

Local Health Care Provision as a Territorial Power-Building Strategy

Non-aligned mayors in Argentina

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What explains variation in local health services? Comparative scholarship highlights economic factors, electoral competition, and partisanship to account for service disparities. Employing an original data set and qualitative case studies of health service provision in thirty-three metropolitan municipalities in Argentina between 1995 and 2015, we find that mayors are likely to provide more services when they are not aligned with the governor. Unable to access the discretionary resources and electoral support from governors that aligned mayors enjoy, non-aligned mayors exploit automatic provincial revenue-share health transfers, which reward municipalities that provide more services and have more infrastructure, in order to build territorial power. These findings highlight the impact of non-alignment and the conditions under which formula-based transfers encourage local service provision.

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I. Introduction

Over the past three decades, several developing countries have expanded social programs and health services for historically excluded populations.ⁱ While these initiatives have improved welfare and health care outcomes, within-country disparities in social services deserve further explanation. These inequities are especially visible in health policy, in which subnational authorities often play an important role in service delivery. In Latin America, where social policy expansion took place after social service decentralization intensified in the 1980s and 1990s, a key question concerns why some subnational authorities provide more health services than others.ⁱⁱ

In explaining within-country variation in service provision, comparative scholarship has emphasized a number of factors, including economic determinants,ⁱⁱⁱ partisanship and electoral competition,^{iv} the presence of participatory institutions,^v and cultural drivers such as ethnic identities.^{vi} Other studies have underscored how the alignment between national and state-level governments shapes both social policy dynamics and the perpetuation of clientelism in federal systems. Niedzwiecki found that non-aligned governors in Argentina and Brazil were likely to obstruct the implementation of national cash transfers in their provinces in order to prevent national authorities from receiving credit for delivering this benefit,^{vii} while Borges posited that in Brazil, alignment facilitated governors' access to national-level discretionary resources, which contributed to the survival of subnational clientelistic machines.^{viii}

Building on this literature, we point to the importance of alignment between local and provincial authorities on decentralized health service provision, a factor that has received little attention in studies of local politics and social services. Focusing on the metropolitan area of the province of Buenos Aires, Argentina, which comprises thirty-three municipalities that hold close to one-quarter of the country's population and have been largely governed by mayors of the

Peronist party (PJ), a labor-based party that developed clientelistic structures during the third wave of democracy,^{ix} we find that mayoral alignment results in striking differences in local health service provision.

We show that non-aligned mayors are likely to provide more health services and we contend that increased health service provision is a power-building strategy that non-aligned mayors employ to consolidate their hold on local politics. In a context of weak institutions,^x non-aligned mayors lacking support and/or discretionary resources from governors embrace this strategy because health services are both rewarded with automatic provincial transfers and valued by voters. Health expansion therefore provides resources that governors have little capacity to block or allocate with discretion. These funds allow non-aligned mayors to showcase the effectiveness of their administrations, increase their popularity, and consolidate their hold on power. Aligned mayors, by contrast, are more likely to avoid the administrative complexity and effort involved in municipal-level health service development, relying instead on governors' support and discretionary resources to entrench their power.

Our main contribution in this article is to connect variation in local health services with the power-building strategies of non-aligned mayors. This finding adds to the comparative literature on national social policy adoption and implementation by considering a neglected question, the expansion of services that are under the purview of municipal authorities.^{xi} Our study also speaks to the literature on clientelism, which emphasizes the roles of brokers and the use of selective handouts and favors to build local political support.^{xii} We depart from this literature by showing how non-discretionary resources—in this case, automatic revenue-sharing transfers for health service delivery—play a fundamental role in non-aligned mayors' power-building strategies. Furthermore, departing from the existing consensus on how partisan machines are unlikely to

develop rule-based programs,^{xiii} we show that local health service expansion is pursued by non-aligned mayors with strong records of clientelism. The key to understanding when this strategy is employed lies not in the features of the incumbent party but rather in the mayor's alignment with the governor.

In the next sections, we discuss the question of territorial power building, lay out our expectations regarding non-aligned mayors, and present the institutional features of decentralized health care provision in the metropolitan area of the province of Buenos Aires. Municipalities in this area are representative of other densely populated districts surrounding capital cities in Latin America, where weak institutions, local clientelism, and geographic disparities in social service provision are common. Known as the *Conurbano*, this area has been a laboratory for numerous studies of clientelism while comparative research on local service provision and non-aligned mayors' power-building strategies has been surprisingly absent.^{xiv} Next, we combine statistical analyses of service provision in thirty-three municipalities across five administrations—since decentralization began in 1995 through 2015—and we present case studies of four districts that maximize variation in potential explanatory factors.^{xv} Quantitative evidence suggests that regardless of socioeconomic conditions and levels of electoral competition, mayors were likely to deliver more health care services when they were not aligned with the governor. Qualitative case studies based on process tracing^{xvi} and triangulation of evidence from interviews, newspaper articles, and government documents, allow us to both identify the mechanisms by which alignment influences local health provision and discard alternative explanations.

II. Non-aligned Mayors and Territorial Power

Territorial power involves political support and control within a designated unit that help leaders govern effectively and win elections. Building territorial power within a district entails creating institutions and structures that cultivate electoral support, allow local politicians to govern, and help incumbents fend off competitors.^{xvii} A rich comparative literature addressing subnational politics in Latin America identifies clientelism—including both patronage and vote-buying mechanisms—as well as “boundary control strategies,”^{xviii} by which incumbents ostensibly curtail the expansion of the opposition, as critical forms of territorial power building. Scholars contend that provincial-level political machines use the public bureaucracy to award political appointments with the aim of entrenching their control and building loyalty.^{xix} In some cases, incumbents also consolidate their territorial power by manipulating institutions at the expense of their opponents. They modify electoral rules and/or districts to increase the representation of incumbent strongholds in the legislature, block the distribution of resources for opposition-led municipalities, and provide legislative support for national incumbents to discourage them from intervening in provincial politics.^{xx}

