communities. It analyzes connections between changes in the nursing profession and hospitals that have closed and subsequently sat in ruin for years. Through tracing the stories of hospital closures and recent changes in the nursing profession, I argue that hospital closures reflect major health care restructuring in the context of economic retrenchment. These closures facilitate three mutually constituted restructuring processes in the urban built environment, the health care industry, and the nursing workforce, which happen through the devaluation of social reproduction under capitalism.

After setting the context for hospital closures in New York City, I bring Harvey's (1978, 2010, 2014) work on capitalist urbanization together with feminist theories on social reproduction (Katz 2001; Mitchell, Marston, and Katz 2003). Integrating these theories of social reproduction demonstrates the implications of capitalist investment in the built environment on social reproduction. Taken together, these theories provide a useful framework for understanding how social reproduction—the reproduction of bodies, everyday life, and capitalist social relations—is part and parcel of the built environment and the work that happens in it. I then outline each of the three restructuring processes under way in New York's health care system, showing how each is implicated in the others. In conclusion, I point to how these restructuring processes ultimately signal a restructuring of social reproduction that threatens access to good health and good jobs.

The Story of Hospital Closures

New York City has lost twenty-two full-service hospitals in the past decade, and many others struggled to remain in operation through the 2008 recession. Brooklyn, Manhattan, and Queens have felt the brunt of the closures, losing a total of eighteen hospitals since 2003, eleven of which closed post-2008.[1] This means that nearly all of the city's closures have been in the three most populous boroughs. Queens, in particular, is underserved. When the borough lost three facilities in the winter of 2008–2009, residents already traveled further for care than New Yorkers in most other parts of the city (Reddy 2010). In 2013–2014, Brooklyn nearly lost Interfaith Medical Center, which emerged from bankruptcy intact as a full-service hospital in June 2014 (Goldberg 2014a). But community activists could not save Long Island College Hospital (LICH) in Cobble Hill, Brooklyn. It closed in May 2014 after a two-year court battle (Hartocollis 2013; Frost 2014; Goldberg 2014b). Like many hospitals before LICH, the new property owners will convert the space into residences and an urgent care center (UCC) or free-standing emergency room.

New York's hospital system has a very uneven geography. The eastern side of Manhattan, known to some as "bed pan alley" (Lambert 1994), has one of the highest densities of hospitals in the country, with nine facilities. In comparison, Manhattan has twenty-seven hospitals, yet Queens has only eleven hospitals and 800,000 more residents (New York Department of Health n.d.; U.S. Census n.d.). Manhattan has 4.7 beds per 1,000 people, but other boroughs have considerably less capacity. The Bronx has 2.5 beds, Brooklyn has 2.2 beds, Staten Island has 2.4 beds, and Queens has 1.7 beds per 1,000 people. Hospital closures have had a noticeable impact on admissions and emergency room wait times. As a nurse at the Queens Hospital emergency room explained, per shift, her regular patient load nearly doubled after three Queens hospitals closed during the 2008 financial crisis (Reddy 2010).

These closures mean a loss of services, jobs, and community anchors. As each facility prepares to end service, affected communities and workers have made explicit the connections among hospital closures, community viability, and gentrification. As I discuss later, many hospitals have become residential spaces, and community members, aware of this trend, protest with signs saying, "Condos Rise, Brooklyn Dies" and "Please don't DIE on your way to another hospital" (Keep Brooklyn Hospitals Open for Care n.d.; Einhorn, Kadinsky, and Goldsmith 2009). In the fight to keep LICH open, New York State Nurses Association (NYSNA) Executive Director Jill Furillo stated, "Communities are being left behind. When you close

a hospital you close 20 percent of community-based clinics" (Frost 2013). Thus, the community hospital is an important access site for health care services. The condominiums and apartments that replace hospitals are part of a bigger process of dispossession in the neighborhood.

Hospitals are closing for many reasons. Nearly all hospitals in New York City operate at break-even or negative profit margins (Weinberg 2003; Levine 2010; Ford 2013). Insurance is an important factor. Medicaid in New York State is one of the most expansive systems in the country, providing coverage for 3 million city residents (Kaiser Family Foundation n.d.; New York Department of Health 2013a). Medicare and Medicaid do not reimburse for all of a patient's expenses, leaving hospitals to absorb the remaining costs (Weinberg 2003). Additionally, approximately 1.2 million to 1.4 million city residents are uninsured, and the Affordable Care Act (ACA) only cuts that number by about a third (Cadogan et al. 2010; Blavin, Blumberg, and Buettgens 2013). Hospitals stay in the black by finding the right combination of patients with private insurance, with state coverage, and without insurance. Payments from the privately insured help hospitals cover losses from the uninsured and underinsured. With roughly half of the city's residents without private insurance, many hospitals struggle to find a balance of payment schemes.

This balance is also racialized, gendered, and classed. Hospitals located in poorer neighborhoods especially struggle to break even, as Medicare and Medicaid predominantly serve socioeconomically disadvantaged women, children, and people of color (New York Department of Health 2013a). Furthermore, patients on Medicare and Medicaid have lower health literacy than patients on private health insurance (Baker et al. 2002; Scott et al. 2002; Kutner et al. 2006). They are less likely to use preventive health care services and are generally in poorer health than people with private insurance. Even in areas like New York with more robust social safety nets, uninsured Americans have less access to services and higher rates of unmet medical needs than the privately insured (Cunningham and Kemper 1998; Kirby and Kaneda 2005). The hospital and emergency room, not clinics, have historically served as primary service spaces for the uninsured and underinsured. Health research shows that hospital closures negatively affect patients' overall health status (Bindman, Keane, and Lurie 1990; Buchmueller, Jacobson, and Wold 2006; Bazzoli et al. 2012). Patients lose service providers, facilities are further away, and more often than before the closure, people are denied services. Additionally, New York's previous wave of hospital closures is an example of the racialized and classed impacts of hospital closures. In the closures of the late 1960s to early 1980s, McLafferty (1982, 1671) found that "the racial composition of the neighborhood is an important predictor of hospital failure," as closures happened predominantly in areas of higher poverty and larger populations of people of color. In other words, the hospitals with the most vulnerable patient populations are also those that struggle the most to find a mixture of patients and payment plans that can allow the facility to survive financially. Hospital closures threaten the health of those most at risk.

Additionally, New York State has facilitated the recent closures in two ways. First, the state deregulated reimbursement rate negotiations between hospitals and insurance companies. In the 1980s, the state was much more heavy-handed, treating the hospital industry more like a "regulated public utility" and making sure that reimbursement rates could guarantee hospitals' survival (Levine 2010). Governor George Pataki, however, introduced a deregulated, free-market model in the 1990s (Salit, Fass, and Nowak 2002; Dinallo 2009). Hospitals now negotiate the terms of reimbursement directly with insurers. This new system privileges large facilities and multihospital systems that are more powerful negotiators and better able to absorb lower reimbursement rates. Small and standalone hospitals often have to accept the rates that larger hospitals and corporations have negotiated, which, for smaller facilities, are frequently unsustainable. Second, over the mid-2000s the state embarked on a mission to reform the hospital and long-term care system in New York. The Commission on Health Care Facilities in the Twenty-First Century—or the Berger Commission, named for its chair, Stephen Berger—aimed to "rightsize" the system, meaning "the possible consolidation, closure, conversion, and restructuring of institutions, and reallocation of local and statewide resources" (Berger Commission 2006, 59). As I address later in more detail, this was state-sanctioned downsizing by another name.

At the same time, the health care workforce is changing. The United States has experienced a nursing shortage off and on since at least the 1970s (Kingma 2006; Dall 2007). In the early 2000s, facilities offered thousands of dollars in signing bonuses to registered nurses and heavily recruited from abroad. Inner-city and rural facilities have struggled the most

to staff sufficiently. But since 2006, and particularly since the recession began in 2008, economists and the industry have declared the shortage over (Buerhaus, Auerbach, and Staiger 2009). With more hospitals financially unstable or closing, employment opportunities have declined. Now, hospitals mostly hire only the most experienced nurses, and new graduates and migrant nurses struggle to find work (Evans 2008; Kurtz 2013); my interviewees corroborate this. Hannah, who recently started her first job, and Katherine, who is finishing school, both explained the stress, fear, and luck involved in the job search.