Scholars have also shown that the provision of clientelistic benefits at the local level through municipal agencies or distributional broker and party networks has been a critical strategy employed by incumbents to mobilize voters, win over competitors, and diffuse discontent that could otherwise be mobilized against their administrations.^{xxi} Mayors in Argentina, and in the Conurbano in particular, are probably one of the most—if not the most—studied cases of local clientelism in Latin America. While scholarship has typically focused on how local brokers mobilize voters’ support with handouts, recent studies have also shown that brokers occasionally provide public goods to boost their reputations among constituents and consolidate their

support.^{xxii} Specifically looking at locally administered social benefits, scholars have also found that mayors are more likely to rely on clientelism when they govern over districts with higher poverty rates and limited electoral competition.^{xxiii}

Acknowledging these important findings, we focus on two aspects of local politics that have been neglected in this literature. The first concerns whether locally provided non-discretionary services play any role in mayors' territorial power-building strategies, even in districts with high levels of poverty. Given that mayors may not only administer discretionary funds but also manage the provision of fundamental social services, such as health care,^{xxiv} one key question concerns whether these services are relevant tools for gaining voters' support and consolidating local political power. A second fundamental question concerns whether mayors' territorial power-building strategies are associated with partisan alignments across levels of government. Several studies of clientelism—especially in the Conurbano—assess the behavior of local machines that are aligned with provincial incumbents, paying little attention to how such alignment affects mayors' strategic choices.^{xxv} A related and similarly neglected issue is how *non-aligned mayors*—meaning both those who belong to the same party as the governor but compete against her in elections and those who belong to a different party—try to build territorial power.

Power Building in the Conurbano

To build territorial power, mayors need resources. Mayor-governor alignment is critical for accessing resources in the Conurbano. Aligned mayors benefit from discretionary resources during campaigns—as widely identified in the literature—as well as from overall provincial-level political support. This is especially important in Argentina because the constitution establishes that national transfers to municipalities are mediated at the provincial level. Even when mayors are not

aligned with governors but are instead supported by national authorities, governors can limit their access to funding and may sponsor alternative candidates in their districts. Non-aligned mayors therefore need resources beyond discretionary provincial-level ones.

We argue that resources that governors have little capacity to block or distribute with discretion are critical for non-aligned mayors' attempts to build territorial power in weakly institutionalized systems.^{xxvi} Private sponsors could be a potential source of funding.^{xxvii} In the Conurbano, however, private fundraising is not a visible strategy among opposition parties and may be inadequate when mayors compete against a provincial patronage machine that mobilizes vast state resources.^{xxviii} Decentralized policies for which mayors may claim credit^{xxix} or even determine the implementation conditions thereof are especially important in a context of non-alignment. With funds and policy authority that are returned to their districts, mayors can improve social provision, create signature initiatives within these policy areas, and focus their policy agendas on decentralized services to showcase the effectiveness of their administrations and cultivate voters' support.

Since 1990, substantial transfers have been available for the expansion of local health care provision in the Conurbano.^{xxx} These funds are allocated automatically on the basis of health care infrastructure (e.g., number of hospital beds) and service delivery (e.g., number of consultations or hospital discharges), rewarding those districts with more infrastructure and more services. By investing in these critical services, mayors can not only enhance their popularity among voters but may also reduce the appeal of challengers in their districts.

Governors have no direct political control over these transfers, and they cannot impede or oppose mayoral initiatives to inaugurate new health care infrastructure and services that voters

need and value. Opposition to local health service expansion, even when it is based on technical grounds, is a losing strategy and can be invoked by mayors to undermine a governor's popularity.

While automatic direct transfers to expand local services are available for all mayors in the Conurbano, non-aligned mayors are more likely to tap these resources. Although this may seem counterintuitive, as alignment is typically associated with lower-level authorities receiving more resources in multilevel systems,^{xxxii} the administration of a wide set of local health services is a laborious and challenging task. It requires coordinating complex service delivery, managing a vast health care infrastructure, and hiring personnel who, unlike the politicized local bureaucracies that are susceptible to manipulation by Conurbano mayors,^{xxxiii} tend to form or join more powerful labor unions to negotiate or protest working conditions.

Aside from the complex tasks involved in service expansion, the publicity that mayors grant to their health care initiatives raises the salience of these services, potentially generating more demand. Increased service provision may therefore present mayors with growing demand for services as well as higher expectations for health care delivery and quality. In describing this situation, a long-time politician sustained that local health services are a favorable strategy in the short term. In his words, “food today, hunger tomorrow.”^{xxxiii}

Faced with the opportunity to augment services, but given both the efforts associated with doing so and their reliance on other power-building strategies, aligned mayors tend to refrain from expansion and delegate complex services—especially hospital care—to the provincial level. For this reason, we interpret the expansion of local health services as a power-building strategy of last resort, one that mayors lacking other sources of support and revenue—which is the case for non-aligned mayors—would more decisively pursue.

Although it is true that the cost and scope of services may increase over time once new services have been developed, mayors may attract contracts with third parties such as health insurance contractors. These arrangements may help maintain services and keep up with improvements, but they also require building more sophisticated administrative capacity, which further entrenches these services.

This power-building strategy of last resort has become more prominent in Conurbano districts in recent years. Although the PJ governed the province of Buenos Aires continuously from 1995 through 2015, and 83 percent of Conurbano mayors (137 of 165) during this time belonged to the PJ, non-aligned mayors have not been in short supply. This is because while partisan affiliation is a critical aspect of alignment, divisions within party structures in contexts of institutional weakness and clientelism may constitute important sources of opposition at the local level, resulting in party fragmentation and non-alignment. In the Conurbano, the PJ has become deeply divided.^{xxxiv} While governors supported different tickets simultaneously in local elections, mayors seeking to protect their territories sometimes set out to build their own power autonomously from governors, splitting from the PJ's main faction and competing as a separate party in certain elections. According to our data, 33 percent of Conurbano mayors were not aligned with the provincial governor during the 1995–2015 period; 49 percent of this subset belonged to other parties and 51 percent belonged to different factions of the PJ and competed outside of the incumbent PJ faction in some legislative or gubernatorial elections. In the 1990s, 2000s, and 2010s, the proportion of non-aligned mayors was 24, 41, and 36 percent, respectively (see Table A2, Appendix A).

III. Health Care Services in the Conurbano

From 1995 through 2015, between 40 and 48 percent of the population in the Conurbano lacked health insurance through formal-sector employment or private health funds and relied exclusively on publicly provided health care services.^{xxxv} Districts with aligned and non-aligned mayors show similar rates of outsider populations: 45.6 and 43.8 percent on average, respectively, throughout the 1995–2015 period.

Argentina developed significant health care provision in the first half of the twentieth century. Although provincial governments were responsible for health care services for decades, changes in revenue-sharing rules and decentralization of primary care in Buenos Aires in the late 1980s and mid-1990s, respectively, incentivized municipal governments to expand local provision of both primary care and inpatient hospital services. The total share of provincial state spending transferred to municipalities grew from 9.25 percent in 1980 to 16.5 percent in the late 1980s.^{xxxvi} In 1989, the government earmarked 37 percent of provincial revenue-sharing transfers to municipalities for local health services. These funds are allocated automatically on the basis of capacity and service delivery. Districts with more infrastructure and higher levels of service provision receive more transfers.^{xxxvii}

While provincial health centers were decentralized to local governments in 1994, the province of Buenos Aires continued to finance existing provincial hospitals, as well as a few new hospitals that it either built or absorbed (“provincialized”) from municipal jurisdiction. Municipalities are responsible for primary care facilities, which in 2010 comprised 870 health centers,^{xxxviii} and they can establish their own hospitals as well. Across the Conurbano some districts only have provincial or municipal hospitals while others have both types of facilities. Table 1 presents a snapshot of the existing infrastructure (hospitals and beds) and service

provision—measured as medical consultations per capita of the uninsured (i.e., outsider) population—for each mayoral election year in the Conurbano between 1995 and 2015.

[TABLE 1]

As shown in Table 1, municipal infrastructure grew at a higher rate than provincial infrastructure, and municipal services—medical consultations—increased dramatically while provincial ones stagnated. One important aspect of the longitudinal increase in municipal consultations is its variation across districts. In our data, consultations per outsider population range from .7 to 24, with an average of 5.8 (see Appendix A, Figures A2 and A3).

IV. Empirical Analysis

We first analyze the association between alignment and health care provision using an original data set of the thirty-three Conurbano municipalities covering 165 administrations from 1995 to 2015. Case studies of four municipalities that were selected to maximize variation on potential explanatory factors are presented next. These case studies seek to elucidate the mechanisms by which non-alignment encourages health service expansion.

The Outcome: Local Provision of Health Care Services

For the quantitative analysis, we measure our dependent variable as the number of medical consultations per uninsured resident (*consultations*).^{xxxix} This variable is a clearer and more immediate measure of service provision than other initiatives (e.g., hospital construction) and includes a broad range of outpatient services such as pre-natal and well-child consultations.^{xl} In the qualitative case studies, we also analyze the inauguration of municipal hospitals and health

centers. An alternative measure of mayors' health care efforts is expenditures. We discard this metric because of the well-known critiques of the use of expenditures as a proxy for welfare provision^{xli} and the absence of systematic data on municipal spending for all districts for most years. Although mayors may want to overreport the number of consultations to receive more transfers, they need to have the infrastructure to justify such services. Our data on consultations come from close to one thousand health centers and hospitals run by municipal governments in the thirty-three Conurbano districts for twenty-one years.

Based on our expectations regarding mayors' decisions, we take each mayoral administration as the unit of observation. We assume that mayors are particularly concerned about their or their party's continuity, and we measure consultations on the last year of a given administration, when mayoral elections are held, assuming that if a mayor decides to expand health services, these efforts are more likely to materialize by the end of her administration. As a sensitivity test, in order to determine whether results are driven by the electoral cycle, we also measure the average annual consultations per outsider population during each administration (Appendix C).

Main Explanatory Variable

Our key explanatory variable is alignment between the mayor and governor. We understand mayors who belong to the same party as the governor and who support the governor's party in each election as *aligned* with the provincial government. Mayors who belong to other parties or to a faction of the governor's party that competes against that of the governor in legislative or gubernatorial elections are *non-aligned*. Therefore, alignment may be independent of party affiliation in the context of party fragmentation. We assume that non-aligned mayors lack access to discretionary resources from the provincial government to build and maintain territorial power.

Given the structure of revenue sharing in the Conurbano, we also expect non-aligned mayors to be more likely to expand local health services in order to obtain more automatic revenue-sharing resources that can be leveraged to build territorial power. We code non-alignment as 0 and alignment as 1 (see Appendix A, Table A2).

Control Variables

We also control for a number of factors highlighted in existing theories of public goods provision and social policy.^{xlii} A broad literature contends that *wealth* is associated with health spending and outcomes, such that the wealthier a country—or district—the higher the spending on health care and the better the health indicators. It is reasonable to test the “wealthier-is-healthier hypothesis”^{xliii} in the Conurbano because of the dispersion in geographic gross product (GDP) per capita across districts.^{xliv}

Among political factors potentially shaping variation in health service provision, we control for the effect of *electoral competition*.^{xlv} The existing literature has argued that electoral competition, along with efforts to court poor voters, has driven national incumbents to expand social programs in Latin America.^{xlvi} Mayors who assume office following highly competitive elections may be more likely to expand local health services so that they can claim credit for improvements in order to gain or consolidate voter support. Even if health care services are already available, having medical facilities closer to home, modern hospital infrastructure, and reduced waitlists are achievements that mayors may pursue and publicize to win votes. To measure electoral competition, we analyze the margin of victory between the winner and the runner-up candidate in mayoral elections. We also consider the impact of *reelection* on mayors’ policy choices. Throughout the period investigated, mayors in the Conurbano could be reelected

indefinitely. Reelection may increase mayors' incentives to invest in health services instead of focusing on short-term provisions to mobilize voters. We expect mayors who were reelected to a consecutive term to provide more health services.