> It's very hard as a new graduate, because the hospital has to invest a good amount of money to train you. I think like eight months I looked. I had a connection at this hospital, which is, in my opinion, why I got this job. I think a large part of it was that I knew somebody at the hospital. (Hannah)

> I'm terrified. But I feel like I'll be okay . . . like I could walk into an interview and relate to a person. It's still scary. I'm more scared of the timetable. Some people it takes nine months to find a job. What are you supposed to do in the in between? (Katherine)

These statements would be unthinkable a decade ago. But nurse shortages and hospital closures are not discrete phenomena, and investigating them more closely shows how these intertwined processes are instrumental in the overall restructuring of health care.

Methods

The New York hospital crisis is still unfolding. A media analysis, complemented with interviews with nurses and site visits to closed hospitals, was an effective way of capturing the ongoing process. Many of the closures attracted considerable media attention. I tracked coverage of each of the closures since 2003 in major New York publications, borough newspapers and blogs, and industry publications for real estate and finance. I also analyzed New York State and City Department of Health documents on the closures and those from the Berger Commission. Finally, I tracked changes to closed hospital sites through site visits in 2013 and 2014. As many of the sites sat empty after closure but changed ownership repeatedly, I visited closed hospital sites to document the conditions of the buildings and changes to the site as redevelopment progressed.

Over 2013, I interviewed twenty nurses working in a variety of subfields and at different points in their careers, ranging from recent nursing school graduates to recently retired nurses. Eleven had returned to school for additional education. Half of the nurses were white, and nine were people of color, which is a slightly more diverse sample than the national nurse workforce. Two interviewees were foreign-trained nurses. Gender reflected the gendering of nursing, with eighteen women and two men. Nurses worked and lived across the city and surrounding counties. These interviews captured nurses' everyday working conditions and work–life balance strategies, as well as workplace and health care system changes over the course of their careers. Nurses occupy multiple roles in the health care system; they are frontline workers, managers, patient advocates, intermediaries between families and doctors, nurturers, and skilled medical experts. Their testimonies illustrate the intimate and systemic impacts of health care restructuring.

Social Reproduction and the Built Environment

Feminist theories on social reproduction (Katz 2001; Mitchell, Marston, and Katz 2003; Duffy 2010) and Harvey's work on urbanization under capitalism (1978, 2010, 2014) provide a useful combination for understanding the relationship between hospital closures and the nursing labor supply. On the one hand, Harvey's theories on urbanization and investment in the social reproductive built environment help to explain hospital closures and turnover in the built environment. On the other hand, feminist theories of social reproduction help in understanding the relationship between the feminization of care work and nursing shortages (Yeates 2004; Raghuram 2009).

Harvey (1978) uses social reproduction to refer specifically to the reproduction of labor power and the "wide range of social expenditures" and physical infrastructure related to this process (108). What he called the social reproductive built environment is infrastructure that is an unappealing investment for capitalists. Investment here comes out of need, as capitalists must "fashion an adequate social basis for further accumulation" (108). In other words, capitalists have to provide the infrastructure—the social reproductive built environment—for the labor force to reproduce itself. This infrastructure, though, is also an opportunity to absorb surplus capital and avoid crises of

accumulation. Capitalism needs a landscape that can help capital produce, reproduce, and expand (Harvey 2010). Yet, this built environment can become outdated and act as a roadblock to further accumulation. At this point, capitalists "revolutionize" the infrastructure (Harvey 2014, 146). In this case, hospital closures are part of revolutionizing the landscape.

Feminists, critical of Harvey's narrow definition, have a more comprehensive understanding of social reproduction, emphasizing bodies, emotions, and social relations. Social reproduction is the biological reproduction of people and the reproduction of everyday life and capitalist social relations (Katz 2001; Mitchell, Marston, and Katz 2003). It involves both relational nurturing care work and nonrelational reproductive work such as cleaning and cooking (Duffy 2010). Importantly, feminists have shown how social reproduction has inequality built into its essence, as production's "other." Through both feminization and being nonproductive work, paid and unpaid social reproductive labor is undervalued and devalued (Glenn 1992; Duffy 2010). By being the "natural" work for women, social reproductive labor is thus not work. Its feminization as nonwork facilitates the devaluation, even when waged. Although feminization happens in different ways, impacts across occupations are similar. Often, this work is undervalued economically and socially, jobs are precarious, and, at times, workers are subject to abuse, manipulation, and violence (Raghuram 2007; Silvey 2008). Similar to other feminized work, nursing has been devalued in particular ways. For example, wages remained stagnant from the 1970s into the late 1990s, finally rising in the face of an acute labor shortage (Duffy 2010).

These two approaches to social reproduction are not discrete definitions. The latter does not preclude the built environment, and a rich understanding of the former helps emphasize the ways in which social reproduction is both a social and a spatial process. Feminists have demonstrated the spatiality of gendered processes and social reproductive work. For example, feminist geographers have addressed the ways in which space and the built environment are gendered (McDowell 1983; Hanson and Pratt 1991) and the geography of the gender division of labor (Nagar et al. 2002; England and Lawson 2005). This work shows the importance of space in social reproduction. Yet, as the built environment reflects a division of productive and reproductive spaces, bodies, and activities (McDowell 1999), social reproduction theory needs a better appreciation of capitalist investment and accumulation in the built environment. This is a missing link between these different definitions and theories of social reproduction that can explain the interconnections between hospital closures and nurse shortages. The theories need more integration. Mitchell, Marston, and Katz (2003) explained that "how we live *in space* constitutes us as contemporary subjects in life's work" (418) or social reproduction. The particular spaces or built environment that we produce, however, also constitutes us as contemporary—and healthy—subjects. The missing link—an integrated analysis of these two approaches to social reproduction with attention to capitalist investment—is key to understanding how social reproduction happens, as a process, act, and set of relations that are rooted in and produce the built environment. Thus, Marxist analyses of investment and turnover in the social reproductive built environment need to integrate a deeper understanding of life's work, just as theories of life's work need to more fully incorporate the ways in which capital moves through the social reproductive (and productive) built environment. Merging these two literatures together brings to the fore the bodies and work involved in social reproduction as well as how capitalist interest or reluctance to invest in the built environment enables or inhibits social reproduction.

Consider the following statements from nurses I interviewed:

> One of my friends had to work fifteen more days [at St. John's Queens Hospital] and she would have gotten all of her retirement benefits. Nobody ever though it would close! The St. John's clinic [closed earlier and laid off nine of the thirteen nurses]. . . . One was a pediatric nurse and they told her she could go back to the hospital and they would train her to work with adults on the floor, but the hospital closed within a month. And the clinic still had this patient basis; patients in the clinic make appointments a month in advance. A lot of them were kids who needed inoculations. It was horrible. Nobody thought it would come to that. At the last minute, they thought someone would come in and save them but reimbursement rates have been terrible . . . St. John's was what was considered valuable real estate, but nothing's happened with it. (Connie, RN)

> It's like a rat race. You drop your patient off, you give report, you put orders in, and you're running to see your next patient . . . I've noticed our volume has increased. Long Beach Medical Center closed because of Hurricane Sandy. It was destroyed. With that closing, we saw a jump in volume, which of course [management] loves because it's a business. However, doing that number of

> cases means longer days. They need to make changes, which I don't see happening as quickly. They need to hire more operating room nurses. That's not happening. . . . There's fewer hospitals, the amount of people hasn't changed, so of course the numbers are going to go up. And of course workload, stress load—if I was to say, are the OR nurses happy? Not at all. There's a lot of grumblings. (Sandra, Certified Registered Nurse Anesthetist)

Connie's and Sandra's stories demonstrate my argument: Through the case study of New York City's health care system, I argue that spaces, turnover, and investment in the built environment are essential to social reproduction. When hospitals close—when the spaces of work and health care provisioning go away—nurses lose jobs, workload increases, and patients lose access to care. In other words, the life's work of social reproduction not only makes the built environment but also depends on the built environment to happen. Systemic hospital closures could not happen without a restructuring of both the nursing workforce and the health care provision landscape. At the same time, the persistent devaluation of nursing work, in terms of stagnant wages and increased workload in the past four decades, enables these closures. Together, each of these restructurings reflect broader global political economic dynamics, specifically the persistent subordination of reproductive processes to productive ones (see Federici 2004). Finally, these restructurings illustrate the mutual constitution of the built environment, health care provisioning, and nursing employment.

Health is particularly apt for making this claim. Health is more than a single aspect of social reproduction or a lens for analysis. It is the most special element of social reproduction. Social reproduction does not happen if people cannot lead healthy lives, do not have health care workers to help them deliver babies and nurse them back to good health, and do not live in healthy environments. In fact, struggles over health have been central to feminist and anticapitalist resistance more broadly (Loyd 2014). A lack of good health threatens social reproduction, both biological and in everyday life. Because it involves both the reproduction of the population and the production of new commodities (e.g., pharmaceuticals), health demonstrates the fraught binary of production and reproduction (Fannin 2003; Armstrong and Armstrong 2005; McDowell 2009; Jackson and Neely 2015). Nursing is a complicated form of social reproductive work, as it brings together the skilled practice of health care and the nurturing, relational side of social reproduction. It also touches on all three aspects of social reproduction. Nurses deliver babies and help repair workers while also serving as the "backbone of the entire healthcare system" (Henry 2015, 166).

In what follows, I outline each of the three ongoing restructurings in New York's health care system. I show how each process is unfolding and the role each plays in the other two restructurings. Through these restructurings I illustrate the missing link between these two approaches to social reproduction.

Restructuring Space

The first restructuring is spatial. In this process, the built environment itself is restructured, with large spaces opened up for reinvestment and redevelopment. Hospital closures follow a common pattern. After the facility closes, it sits empty, often trading hands of buyers or sitting in bankruptcy court. This dormancy can last a year or two, as in the case of St. Vincent's (Hughes 2013). It also can last many years, such as Parkway in Queens, which closed in 2008, or St. Mary's in Brooklyn, which closed in 2005, both of which only began redevelopment in 2014 (Brownstoner 2014; Budin 2014). Often, a property bounces from one owner to another, and maybe to another, until finally, someone buys it for a considerably higher price than the original buyer paid.

At least ten of the former hospitals have become housing—a few at market rate and rental but mostly higher-end condominiums. For example, St. Vincent's will be home to designers and celebrities when construction finishes (Hughes 2013). Other sites continue to provide medical services. St. Mary's will become a nursing home (Brownstoner 2014). Two sites have become drug treatment facilities or outpatient clinics (Berger Commission 2006; Mogul 2013). Residences, though, are the most common form of redevelopment. In this turnover process, the line between productive and reproductive is constantly blurred, as hospital sites move between these two spheres. For example, the hospital property as hospital is a designated space of social reproductive infrastructure. On closing, it goes on the market as real estate and then a space for reinvestment via construction (read: productive). Finally, as in most cases, it becomes housing, falling back into use as part of the social reproductive infrastructure. Recall the case of St. John's in Queens that Connie spoke of earlier. After closing in 2008, the building sat empty on a main street in Queens until a third owner finally began to redevelop it into mixed residential and retail space in late 2013.

These are enormous properties with particular types of buildings that are expensive to tear down or convert, and theories of property transaction could explain the long turnover times. In this article, I am concerned for what this turnover and redevelopment means for the work that happens in these spaces. The built environment—the physical spaces in which industry operates, workers earn wages, and people receive care—is deeply implicated in this and the other two restructuring processes I address next. Through hospital closures, though, the built environment can turn over. The closures open up large plots of potentially profitable land for reinvestment in productive industries or for new investments in the social reproduction infrastructure, as I outlined in the hospital–real estate–housing process earlier. The devaluation of the built environment frees up that space for reinvestment, and an abandoned hospital is an ideal site for "renewed accumulation" (Harvey 1978, 116). It occupies a large piece of property, and the building itself retains a use value as a potential new hospital or other large facility. Furthermore, letting it sit vacant manipulates property values—both devaluing the property (Smith 1979) and enabling renewed accumulation through, quite often, high-end condominiums.

Restructuring Industry

The second restructuring involves the health care industry and the ways in which patients receive health care services. Broadly speaking, hospitals close and services are centralized to larger hospitals with larger catchment areas. In some areas, UCCs have been opening to fill the care deficits left behind.

As I mentioned earlier, New York State formed the Berger Commission in the mid-2000s to review and offer recommendations for improving the state's acute and long-term care services. The Commission included lawyers, business owners, consultants, marketing experts, health care administrators, and a bishop, but no labor representatives. It recognized that health care services were wildly uneven, with minimal to no services in some areas and "excess" and "unnecessary duplication of services" in others (Berger Commission 2006, 1). The Commission, therefore, aimed to "rightsize" the system across the state. As the report states,

> The Commission reaches a stark and basic conclusion: our state's health care system is broken and in need of fundamental repairs. Today, New York is struggling to maintain a 20th century institutional infrastructure in the face of mounting costs, excess capacity, and unmet needs for community-based alternatives. . . . Absent intervention, the Commission believes that the future of our state's health care system is bleak. Unless we act decisively, further facility closures and bankruptcies are almost certain to occur. Moreover, the facilities that close due to market forces alone may be the ones most critical to preserving access. Without intervention, our providers will spiral further into debt and be forced to make difficult decisions to cut services and lay off workers. (Berger Commission 2006, 4)

Solving these problems, the Commission argued, "[would] require difficult, perhaps unpopular decisions and strong leadership from our elected officials and others" (6). The Commission argued that New Yorkers "cannot deny our reality" and "must overcome our reliance on outdated institutions" to "demand a 21st century health system that is more flexible, leaner, stronger, and more affordable than the one we have today" (6).

The Commission recommended shrinking the entire New York metropolitan hospital and long-term care system, closing or downsizing twelve hospitals in the city and an additional two in surrounding counties (Berger Commission 2006). The rightsizing would save the state's health care system considerable money. As the report argues,

> The closure of a facility has many advantages including the removal of fixed operating costs, forgone capital expenses, elimination of duplicative services within the market, increased efficiency at remaining institutions and opportunities for lease, sale or conversion of the facility's property. . . . Additional savings are realized by forgoing renovations on aged physical plants. . . . Furthermore, the benefits of these eliminated costs accrue indefinitely. (59–60)

Not only is money saved through simply closing, but it is also saved and recouped through selling the property. Furthermore, this "elimination of systemic redundancies could save money without compromising access to care" (Berger Commission 2006, 57). A strong argument can be made that two specialty cancer hospitals in Brooklyn is financially inefficient for meeting overall health care needs. Yet, these are not the redundancies that the Berger Commission's recommendations address. Most of the recommended closures and rightsizings involve full-service community hospitals, predominantly in middle- to lower class neighborhoods in underserved Queens and Brooklyn.

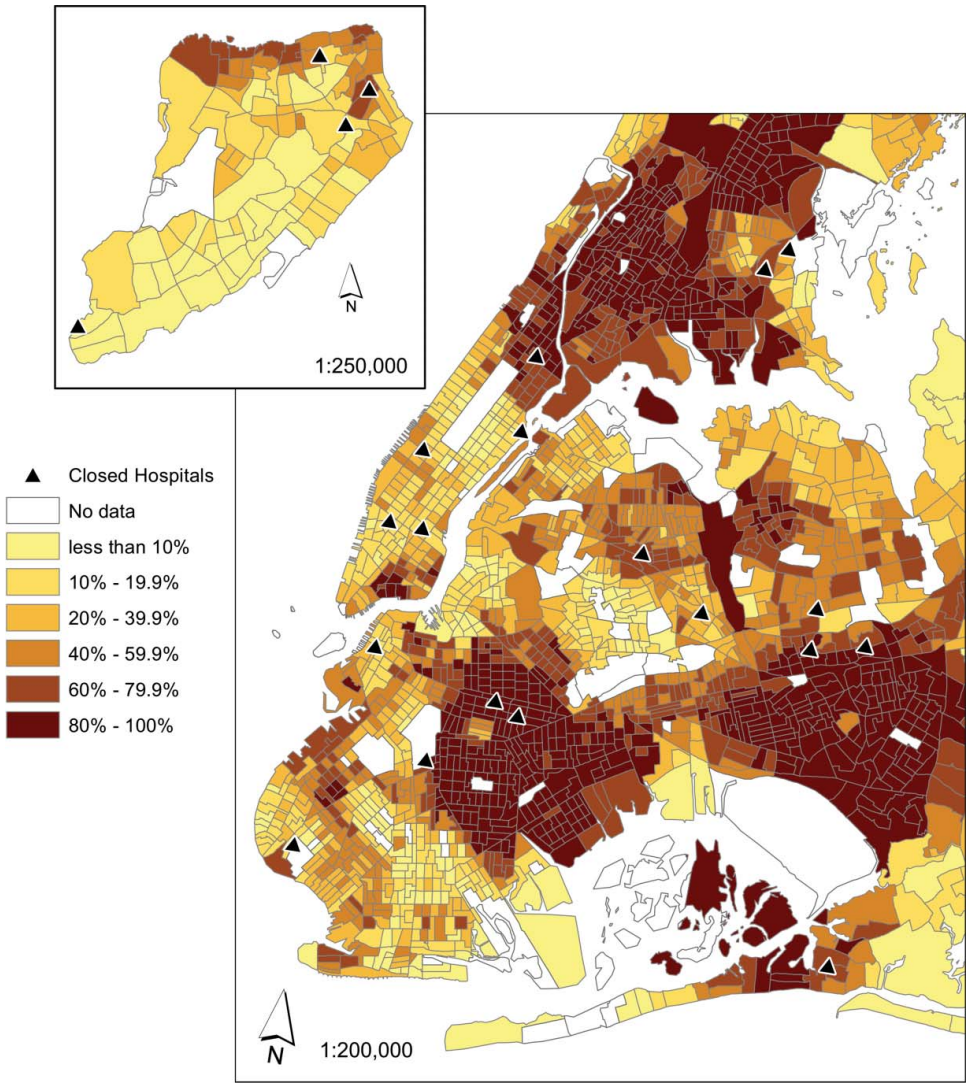

Figure 1. Hospital closures and residents of color by census tract (2010). *Source*: U.S. Census Bureau (2010); New York Department of Health (n.d.). (Color figure available online.)