Given that the Conurbano has seen protests by large-scale movements of unemployed and low-income informal workers, we assess whether these protests are associated with municipal health care provision. We measure *protest* as the sum of protest counts in each municipality for each administration. Because these movements have directed their claims at the national government, where their impact on social policy has been significant, we do not expect protest to have a strong effect on mayors' policy decisions.^{xlvii}

To gauge whether need is associated with mayors' choices to provide local health services, we control for *outsider municipality*, meaning districts in which outsiders constitute the majority (at least 51 percent) of the population. Being an outsider municipality may depress the amount of services per capita, given the sizeable share of citizens in these districts who need public services. We also control for distance from the City of Buenos Aires (CABA)^{xlviii} to assess whether proximity has a downward effect on local provision. Residents living closer to CABA may prefer to take advantage of the city's extensive hospital network as opposed to obtaining health care in their own municipalities, prompting mayors to provide fewer services. Finally, we control for the number of consultations per outsider population provided by provincial hospitals in each district, as we expect provincial consultations to satisfy some of the demand for health care services and therefore be associated with less local provision.

Quantitative Analysis

Our data set includes observations for the thirty-three districts of the Conurbano for each of the five administrations that governed between 1995 and 2011. Because observations are generated

every four years, this data set avoids the artificial inflation of significances associated with panel data with more frequent time periods (e.g. years).^{xlix} In Table 2 we present the bivariate regression between the number of consultations per outsider population and alignment between the governor and mayor. As the table shows, there is a negative and statistically significant association between alignment and the number of medical consultations.

[TABLE 2]

We model the relationship between alignment and consultations controlling for the other independent variables. We use a random-effects regression because our data are characterized by little longitudinal within-case variability and time-invariant values on some independent variables.^l Given the panel structure of our data, a pooled OLS model is not appropriate.^{li} Because of the relatively small T ($N:33 > T:5$), dynamic models with a lagged dependent variable are not advisable either.^{lii} Another possible approach for this structure of data would be to use a fixed-effects model. Yet the fixed-effects estimator is not useful because it relies on within-case variance. Random-effects models are therefore best suited for our data.

Table 3 reports the results of the quantitative analysis. As expected, all four models show a negative association between political alignment and the number of consultations. Substantively, this suggests that when the mayor is aligned, the district has between 2.2 and 2.8 fewer consultations per uninsured resident per year. Although the dispersion of this variable over time and across cases is large, this coefficient is important when compared with the median and mean number of consultations per outsider population for the period (4.3 and 5.8 respectively). If we employ the average number of consultations per outsider population in each administration as dependent variable, the association and the statistical significance persist (see Appendix C).

[TABLE 3]

Consistent with the classic economic development literature, our models support the proposition that higher GGP per capita is associated with more consultations. However, this effect is substantively small such that one more consultation per outsider population would require an increase in GGP per capita that is higher than the median value of this variable in Models 1–3 and about 50 percent of the median value in Model 4. As we expected, there is a negative association between the number of consultations at provincial hospitals and those at municipal hospitals, which is statistically significant. An increase of one provincial hospital consultation is associated with a decrease in .7 consultations with municipal providers, all else being equal.

Turning to the other control variables, in Model 1 electoral competition is statistically significant at $p < .05$, suggesting that the less competitive the mayoral election, the higher the number of consultations. In the remaining models, this factor loses significance. The other control variables are not statistically significant. While candidate reelection and outsider municipality show the expected direction, distance from the city of Buenos Aires does not.

Qualitative Evidence: Comparative Case Analysis

The statistical analysis provides empirical evidence that mayors who are not aligned with the governor are likely to provide more local health services. This association between non-alignment and service provision remains even after controlling for the effects of other potential sources of variation in service provision—such as wealth, electoral competition, and need. In this section we employ qualitative cases studies to uncover the drivers of mayors' decisions to expand services. We process-trace health care choices across mayoral administrations in four municipalities. Along with consultations, we also look at the creation of hospital infrastructure.

To select our cases, we focus on districts and mayoral administrations that vary along two key factors: alignment, which is our main explanatory variable, and wealth, which is statistically significant—though marginal in substantive terms—in our models.^{liii} To measure wealth, we employ per capita GGP, which serves as an indicator of the existing resources that could be exploited to fund health care services.^{liv} We chose José C. Paz and Malvinas Argentinas, which qualify as lower-income, and San Isidro and Avellaneda as higher-income districts. Mayoral administrations within our selected districts allow us to analyze all possible combinations of socioeconomic conditions and alignment/non-alignment (Table 4). Of all the potential cases, Malvinas and José C. Paz are particularly interesting because they were formed in 1994 out of the division of General Sarmiento and share major similarities in terms of their history, population, and location.^{lv} San Isidro and Avellaneda, on the other hand, are long-standing districts located in different areas of the Conurbano—the north and south, respectively.^{lvi} Based on our theoretical expectations, districts with similar economic conditions will show variation in service provision depending on their mayors' alignment status.

[TABLE 4]

José C. Paz

In 1995, when its first mayor was elected, José C. Paz had limited health infrastructure, with only thirteen primary care centers^{lvii} for approximately 130,000 residents who relied on state services—63 percent of the district's population—and one provincial hospital, which was inaugurated soon after the district's creation.^{lviii}

Between 1995 and 2015, mayors were aligned with successive PJ governors and faced little electoral competition. The district's first mayor, Rubén Glaría (1995–1999) of the PJ, was aligned with governor Eduardo Duhalde (1991–1999). In 1999, Mario Ishii, who had been president of the

PJ-dominated local council, won the mayoral election. Experienced in clientelist practices,^{lix} Ishii was aligned with governors Carlos Ruckauf (1999–2002) and Felipe Solá (2002–2007), Ruckauf’s successor, as well as with Daniel Scioli of the PJ-Victory Front (FPV), from 2007 through 2015. After spending two years as a national senator, Ishii became mayor again in 2015, winning by a landslide.^{lx}

During this period of governor-mayor alignment, local health services were inadequate. José C. Paz inaugurated twelve health centers after 1995, but consultations remained below the Conurbano’s average, and the number of provincial hospital beds per uninsured resident was also insufficient—54 percent of the Conurbano’s average.