Community hospitals, which provide emergency and other basic health care services, are not "redundant" services. The Commission acknowledged that the market is disproportionately affecting "the [facilities] most critical to preserving access," but many of its recommendations downsize or close these very hospitals.

These recommendations do compromise access to care. Both the recommendations and the actual closures predominantly involve community hospitals in the most populous parts of the city—areas that are also gentrifying and have populations of predominantly people of color. As Figure 1 shows, fourteen hospitals have closed in or near neighborhoods of at least 60 percent residents of color. Gentrification tells a similar story of dispossession (see Figures 2 and 3); overall, the city is becoming wealthier, and hospitals have closed in the areas with the greatest increase in wealth since 2000—midtown Manhattan, central Brooklyn, western Queens, and northern Staten Island. Poorer residents are doubly dispossessed, forced from their neighborhoods via gentrification and losing health care through hospital closures.

Furthermore, many of the now-closed hospitals were not in the recommendations but have helped accomplish the Commission's goals. The distribution of recommended "rightsizings" would have resulted in a similar loss of beds per borough. The 2008 fiscal crisis came at a convenient moment for politicians who were advocating the closures. Rather than using government mandates, the state could just let facilities close under the rhetoric of austerity and tough financial times. As St. Vincent's closed in 2010, the state

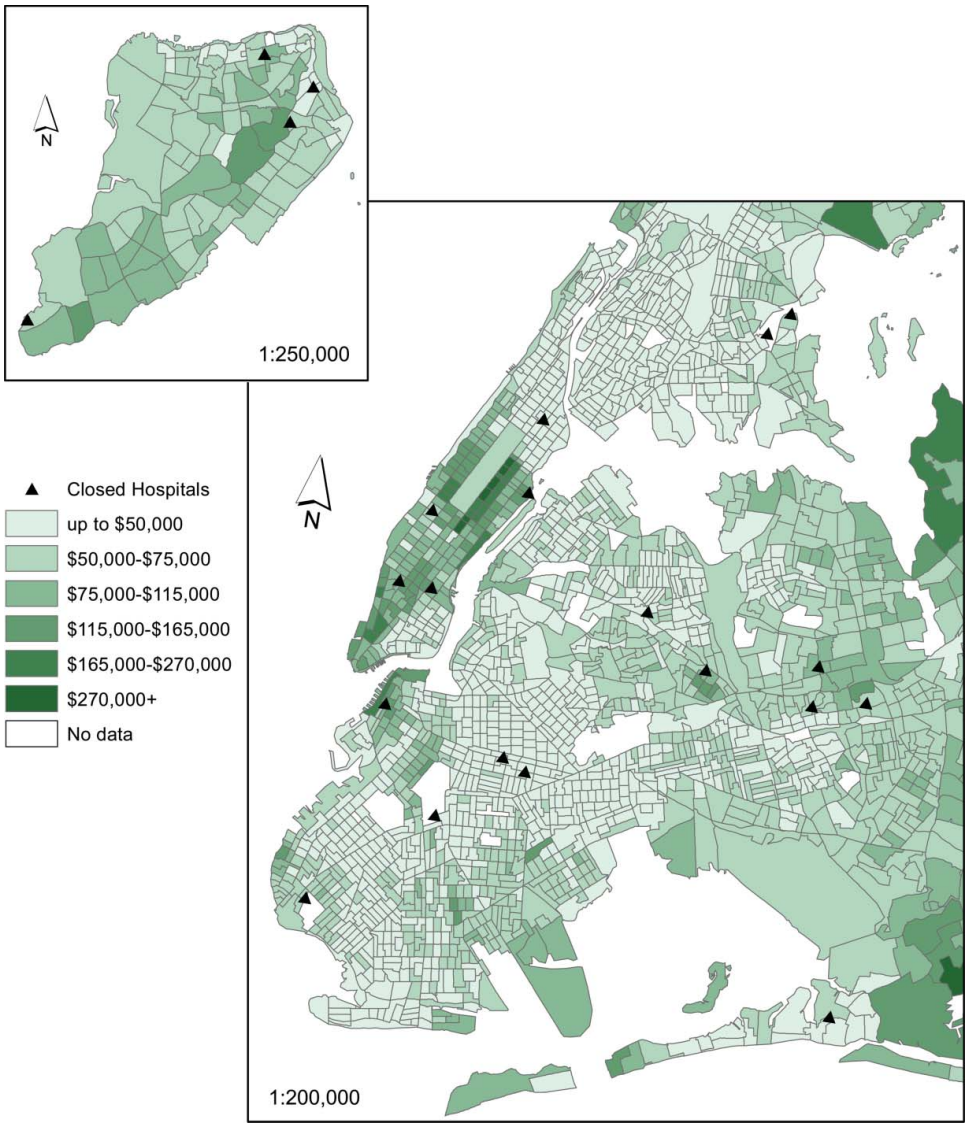

Figure 2. Hospital closures and household income by census tract (2000). *Source:* U.S. Census Bureau (2010); New York Department of Health (n.d.). (Color figure available online.)

health commissioner's spokesperson explained that "there is just not enough money anywhere given the state's finances to allow it to keep this hospital going, or any hospital in a similar situation" (Hartocollis 2010).

At its foundation, the Berger Commission's analysis ignores the daily and intimate work of social reproduction. This is not entirely surprising given the absence of labor on the Commission. For example, the Commission ran models to see whether surrounding hospitals could absorb patients from facilities proposed for closures. This model measured a facility's feasibility as an alternative service site by testing travel times from residence to hospital for people in the new catchment areas (Berger Commision 2006). A closure was acceptable if patients could reach the new hospital in a comparable time to their current facility and if the new facility was able to accept an increased capacity (all determined by the number of vacant beds). The model does not address workload or staffing levels to deal with more patients, and it assumes operating always at full census, leaving no flexibility in patient load or cushion for times of high need. In interviews, nurses complained of heavy workloads. When they have fewer patients, the day is easier, and they can provide better care, but, most often, nurses are overworked and understaffed. They strive to meet the needs of their patients but are often only able to do so by sacrificing their own

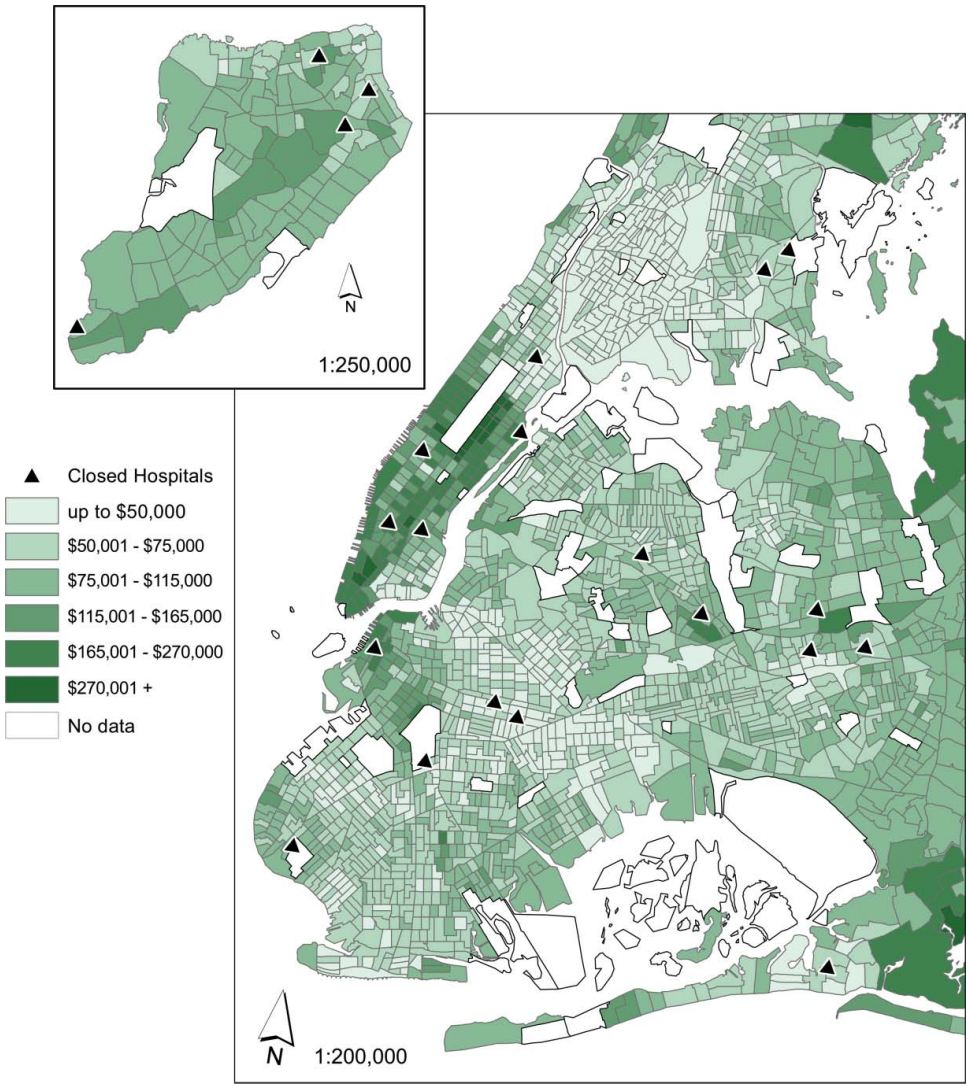

Figure 3. Hospital closures and household income by census tract (2010). *Source*: U.S. Census Bureau (2011); New York Department of Health (n.d.). (Color figure available online.)

well-being and the overall quality of care. This means cutting corners on the emotional labor—the conversations with patients, small observations, eye contact—and working for nearly twelve hours straight. In interviews, nurses explained they have little time for bathroom breaks, often do not eat or drink anything over their twelve-hour shifts, and so the quality of care suffers.

> The patient to nurse ratios can get very unsafe . . . the quality of the care is less. You're rushing around. Someone simply asks you for a cup of water and you never get it for them because you totally forget. And who is going to get them a cup of water when there are people needing medication anyway. It would be nice to not have to run around like that and have enough nurses to be able to address what these people actually need, even if it is just a cup of water. (Hannah)

> You don't have time because of your workload. If you have a high acuity patient in one room, you can't tell your other patient, "Well I can't be with you because of this other patient." But sometimes the other patient is more important or they need more care, so staffing affects quality of care. (Krista)

Furthermore, hospitals run on staffing levels worked out by human resources departments and executives that aim to run as financially efficiently as possible, and nurses know that increasing staff is an often arduous process. As Donna explained, when staffing was an issue at her previous job,

> [The administration] didn't keep up with the volume and give approval for staffing increase in time. By the time they would finally get an increase census would have changed again. It was such a slow process to prove that you need more staff … you never really had what you needed … you never felt like you were ahead of the game.

Staffing needs and staffing allotment are a challenging match to make.

Finally, the Berger Commission (2006, 73–75, in particular) suggested a new means of health care service delivery. Repeatedly and vaguely, it pushes for more home- and community-based alternatives to nursing home placements and hospital services. This prompts a few questions: What is both less expensive and more efficient about home-based care? What exactly are community-based alternatives? Are community hospitals not community-based services? Although the Commission is not specific as to what it means by "community-based alternatives," UCCs are perhaps one of these alternatives.

UCCs first began appearing in the United States in the 1970s, but numbers have grown rapidly in the past ten years. According to the Urgent Care Association of America (n.d.), UCCs are increasing by more than 300 facilities per year, and more than 9,000 UCCs exist nationwide. A UCC is like an emergency room without the trauma center, treating many patients quickly for about $155 per visit (Creswell 2014). UCCs in New York are almost impossible to comprehensively track, and anywhere from twenty-five to hundreds operate in the city (New York Department of Health 2013b). There is significant evidence, however, that they are on the rise in the city. Besides their growth nationwide, nurses in interviews frequently referenced them as helping to alleviate ER traffic and as a replacement for family care doctors. Jane discussed their increasing popularity:

> In the past year, there's been such a crazy inundation of those—I call them Doc-in-the-Box—those stat-med, first-med places, and I feel that's helping to decompress the ER as well. If people used the ER for what it was intended for there would definitely be a lot less wait. It would be a lot quicker of a system, you know, a lot more streamlined.

Additionally, UCCs are a pacification strategy, as politicians and redevelopers have tried to calm resistant communities by promising to replace hospitals with UCCs (Goldberg 2014b).

UCCs are not meeting needs, though. Nationally, hospital corporations, insurance companies, and finance companies most commonly own UCCs; they are also of interest to private equity investment firms (Creswell 2014). Although UCCs might be convenient for many patients needing quick but nonemergency care and fill some of the care deficit left by a shortage of primary care physicians, their lack of regulation across the country has implications for who can actually access their care. Because most do not accept Medicare and Medicaid, they are free to refuse services to those without private insurance (Creswell 2014). Therefore, UCCs are limited not only by the scope of their services, but by also being private and for-profit, they limit who can access the care. In New York, with the shift from hospitals to UCCs, the for-profit health sector is growing. All hospitals in the city are either public or nonprofit hospitals. Very few for-profit facilities survived the closures of the 1960s through the 1980s (see McLafferty 1982). UCCs present a new opportunity for private, for-profit health care corporations to enter the city's market. Thus, UCCs do not fill gaps left behind by closed community hospitals; rather, they can create a more uneven geography of health care services.

Restructuring Labor

The third restructuring process deals with labor—a restructuring of the nursing workforce. In many ways over the past forty years, nursing is and has become a more stable and accessible job, particularly for those against whom the profession has historically discriminated. Although union membership rates have been in decline in the United States since the 1970s, nursing has seen significant growth in unionization recently. Unionization nurtured its roots in labor strongholds like California and New York, but in recent years, unions have successfully organized in places as politically far and wide as Illinois, Missouri, Pennsylvania, and Texas. Currently, over 20 percent of U.S. nurses are unionized, and most of that unionization has happened since the late 1980s (Cobb 2010; Spetz et al. 2010). New York has some of the oldest, largest, and increasingly powerful nursing unions in the country, and nearly all of the nurses I interviewed are or had been union members in at least one job over their careers. Unionization has real impacts for nurses at work. As Jocelyn explained, unionized nurses have a greater voice in hospitals.

> Hospitals that are doctor-driven, the nurse has no say. Like a nurse is not supposed to take any verbal orders. Everything has to be written. And at doctor-driven hospitals, the doctors give you verbal orders and you have no choice. And if something goes wrong, it's your word against the doctor. So you know who's going to win. It'll be the doctor. But in other hospitals, where it's union, the nurse has a voice.

Certainly, part of this unionization success has been thanks to the cycles of nursing shortages in the late 1980s and late 1990s into the 2000s. With the recession and increased hospital closures, the nurse shortage became a job shortage. Hospitals had less money and fewer facilities existed to hire nurses, making closures central to this shift in labor supply. As Harvey (1978) explained, "The greater the labor surplus and the more rapid its rate of expansion, the easier it is for capital to control the struggle in the workplace" (125). This does not clarify why unions are still successfully organizing under the current conditions of job shortage; to understand those successes, we must consider nurses' struggles over working conditions and quality of patient care. But Harvey's argument does point to why unions and communities have been so unsuccessful in preventing hospital closures. The end of the nurse shortage and the start of closures coincide in the early to mid-2000s. Closures are union busting by another means. They are part of capital's response to nursing's increased leverage—a way to control the job market and to thus control the labor supply. Indeed, it is telling that NYSNA, the largest nurse union in New York State, has been leading the fight against closures. The spaces of employment are key to the labor struggle for nurses, whether the issue is unionization or the existence of jobs, as nursing cannot be automated or outsourced.

The first two restructuring processes are instrumental in the changes to the spatiality of nurse employment. Hospitals are the main employer of registered nurses (RNs). Federal law only requires that long-term care facilities have eight hours of RN coverage per twenty-four-hour period, and these facilities staff mostly with licensed practical nurses (LPN) and assistants. UCCs, doctors' offices, and other clinics also rely primarily on techs or medical assistants and nurse practitioners (NPs), although they do use some RNs. Nurse practitioner, according to the Bureau of Labor Statistics (2012, 2014), is one of the fastest growing occupations, expected to grow by 34 percent by 2022. New York State has the highest number of NPs in the United States, and the New York metropolitan region has the highest employment level of NPs of any metropolitan region in the country (Bureau of Labor Statistics 2014). In interviews, over half of the nurses expressed interest in or were already pursuing an NP degree. There is a trend in the profession to skill up.