A radical change of strategy occurred in 2015. Shortly after initiating a new term in office, Ishii announced that his administration would undertake a “revolution in health care” and build six hospitals.^{lxi} After years of neglect, the determination and speed with which Ishii launched this strategy are remarkable, especially given that his campaign promises for the 2015 elections focused—as in his prior mayoral campaigns—on improvements in paving and garbage collection.^{lxii}

Yet the PJ unexpectedly lost the gubernatorial election in 2015 after twenty-eight years of uninterrupted rule, and Ishii’s alignment with the governor ended. Lacking support from an aligned governor to maintain his territorial power, health care expansion became the non-aligned mayor’s power-building strategy of last resort. This shift in Ishii’s strategy was described by a top provincial official as connected with the mayor’s attempt to capture automatic health transfers.^{lxiii} In 2016, municipal health care spending jumped to 16.2 percent from the 2010 level of about 7.5 percent, reflecting the new course of action.^{lxiv}

As expected in our framework, the non-aligned mayor focused on health care services in order to obtain automatic transfers that would allow him to showcase the effectiveness of his administration with the aim of cultivating voters' support. As soon as medical facilities were inaugurated, moreover, the district began to contract out services with insurance providers and collect payments from wealthier residents for some treatments with the aim of consolidating a strategy that was both effective and fiscally sustainable.^{lxv}

Could other factors explain this change in strategy? Need is high in José C. Paz, but this alone can hardly account for the timing of expansion.^{lxvi} Considering the size of the outsider population and the district's poverty rates, need was more pronounced in the early 2000s as a result of the 2001 financial crisis. Yet, throughout the period studied, the district's provincial hospital was described as one of the weakest in the Conurbano;^{lxvii} not only was it understaffed but its services were also undermined by defective diagnostics equipment and by strikes denouncing these conditions.^{lxviii} An increase in local-level wealth also fails to explain this change in strategy, as per capita GGP remained relatively low over time.

Malvinas Argentinas

Unlike José C. Paz, Malvinas inherited valuable local infrastructure following the division of General Sarmiento. In 1995, the district had two municipal hospitals and sixteen health centers serving about 58 percent of its population, or 145,000 residents.^{lxix}

During the 2000s, Malvinas came to develop a broad array of local health services. By 2016, it had twelve municipal hospitals, some offering high-complexity services and state-of-the-art medical equipment, forty-two health centers, and one of the highest rates of consultations in the Conurbano. Municipal hospital beds jumped from 54 to 827 between 1995 and 2015.^{lxx} The

district's annual budgets reflect this transformation. While health care expenses ranked third behind municipal administration and public services—e.g., garbage collection^{lxxi}—they became the primary line item in the district's budget starting in 2003. In 2010, health care expenditures represented 48 percent of the municipal budget.^{lxxii}

The first mayor of Malvinas, Jesús Cariglino, was elected in 1995 on the PJ ticket and was reelected continuously until 2015, when a FPV candidate defeated him. Cariglino was aligned with PJ governors Eduardo Duhalde (1991–1999) and Carlos Ruckauf (1999–2001). Beginning in 2003, however, he was not aligned with governor Solá and supported Duhalde's faction in the 2005 midterm elections, running against the incumbent FPV coalition. After Duhalde's defeat, Cariglino aligned temporarily with Solá until the 2009 midterm elections, when he refused to join the FPV ticket led by ex-president Néstor Kirchner and then-governor Scioli (2007–2015). In 2011, he joined Duhalde's newly created party, remaining non-aligned with governor Scioli. Cariglino's trajectory shows strategic changes in his alignment with provincial governors and underscores his search for autonomy.^{lxxiii} Overall, we score his administrations as non-aligned beginning in 2003.

The expansion of health care infrastructure and services was a fundamental aspect of Cariglino's territorial power-building strategy. Chiara et al. contend that Cariglino's first initiatives to expand services partly sought to address need but primarily aimed to gain autonomy for the district.^{lxxiv} Funding for these initial investments came from local resources and then from revenue-sharing transfers collected through increased service provision and expanded infrastructure.

Beginning in 2005, opportunities to further expand services grew with changes in the national program for retired persons (PAMI) when it began to contract out services with public

hospitals,^{lxxv} a decision that Malvinas embraced. According to Chiara et al., the mayor set out to build high-complexity hospital services with the goal of offering them to Malvinas residents at no cost, as well as to a broader universe of users, including those both with and without health insurance, for a fee.^{lxxvi} Third-party contracts enabled Malvinas to expand the breadth and depth of health services. Whereas in 1997 less than 10 percent of Malvinas' health care funding came from insurance providers, in the 2000s it represented between 20 and 31 percent.^{lxxvii}

Chiara et al. mark the beginning of Malvinas' health expansion between 2001 and 2003, which actually coincides with Cariglino's non-aligned status.^{lxxviii} While some of the growth in infrastructure, such as the construction of some new health facilities, began in 2001, it was in 2003 that it ultimately gained steam.^{lxxix} Our data on consultations show an upward trend that spikes during Cariglino's 2003–2007 administration.^{lxxx}

Given Cariglino's sweeping victories, electoral competition was not a driver of his decision to expand health care services in Malvinas.^{lxxxii} The district also lacked any dramatic increase in wealth that could explain changes in health care services. Likewise, it would be hard to argue that the mayor had a programmatic commitment to human development policies, as he was temporarily imprisoned in 2003 for fraud, faced several lawsuits for corruption in the early 2000s, and allegedly had thugs operating on his behalf to assault opponents during the 2011 and 2015 elections.^{lxxxii}

The construction of hospital facilities—and provision of broad health service—was a strategy for building territorial power. Transfers for health care services, and to a lesser extent insurance payments, allowed Cariglino to develop a wide local health system and cultivate popular support without aid or interference from higher-level authorities.

San Isidro

That San Isidro provides extensive health care services may seem unsurprising. The district is one of the wealthiest in the Conurbano and inaugurated a municipal hospital in the first decade of the twentieth century. Although outsiders represented a relatively small share of the district's population—ranging from 21 to 30 percent during the period analyzed—San Isidro invested heavily in renewing and expanding its hospital infrastructure. In 1993, the district inaugurated a new municipal hospital to meet demand closer to low-income areas, and in 2003 it opened a new general hospital building that was three times larger than the original 1909 facility. San Isidro also has a long-standing maternity clinic and a children's hospital that provides high-complexity pediatric services; the two merged in 1994 and underwent significant improvements.^{lxxxiii}

Throughout the period studied, San Isidro generally ranked at the top of the Conurbano municipalities in service delivery. Consultations were 70 and 110 percent above the Conurbano average in 1995 and in 2015, respectively, and the number of hospital beds was almost three times higher in 2015. In line with the scope of the district's health services, health care represented between 27 and 31 percent of total municipal expenditures between 2003—the first year for which detailed budget data are available—and 2013.^{lxxxiv}

While the fact that mayor Melchor Posse (1983–1999) of the centrist and middle-class Radical Party (UCR) was a doctor may have had some influence on the district's health agenda, the municipal health investments beg further explanation. Between 1987 and 2015, the mayoral office—headed since 1999 by Posse's son Gustavo—was not aligned with the provincial government. Although constituencies of the Posse administrations, such as the non-poor informal sector, benefit from the district's health services, the UCR draws most of its support from voters who are less likely to use municipal health facilities.^{lxxxv}

Expanding local health services primarily helped the mayor build territorial power. The main mechanisms in our argument by which non-alignment drives mayors to invest in health services are identified in this case. As acknowledged by a top politician from the mayor's party, health provision is a tool for obtaining automatic transfers from the provincial government, which are allocated "based on health statistics."^{lxxxvi} These health transfers help mayors run a more effective administration that expands valuable services. Mayors perceive health services as helping them cultivate and retain electoral support. As noted by a top local official, the inauguration of the new general hospital building "served Posse in two elections."^{lxxxvii} Finally, the creation of comprehensive health services also helped San Isidro's mayors reduce the chances that governors would make health-related investments in the district, which could benefit provincially-sponsored competitors and overshadow their local administrations. Referring to health care investments from other jurisdictions, a top politician asserted, "San Isidro has historically been wary of the province or the national government setting foot in the district. This is one of the advantages of the Posse family: to secure autonomy."^{lxxxviii}

The expansion of broad health care infrastructure, especially high-quality hospital services, has enabled mayors to offer and sell services to health insurance funds for formal workers and pensioners. While these resources are relatively more modest than revenue-sharing transfers, and San Isidro, unlike Malvinas, has not established a well-oiled mechanism for collecting health insurance payments, these funds constitute a valuable source of revenue for the municipality.^{lxxxix}

Neither electoral competition or changes in the district's wealth help explain the extent of services provided.^{xc} Though it may have been easier for San Isidro to build comprehensive health facilities than it was for lower-income municipalities, level of development can hardly account for this outcome. The motivation to capture automatic transfers, which allowed mayors to provide

services that citizens value and that therefore helped them cultivate popular support while also crowding out provincial investments, mainly accounts for the emphasis on health care.

Avellaneda

Avellaneda, a higher-income district whose mayors were mainly aligned with the governor, did not expand local services. In 2014 Avellaneda's mayor transferred its sole local hospital to provincial authorities. This is one of the four cases of provincialization that were carried out in the Conurbano during the period of analysis, all of which were led by aligned mayors.^{xci}

Mayors in Avellaneda did not use the expansion of local health services as a strategy for building territorial power. In 1995, the district's health infrastructure was significant, with three provincial hospitals, a local hospital founded in 1932, and twenty-six health centers to serve outsiders, who then represented 35 percent of the district's population.^{xcii} Provincial and municipal consultations as well as municipal consultations alone were 35 and 12 percent above the Conurbano average for the period, respectively, and hospital beds were 23 percent above average. In contrast with San Isidro, Avellaneda's municipal consultations stagnated, and hospital beds decreased between 1995 and 2015.

Between 1995 and 2015 Avellaneda was governed by PJ mayors, with the exception of the 1999–2003 administration headed by Oscar Laborde of the Alliance, a coalition of the FREPASO (a center-left PJ offshoot) and the UCR. Yet mayors were nonaligned with the governor between 1999 and 2007. Carlos Álvarez of the PJ, who served as mayor between 1995 and 1999 and was then aligned with governor Duhalde, was elected again in 2003 and allied with Duhalde's PJ faction in the 2005 midterm elections against governor Solá of the FPV, becoming non-aligned. After being reelected in 2007, Álvarez aligned with governor Scioli of the FPV and was appointed

minister of social development in 2009. He was replaced by Juan Carlos Ferraresi, who was reelected in 2011 and remained aligned until 2015, when the FPV lost the gubernatorial election.

Mayor Ferraresi provincialized the municipal hospital in 2014. In justifying this measure, local authorities sustained that the facility was too costly for the district and that transferring it to provincial jurisdiction would improve coordination with provincial hospitals.^{xciii} Opposition emerged from Álvarez, who belonged to a competing PJ faction and had many councilmembers ally with him.^{xciv} Those criticizing the provincialization argued that the mayor had deliberately failed to invest in facility maintenance and administrative capabilities that could collect payments from insurance providers in order to justify provincialization.^{xcv} While the hospital's personnel also rejected provincialization, arguing that provincial hospitals suffered from limited funding and labor conflict,^{xcvi} the largest health care workers' union—which was dominated by provincial-level workers—celebrated it. In their view, provincialization would not only help coordinate service provision but would also homogenize salaries among health workers.^{xcvii}

Despite the mayor's concern for coordination, and the fact that provincial provision was quite significant, why would he give up a source of funding and an opportunity to claim credit? We contend that mayor-governor alignment offered strategies for building territorial power other than running health facilities, which is a difficult strategy of last resort. The provincialization of the only local hospital by Ferraresi reinforces our argument that aligned mayors do not use health care services to build territorial power. Aligned mayors are not only likely to provide fewer services than nonaligned mayors, but while the latter struggle to construct and administer new services and infrastructure, the former may even transfer existing hospitals to the province.

In sum, our case studies lend support to the importance of alignment for mayors' power-building strategies. The contrasts across districts and administrations attest to this. Among low-income districts, non-aligned mayors in Malvinas developed large-scale health services as their key power building strategies, while in José C. Paz aligned mayors did not expand health services until 2015, when the mayor became nonaligned. Among wealthier districts, non-aligned mayors in San Isidro continuously increased the scope of local services as a central power-building strategy. On the other hand, Avellaneda's mayors chose to provide more limited local services, with one aligned mayor even provincializing the municipal hospital.