Health care facilities are also using fewer RNs overall to save money (Weinberg 2003). Early in her career, Krista worked in nursing homes and eventually moved to a hospital in Brooklyn; she has watched staffing change over her career.

> Ten years ago, a lot of RNs were working in the nursing homes. It's not so right now. It's more Licensed Practical Nurses. Because they had LPNs in the hospital and there's less LPNs now in the hospital. The thing now is to have just RNs in the hospitals.

Similarly, Jocelyn explained the geography of the nursing hierarchy.

> If you go to a private doctor's office, there's no nurses there. If you go to these urgent care centers that are popping up everywhere, there's no nurses there. It's doctors and medical assistants, okay? Now in the hospitals, they have regulations so you have to have nurses in these clinics. . . . You will see nurse practitioners in the private doctors, but you will not see RNs.

The type of health care facility thus directly relates to who works there.

Additionally, as nursing has professionalized, RNs have taken on more managerial roles and emphasized the technical and higher skilled aspects of their work. Aides and technicians, who earn two thirds less than RNs, perform the less-skilled and more intimate bodily tasks (see Weinberg [2003] for an excellent ethnography of this change; Bureau of Labor Statistics 2012). Furthermore, employers increasingly require nurses to have a bachelor's degree, whereas until recently, registered nursing never required a four-year degree (Perez-Pena 2012). Jocelyn's employer, for example, recently began to require RNs to have a bachelor's degree:

> When I graduated, you didn't even need a bachelor's; all you needed was an associate. I had to go back to school if I wanted to stay in my job. I think in a few years it's going to be the same thing. They're gonna want nurses to be nurse practitioners, and we'll have to go back to school. It's the trend that I'm seeing.

Nursing, then, is changing in ways that involve education, training, and space. Fewer employment spaces for RNs exist, both RNs and NPs are becoming more difficult to obtain, and the health care industry is relying increasingly on technicians and aides to perform

the work RNs used to do. This changing geography of services has impacts on the nursing hierarchy that are reminiscent of its history of segregation. Although nursing has been a stable and respectable job for women, as a middle-class profession, it has been an unobtainable profession for many (Reverby 1987; Duffy 2010). Nursing's history is one of a racialized and classed hierarchy that protected the most prestigious positions of RNs for white women of middle-class background (Reverby 1987; Clark Hine 1989; Glenn 1992). From the late nineteenth century into the postwar era, most nurses were white, middle-class women—women who supposedly embodied "natural" qualities of moral, clean, and nurturing women. As women of color began to enter nursing, a skill hierarchy segregated the profession. RNs were almost exclusively white and middle-class women, whereas the less educated LPNs and nurses' aides or technicians were women of color and of lower class. The legacy of this racialized, classed hierarchy still exists, but in recent decades, registered nursing has become more diverse, more closely reflecting national demographics (Bureau of Labor Statistics 2013). Presently, a bifurcation of the nursing workforce is beginning, built on nursing's historical and racialized hierarchy. One stream of nursing is increasingly high-skilled, highly trained, and well paid, whereas the other is low-skilled, requires much less education, and is poorly paid. The restructuring of the spaces of employment—the places where patients receive care and nurses go to work—facilitates this process, because some work spaces favor RNs, whereas others favor technicians, and still others NPs. The workforce begins to match the "revolutionized" landscape.

Conclusion: For Good Health and Good Jobs

This article has shown how the three restructuring processes are intertwined. Changes to the built environment affect service delivery and the geography of the job market. Changes in the delivery of health care services shape what spaces and workers are needed. Changes to the nursing job market impact service delivery and the landscape that provides those services. These restructurings have the potential to make health care increasingly inaccessible in two ways.

First, the uneven geography of health risks is becoming more uneven. Fiona, a nurse for more than fifty years, has seen a lifetime of changes. She explains the care deficit in Rockaway, a peninsula community in Queens. Only one hospital remains for Rockaway's nearly 120,000 residents, a third of whom receive public assistance (New York City Department of City Planning 2014). She explained that neighborhood health care is in crisis:

> As far as the community is concerned, we have a problem. My husband had a situation about a year ago, and we had to call 911. The paramedics say they were taking him to St. John's [Episcopal]. Peninsula was closed already. I'm not taking him to St. John's. So they suggest Beth Israel, but I know these hospitals, and they *mean* Kings Highway in Brooklyn [owned by Mount Sinai-Beth Israel Hospital System] . . . It's even worse! But those are issues that the everyday family deals with. They wouldn't know what I would know. . . . If I wasn't there, who knows what would have happened. That's the scary part of getting sick when you live in Rockaway. And that's just one community!

In Brooklyn, Krista expressed personal and professional concern over the many hospitals that have closed.

> It becomes kind of tight finding jobs and doing overtime or anything like that. They closed a few hospitals in Brooklyn a few years ago and a lot of nurses and other staff came to Downstate Medical Center and they were accommodated. But you know, LICH, that was my hospital. I prefer to go to LICH. My pediatrician is at LICH. My OB-GYN is at LICH. I don't want it to close. I don't think hospitals should close. People get sick. People are always gonna be born. They're gonna get sick. They're gonna need a checkup.

Fiona's and Krista's stories demonstrate how hospital closures are implicated in the uneven geography of health care provisioning. Renaming a facility via buyout or merger might obscure poor quality of care. Fewer facilities means longer travel times to services. Patients less familiar with the health care system or without a strong advocate are at a serious disadvantage. Fewer hospitals mean fewer job opportunities for RNs. When hospitals close, people have reduced access to health care services, and communities lose jobs and a social and economic anchor. Neighborhoods are in crisis.

Second, nursing is changing and can become less accessible through a restructuring of the profession. Nursing is becoming either a harder job to attain (e.g., as an NP or RN) or is becoming a lower skilled, lower paid job (in the technician or aide), which means the loss of a stable job opportunity for women.

Furthermore, nursing's segregated history provides a useful lesson. A new era is beginning in which the very nature of nursing is changing and potentially regressing along a racialized, classed, and gendered hierarchy. Although nursing is not exclusively "women's work," there is something important to hold onto in a job that has been a source of secure livelihoods for women for so long—especially when it is becoming a better job through increased unionization, better pay, more attention to safer staffing levels, and more accessible to low-income women and women of color. This threat is intimately connected to the built environment and processes of accumulation. Hospital closures are the mechanism that can make this happen; having fewer spaces where RNs work can mean fewer good jobs. Furthermore, as the stories from Fiona and Krista also remind us, nurses are city residents, too. They need health care and jobs to reproduce themselves. Not only are communities threatened by closures, but so is nurses' ability to socially reproduce themselves and their families. Thus, a health care system is at risk.

U.S. health care is in a time of transition. With the ACA and the aging population, new care needs are emerging and met in new ways, and this is neither the first time nursing or the built environment has revolutionized nor the first crisis of U.S. health care. The built environment reinvents itself through devaluation roughly every twenty years (Harvey 1978). The development and subsequent decline of hospitals maps onto these cycles, from the birth of the hospital in the late nineteenth century to their expansion in the 1920s and later in the postwar era and then to the beginning of their decline in the 1970s (Rosenberg 1979). Between 1967 and 1986 New York City lost 37 percent of its hospitals (McLafferty 1982). This was another period of "openly articulated state government policy of 'shrinking the system'" (Pomrinse 1983, 575); that is, other moments of revolutionizing the social reproductive health landscape.

What is particular about this cycle of crisis is the starting point. Arguably, health care is at a worse point than it was in the previous wave of hospital closures. Even though the ACA is expanding health insurance coverage for millions of Americans, spiraling costs, growing economic inequalities, and the uneven geography of health care services mean that the ACA is a small piece of a giant messy puzzle. Conditions in New York City are stark; the Brookings Institute lists the city as having the sixth highest rate of inequality in the country (Berube 2014). Indeed, New York witnessed the birth of the Occupy Movement in response to inequality and the 2008 recession; the new mayor successfully ran on a campaign to fight growing socioeconomic polarization.

These three restructurings demonstrate the importance of the built environment to the work and practice of social reproduction. Hospital closures—as a phenomenon that is spatial, industrial, professional, and social—represent the contradictions of social reproduction, from its devaluation to the inequalities in access to health. This case study highlights the ways in which health care, work, and spatial restructurings are mutually constituted. As production's other, health as social reproduction is more vulnerable to devaluation and also disappearing. If capitalists have little incentive to invest in the social reproductive built environment, investing in social reproductive health care labor is similarly unappealing. As the ripples of hospital closures show, the restructuring of social reproductive work and services (i.e., health) is part and parcel of the construction of the built environment and risks remaking the landscape into one where good health and good jobs are less accessible.

Acknowledgments

Thank you to Rachel Silvey, Emily Gilbert, Raj Reddy, three anonymous reviewers, and the participants and organizers in the "Gendering Capital, Gendering Crisis" sessions at AAG 2014 for input on previous drafts. Much gratitude also goes to the nurses who participated in this research.

Note

1. The analysis begins in 2003—the year when hospitals began to close in significant numbers in New York City. The first three years saw eight hospitals close in the city, and an additional four closed in the surrounding counties. I focus primarily within the boundaries of the city but pay attention to the surrounding counties: Nassau and Suffolk Counties on Long Island and Westchester, Putnam, and Rockland Counties directly to the north of the city.

References

Armstrong, P., and H. Armstrong. 2005. Public and private: Implications for care work. *Sociological Review* 53 (2): 167–87.

Baker, D., J. A. Gazmararian, M. Williams, T. Scott, R. Parker, D. Green, J. Ren, and J. Peel. 2002. Functional health literacy and the risk of hospital admission among Medicare Managed Care enrollees. *American Journal of Public Health* 92 (8): 1278–83.

Bazzoli, G., W. Lee, H. Hsieh, and L. R. Mobley. 2012. The effects of safety net hospital closures and conversions on patient travel distance to hospital services. *Health Services Research* 47 (1): 129–50.

Berger Commission. 2006. *A plan to stabilize and strengthen New York's health care system: Final report of the Commission on Health Care Facilities in the 21st Century*. http://www.nyhealthcarecommission.org/final_report.htm (last accessed 16 June 2014).

Berube, A. 2014. *All cities are not created equal*. Washington, DC: Brookings Institute Report for the Metropolitan Opportunity Series. http://www.brookings.edu/research/papers/2014/02/cities-unequal-berube (last accessed 20 June 2014).

Bindman, A., D. Keane, and N. Lurie. 1990. A public hospital closes: Impact on patients' access to care and health status. *Journal of the American Medical Association* 264 (22): 2899–904.

Blavin, F., L. Blumberg, and M. Buettgens. 2013. Uninsured New Yorkers after full implementation of the Affordable Care Act: Source of health insurance coverage by individual characteristics and sub-state geographical area. Report for The Urban Institute Health Policy Center. http://www.urban.org/UploadedPDF/412746-Uninsured-New-Yorkers-After-Full-Implementation-of-the-Affordable-Care-Act.pdf (last accessed 10 June 2014).

Brownstoner. 2014. Shuttered Crown Heights hospital will not become condos. *Brownstoner* 12 March. http://www.brownstoner.com/blog/2014/03/shuttered-crown-heights-hospital-will-not-become-condos/ (last accessed 17 June 2014).

Buchmueller, T., M. Jacobson, and C. Wold. 2006. How far to the hospital? The effect of hospital closures on access to care. *Journal of Health Economics* 25:740–61.

Budin, J. 2014. Decaying Parkway Hospital will be converted to condos. *Curbed NY* 8 May. http://ny.curbed.com/archives/2014/05/08/decaying_parkway_hospital_will_be_converted_to_condos.php (last accessed 17 June 2014).

Buerhaus, P., D. Auerbach, and D. Staiger. 2009. The recent surge in nurse employment: Causes and implications. *Health Affairs* 28 (4): w654–w668.

Bureau of Labor Statistics. 2012. Economic news release: Occupational employment and wages, May 2012. http://www.bls.gov/news.release/ocwage.htm (last accessed 17 June 2014).

———. 2013. Labor force characteristics by race and ethnicity, 2012. http://www.bls.gov/cps/cpsrace2012.pdf (last accessed 19 August 2014).

———. 2014. Job outlook: Nurse anesthetists, nurse midwives, and nurse practitioners. http://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm (last accessed 20 June 2014).

Cadogan, M. A., A. Bachrach, A. M. Diop, J. R. Bailey, and C. Brellochs. 2010. *Connecting New York City's uninsured to coverage: A collaborative approach to reaching residents eligible for public health insurance but not enrolled*. New York: NYC Human Resources Administration Office of Citywide Health Insurance Access.

Clark Hine, D. 1989. *Black women in white: Racial conflict and cooperation in the nursing profession, 1890–1950*. Bloomington: Indiana University Press.

Cobb, D. S. 2010. More intimate unions. In *Intimate labors: Cultures, technologies, and the politics of care*, ed. R. S. Parrenas and E. Boris, 280–96. Stanford, CA: Stanford University Press.

Creswell, J. 2014. Race is on to profit from rise of urgent care. *New York Times* 9 July:A1.

Cunningham, P., and P Kemper. 1998. Ability to obtain medical care for the uninsured. *Journal of the American Medical Association* 280 (10): 921–27.

Dall, T. 2007. What is behind HRSA's projected U.S. supply, demand, and shortage of registered nurses? In *Modelling our future: Population ageing, health and aged care* (International Symposia in Economic Theory and Econometrics, Vol. 16), ed. A. Harding, 343–74. Bristol, UK: Emerald.

Dinallo. E. R. 2009. Press release: State report demonstrates cost of deregulation of health insurance premiums. New York State Insurance Department, 8 June. http://www.dfs.ny.gov/insurance/press/2009/p0906081.htm (last accessed 17 June 2014).

Duffy, M. 2010. *Making care count: A century of gender, race, and paid care work*. Piscataway, NJ: Rutgers University Press.

Einhorn, E., S. Kadinsky, and S. Goldsmith. 2009. Councilman Eric Gioia rips hospital closings in Queens. *New York Daily News* 2 March. http://www.nydailynews.com/new-york/queens/councilman-eric-gioia-rips-hospital-closings-queens-article-1.367889 (last accessed 2 February 2015).

England, K., and V. Lawson. 2005. Feminist analyses of work: Rethinking the boundaries, gendering, and spatiality of work. In *Companion to feminist geography*, ed. L. Nelson and J. Seager, 77–92. London: Blackwell.

Evans, K. 2008. Nursing shortage eases with recession's help. *Wall Street Journal* 12 June. http://online.wsj.com/article/SB124477098713308767.html?mod=googlenews_ws j (last accessed 20 June 2014).

Fannin, M. 2003. Domesticating birth in the hospital: "Family-centered" birth and the emergence of "homelike" birthing rooms. *Antipode* 35 (3): 513–35.

Federici, S. 2004. *Caliban and the witch: Women, the body, and primitive accumulation*. New York: Autonomedia.

Ford, R. 2013. Diagnosing Brooklyn's hospital crisis. *Brooklyn Bureau* 2 August. http://www.bkbureau.org/2013/08/02/diagnosing-brooklyns-hospital-crisis/ (last accessed 5 June 2014).

Frost, M. 2013. Crain's health care symposium asks: "Can Brooklyn be cured?" *Brooklyn Daily Eagle* 24 October. http://www.brooklyneagle.com/articles/crain%E2%80%99s-health-care-symposium-asks-can-brooklyn-be-cured-2013-10-25-010000 (last accessed 18 June 2014).

———. 2014. Brooklyn judge rules against first-place bidder for Long Island College Hospital. *Brooklyn Daily Eagle* 13 May. http://www.brooklyneagle.com/articles/brooklyn-

judge-rules-against-first-place-bidder-long-island-college-hospital-2014-05-13 (last accessed 17 June 2014).

Glenn, E. N. 1992. From servitude to service work: Historical continuities in the racial division of paid reproductive labor. *Signs* 18 (1): 1–43.

Goldberg, D. 2014a. Interfaith set to come out of bankruptcy a changed hospital. *Capital New York* 19 May. http://www.capitalnewyork.com/article/city-hall/2014/05/8545551/interfaith-set-come-out-bankruptcy-changed-hospital (last accessed 18 June 2014).

———. 2014b. SUNY ready to "move on" to next LICH bidder. *Capital New York* 29 April. http://www.capitalnewyork.com/article/city-hall/2014/04/8544470/suny-ready-move-next-lich-bidder (last accessed 18 June 2014).

Hanson, S., and G. Pratt. 1991. Job search and the occupational segregation of women. *Annals of the Association of American Geographers* 81 (2): 229–53.