V. Conclusion

Territorial disparities in social services are a critical area for comparative research. Quantitative and qualitative evidence indicate that alignment between mayors and governors plays a role that deserves further attention in the literature on decentralization and local service provision as well as in studies on local clientelism. In this article we advance a new argument for the conditions under which non-alignment drives mayors to expand health services as a territorial power-building strategy. This factor explains significant variation in local service provision across metropolitan districts in Argentina. Although other factors are surely relevant drivers of local health service provision in other settings, we highlight the importance of mayoral alignment as a neglected yet critical element in local politics.

Prominent research on welfare outcomes and health services in contexts of weak institutions have almost exclusively theorized about local political dynamics to account for cross-municipal disparities.^{xcviii} We suggest that this research agenda incorporate the alignment status of mayors and their territorial power-building strategies into their analyses. A similar point should be

made regarding countries in which municipalities have substantial health care responsibilities, such as Colombia, but in which important research has focused exclusively on national programs and politics to explain equity in service provision.^{xcix}

In contrast to the vast literature on clientelism that focuses on the formation of broker structures to mobilize voters in low-income districts, we show that under certain political circumstances, mayors may use institutional resources to build and maintain territorial power. These resources are critical for non-aligned mayors, who lack discretionary funds as well as the support from the provincial government that aligned mayors typically receive. Health care transfers provide these mayors with an opportunity to expand services to win and consolidate voter support.

Important theoretical and empirical implications emerge from this research. First, aside from identifying non-alignment as a critical explanatory factor, the analysis suggests that the policies' programmatic features, and the incentives that programs create, may play a fundamental role in shaping mayors' choices to use or eschew those programs in order to build territorial power. The literature on clientelism in local service provision may need to specify institutional differences across social programs—for example, in terms of funding conditions—as one critical variable that may affect mayors' choices to use or not clientelism. Second, this territorial power-building strategy seems to be difficult, though not impossible, to reverse. Once mayors have developed significant health care infrastructure, changing course is costly because these services are both popular and needed. However, aligned mayors who inherit existing facilities may erode local service provision, and may even do so by transferring responsibility over health services to a higher level of government.

Finally, this study reveals that local service development may not be driven by technical nor distributive decisions but by power-building strategies that become institutionalized in policy arrangements, producing broader or narrower services and contributing to variation in the development of state capacity across districts. Above all, mayors' power-building strategies may be sources of spatial inequality that deserve further attention in both new and old democracies that have transferred critical authority over social service provision and funding to local governments.

Table 1. Health Care Infrastructure and Service Delivery by Jurisdiction, Conurbano, Election Years (1995–2015)

| | Health Care Infrastructure | | | | Health Services | |
|-------------|----------------------------|-----------|--------------|-----------|--|-----------|
| | Hospitals (total) | | Beds (total) | | Medical Consultations ^b (per outsider population) | |
| | Provincial ^a | Municipal | Provincial | Municipal | Provincial | Municipal |
| 1995 | 44 | 33 | 9057 | 3008 | 2.17 | 3.25 |
| 1999 | 48 | 33 | 8974 | 3006 | 2.34 | 3.23 |
| 2003 | 49 | 32 | 8940 | 3281 | 2.57 | 4.25 |
| 2007 | 52 | 35 | 9221 | 3405 | 2.44 | 5.36 |
| 2011 | 52 | 40 | 8848 | 3584 | 2.81 | 6.96 |
| 2015 | 53 | 46 | 8614 | 4012 | 2.36 | 8.90 |

Source: Hospital data from authors' Database of Hospitals. Beds and consultations data from the Ministry of Health, province of Buenos Aires.

a Four municipal hospitals were “provincialized” between 1995 and 2015.

b Medical consultations (*consultas médicas*), see Appendix B.

Table 2. Medical Consultations and Alignment

| | Coefficient | SE | p > t |
|-----------|-------------|-------|--------|
| Alignment | -2.973*** | 0.700 | 0,000 |
| N | 157 | | |

*** $p < .01$; ** $p < .05$; * $p < .1$

Table 3. Determinants of Medical Consultations per Outsider Population, Random-Effects Regression

| | Model 1 | Model 2 | Model 3 | Model 4 |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| Alignment | -2.636*** (0.681) | -2.781*** (0.686) | -2.678*** (0.701) | -2.223*** (0.653) |
| GGP_pc | 0.0001*** (0.0000) | 0.0001*** (0.0000) | 0.0001*** (0.0000) | 0.0002*** (0.0000) |
| Mayor Reelection | 0.587 (0.691) | 0.613 (0.696) | 0.654 (0.691) | 0.589 (0.656) |
| Electoral Competition | 0.035** (0.021) | 0.030 (0.021) | 0.033 (0.021) | 0.021 (0.020) |
| Outsider Municipality | -0.180 (0.759) | - | - | - |
| Protest | - | -0.015 (0.029) | - | - |
| Distance from CABA | - | - | -0.014 (0.022) | - |
| Provincial Consultations (per outsider pop.) | - | - | - | -0.671*** (0.163) |
| N | 147 | 148 | 148 | 148 |
| Adj. R Squared | 0.20 | 0.23 | 0.23 | 0.32 |

*** $p < .01$; ** $p < .05$; * $p < .1$

Table 4. *Alignment and Wealth, Selected Cases.*

| | Aligned | Non-aligned |
|----------------------|-----------------------------------|---------------------------------|
| Lower-income | José C. Paz (1995–2015) | Malvinas Argentinas (2003–2015) |
| | Malvinas Argentinas (1995–2003) | José C. Paz (2015—) |
| Higher-income | Avellaneda (1995–1999; 2007–2015) | San Isidro (1995–2015) |
| | | Avellaneda (1999–2007) |

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Notes:

ⁱ See Evelyne Huber and John Stephens, *Democracy and the Left: Social Policy and Inequality in Latin America* (Chicago: University of Chicago Press, 2012); Candelaria Garay, *Social Policy Expansion in Latin America* (New York: Cambridge University Press, 2016).

ⁱⁱ On decentralization, see Tulia Falleti, *Decentralization and Subnational Politics in Latin America* (Cambridge: Cambridge University Press, 2010).