Hartocollis, A. 2010. 3,500 at St. Vincent's get termination notices. *New York Times* 12 April. http://www.nytimes.com/2010/04/13/nyregion/13vincent.html?_r=0&partner=rss&emc=rss&pagewanted=print (last accessed 18 June 2014).

———. 2013. Nurses roam empty halls as Long Island College Hospital is prepared to close. *New York Times* 18 July. http://www.nytimes.com/2013/07/19/nyregion/State-Prepares-Long-Island-College-Hospital-for-Its-Closing.html?_r=0&pagewanted=print (last accessed 15 June 2014).

Harvey, D. 1978. The urban process under capitalism: A framework for analysis. *International Journal of Urban and Regional Research* 2 (1–4): 101–31.

———. 2010. *The enigma of capital and the crises of capitalism*. New York: Oxford University Press.

———. 2014. *Seventeen contradictions and the end of capitalism*. New York: Oxford University Press.

Henry, C. 2015. Time and the social reproduction of American health care. *Women Studies International Forum* 48:165–73.

Hughes, C. J. 2013. Where St. Vincent's once stood. *New York Times* 25 October. http://www.nytimes.com/2013/10/27/realestate/where-st-vincents-once-stood.html?ref=stvincentshospitalmanhattan&pagewanted=print (last accessed 18 June 2014).

Jackson, P., and A. Neely. 2015. Triangulating health: Toward a practice of a political ecology of health. *Progress in Human Geography* 39:47–64.

Kaiser Family Foundation. n.d. Medicaid enrollment as a percentage of total population, FY2010. http://kff.org/medicaid/state-indicator/medicaid-enrollment-as-a-of-pop/ (last accessed 17 June 2014).

Katz, C. 2001. Vagabond capitalism and the necessity of social reproduction. *Antipode* 33 (4): 709–28.

Keep Brooklyn Hospitals Open for Care. n.d. Funeral march and rally to save Interfaith and LICH. https://www.facebook.com/media/set/?set=a.403824313060776.1073741833.350012111775330&type=3 (last accessed 21 August 2014).

Kingma, M. 2006. *Nurses on the move: Migration and the global health care economy*. Ithaca, NY: Cornell University Press.

Kirby, J., and T. Kaneda. 2005. Neighborhood socioeconomic disadvantage and access to health care. *Journal of Health and Social Behavior* 46:15–31.

Kurtz, A. 2013. For nursing jobs, new grads need not apply. *CNN Money* 14 January.

Kutner, M., E. Greenberg, Y. Jin, and C. Paulsen. 2006. *The health literacy of America's adults: Results from the 2003 National Assessment of Adult Literacy (NCES 2006–483)*. Washington, DC: National Center for Education Statistics.

Lambert, B. 1994. Giants of health care cast larger nets across east side. *New York Times* 8 May. http://www.nytimes.com/1994/05/08/nyregion/neighborhood-report-upper-east-side-giants-health-cast-larger-nets-across-east.html (last accessed 13 August 2014).

Levine, M. 2010. St. Vincent's is the Lehman Brothers of Hospitals. *New York Magazine* 17 October. http://nymag.com/news/features/68991/#print (last accessed 17 June 2014).

Loyd, J. 2014. *Health rights are civil rights: Peace and justice activism in Los Angeles, 1963–1978*. Minneapolis: University of Minnesota Press.

McDowell, L. 1983. Towards an understanding of the gender division of urban space. *Environment and Planning D: Society and Space* 1:59–72.

———. 1999. *Gender, identity, and place*. Minneapolis: University of Minnesota Press.

———. 2009. *Working bodies: Interactive service employment and workplace identities*. London: Wiley-Blackwell.

McLafferty, S. 1982. Neighborhood characteristics and hospital closures: A comparison of the public, private, and voluntary hospital systems. *Social Science and Medicine* 16 (19): 1667–74.

Mitchell, K., S. Marston, and C. Katz. 2003. Introduction: Life's work: An introduction, review, and critique. *Antipode* 35 (3): 415–42.

Mogul, F. 2013. Cascading hospital closures loom over Brooklyn. *Kaiser Health News*. 5 August. http: //khn.org/news/brooklyn-new-york-hospital-closings-loom/ (last accessed 8 July 2015).

Nagar, R., V. Lawson, L. McDowell, and S. Hanson. 2002. Locating globalization: Feminist (re)readings of the subjects and spaces of globalization. *Economic Geography* 78 (3): 257–84.

New York City Department of City Planning. 2014. Community portal: Queens community district 14. http://www.nyc.gov/html/dcp/html/neigh_info/qn14_info.shtml (last accessed 19 June 2014).

New York Department of Health. 2013a. Number of Medicaid enrollees by category of eligibility by social service district—Calendar year 2013. http://www.health.ny.gov/statistics/health_care/medicaid/eligible_expenditures/e12013/2013-cy_enrollees.htm (last accessed 13 June 2014).

———. 2013b. Urgent care policy options. http://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2013-07-17/docs/2013-07-03_urgent_care_policy_options_final.pdf (last accessed 17 June 2014).

———. n.d. New York State hospital profile. http://hospitals.nyhealth.gov/ (last accessed 17 June 2014).

New York State Nurses Association. n.d. Our vow: no more closings. http://www.nysna.org/our-vow-no-more-closings#.VLQ9K2TF9Hh (last accessed 12 January 2014).

Perez-Pena, R. 2012. More stringent requirements send nurses back to school. *New York Times* 23 June. http://www.nytimes.com/2012/06/24/education/changing-requirements-send-nurses-back-to-school.html?pagewanted=all&_r=0 (last accessed 20 August 2014).

Pomrinse, S. D. 1983. Comments on hospital closings in New York City. *Health Services Research* 18 (4): 575–78.

Raghuram, P. 2007. Interrogating the language of integration: The case of internationally recruited nurses. *Journal of Clinical Nursing* 16:2246–51.

———. 2009. Caring about "brain drain" migration in a postcolonial world. *Geoforum* 40:25–33.

Reddy, S. 2010. Queens crunched by hospital closures. *Wall Street Journal* 24 May. http://online.wsj.com/news/articles/SB10001424052748704448304575196161721213250 (last accessed 17 June 2014).

Reverby, S. 1987. *Ordered to care: The dilemma of American nursing, 1850–1945*. Cambridge, UK: Cambridge University Press.

Rosenberg, C. 1979. The origins of the American hospital system. *Bulletin of the New York Academy of Medicine* 55 (1): 10–21.

Salit, S., S. Fass, and M. Nowak. 2002. Out of the frying pan: New York City hospitals in an age of deregulation. *Health Affairs* 21 (1): 127–39.

Scott, T., J. Gazmararian, M. Williams, and D. Baker. 2002. Health literacy and preventative health care use among Medicare enrollees in a managed care organization. *Medical Care* 40 (5): 395–404.

Silvey, R. 2008. Managing migration: Reproducing gendered insecurity at the Indonesian border. In *Beyond states and markets: The challenges of social reproduction*, ed. I. Bakker and R. Silvey, 108–21. London and New York: Routledge.

Smith, N. 1979. Towards a theory of gentrification: A back to the city movement by capital, not people. *Journal of American Planning Association* 45 (4): 538–48.

Spetz, J., M. Ash, C. Konstantinidis, and C. Herrera. 2010. The effect of unions on the distribution of wages of hospital-employed registered nurses in the United States. *Journal of Clinical Nursing* 20 (1–2): 60–67.

Urgent Care Association of America. n.d. About urgent care. http://www.urgentcarecenter.org/about.html (last accessed 12 June 2014).

U.S. Census. 2000. *2000 US Census: Total household income 1999*. Minneapolis: Minnesota Population Center, National Historical Geographical Information System, Version 2.0.

———. 2010. *2006–2010 American Community Survey: Race*. Minneapolis: Minnesota Population Center, National Historical Geographical Information System, Version 2.0.

———. 2011. *2007–2011 American Community Survey: Mean income in the past 12 months*. Minneapolis: Minnesota Population Center, National Historical Geographical Information System, Version 2.0.

———. n.d. State and county quick facts: New York. http://quickfacts.census.gov/qfd/states/36000.html (last accessed 17 June 2014).

Weinberg, D. 2003. *Code green: Money-driven hospitals and the dismantling of nursing*. Ithaca, NY: Cornell University Press.

Yeates, N. 2004. A dialogue with "global care chain" analysis: Nurse migration in the Irish context. *Feminist Review* 77:79–95.

Correspondence: Department of Geography, University of Toronto, Toronto, ON M5S 3G3, Canada, e-mail: caitlin.henry@utoronto.ca.