ⁱⁱⁱ Lant Pritchett and Lawrence Summers, “Wealthier is Healthier,” *The Journal of Human Resources*, 31:4 (Fall 1996), 841–868.

^{iv} Jorge Antonio Alves, “(Un?) Healthy Politics: The Political Determinants of Subnational Health Systems in Brazil,” *Latin American Politics and Society*, 57:4 (December 2015), 119–142.

^v Michael Touchton and Brian Wampler, “Improving Social Well-Being Through New Democratic Institutions,” *Comparative Political Studies*, 47:10 (2014), 1442–1469; Michael Touchton, Natasha Borges Sugiyama and Brian Wampler, “Democracy at Work: Moving Beyond Elections to Improve Well-Being,” *American Political Science Review*, 111:1(2017), 68–82.

^{vi} Singh, Prerna, “Subnationalism and Social Development: A Comparative Analysis of Indian States,” *World Politics*, 67:3 (June 2015), 506–562.

^{vii} Sara Niedzwiecki, “Social Policies, Attribution of Responsibility, and Political Alignments: A Subnational Analysis of Argentina and Brazil,” *Comparative Political Studies*, 49:4 (2016), 457–498.

^{viii} Andre Borges, “The Political Consequences of Center-Led Redistribution in Brazilian Federalism,” *Latin American Research Review*, 46:3 (2011), 21–45.

^{ix} Javier Auyero, *Poor People’s Politics* (Durham: Duke University Press, 2001); Steven Levitsky, *Transforming Labor-Based Parties in Latin America* (New York: Cambridge University Press, 2003); Rodrigo Zarazaga, “Brokers Beyond Clientelism: A New Perspective on Brokerage through the Argentine Case,” *Latin American Politics and Society*, 56: 3 (September 2014), 23–45.

^x Steven Levitsky and María Victoria Murillo, “Variation in Institutional Strength,” *Annual Review of Political Science*, 12:1 (June 2009), 115–33.

^{xi} There is a broad literature on the adoption of national-level social programs: Huber and Stephens; Garay; on implementation of cash transfers, Wendy Hunter and Natasha Borges Sugiyama, “Whither Clientelism? Good Governance and Brazil's Bolsa Família Program,” *Comparative Politics*, 46:1 (October 2013), 43–62; Niedzwiecki, and on national health programs, James W. McGuire, *Wealth, Health, and Democracy in East Asia and Latin America* (New York: Cambridge University Press, 2010); Andrew Shrank, “Cross-Class Coalitions and Collective Goods: The *Farmacias del Pueblo* in the Dominican Republic,” *Comparative Politics* (forthcoming). Our work concerns services that are run by municipalities for which local governments have authority to determine the amount of provision.

^{xii} Mariela Szwarcberg, *Mobilizing Poor Voters: Machine Politics, Clientelism, and Social Networks in Argentina* (New York: Cambridge University Press, 2015); Virginia Oliveros, “Making it Personal: Clientelism, Favors, and the Personalization of Public Administration in Argentina,” *Comparative Politics*, 48:3 (April 2016), 373–391; Zarazaga.

^{xiii} See Herbert Kitschelt and Stephen Wilkinson, eds., *Patrons, Clients and Policies* (Cambridge: Cambridge University Press, 2007). For non-discretionary expansion undertaken by clientelistic parties at the national level, see Garay.

^{xiv} See Appendix A, Figure A1 and Table A1.

^{xv} Henry Brady and David Collier, eds., *Rethinking Social Inquiry: Diverse Tools, Shared Standards* (Lanham, MD: Rowman & Littlefield Publishers, 2004).

^{xvi} Andrew Bennett and Jeffrey T. Checkel, eds., *Process Tracing: From Metaphor to Analytic Tool* (Cambridge: Cambridge University Press, 2015).

^{xvii} See Edward Gibson, “Boundary Control: Subnational Authoritarianism in Democratic Countries,” *World Politics*, 58:1 (October 2005), 101–32.

^{xviii} Gibson.

^{xix} Ernesto Calvo and Victoria Murillo, “Who Delivers? Partisan Clients in the Argentine Electoral Market,” *American Journal of Political Science*, 48:4 (October 2004), 742–57; Carlos Gervasoni, “A Rentier Theory of Subnational Regimes: Fiscal Federalism, Democracy, and Authoritarianism in the Argentine Provinces,” *World Politics*, 62:2 (April 2010), 302–340.

^{xx} Gibson.

^{xxi} Auyero; Levitsky; Susan Stokes, “Perverse Accountability: A Formal Model of Machine Politics with Evidence from Argentina,” *American Political Science Review*, 99:3 (August 2005), 315–25.

^{xxii} Zarazaga.

^{xxiii} Rebecca Weitz-Shapiro, *Curbing Clientelism in Argentina* (New York: Cambridge University Press, 2014).

^{xxiv} In Argentina state-run health services are not used selectively in clientelist exchanges.

^{xxv} See Szwarcberg for an exception.

^{xxvi} Levitsky and Murillo.

^{xxvii} Juan Pablo Luna, *Segmented Representation: Political Party Strategies in Unequal Democracies* (Oxford: Oxford University Press, 2014).

^{xxviii} See Levitsky.

^{xxix} Paul Pierson, *Dismantling the Welfare State?* (New York: Cambridge University Press, 1994).

^{xxx} Laws 10 /87, 10552/89, 11554/94. Chiara, Magdalena, Mercedes De Virgilio, Cristina Cravino, and Andrea Catenazzi, *La gestión del Subsector Público de Salud en el Nivel Local* (Buenos Aires: UNGS, 2000); Alejandro López-Accotto, Carlos Martinez, Irene Grimberg, and Martín Mangas, *La Provincia de Buenos Aires y sus Municipios* (Buenos Aires: UNGS, 2011).

^{xxxi} Borges.

^{xxxii} Oliveros.

^{xxxiii} Interview, local councilor, May 17, 2017.

^{xxxiv} Levitsky.

^{xxxv} Estimated with 1991, 2001 and 2010 census data from INDEC.

^{xxxvi} *Ibid* fn 30.

^{xxxvii} Health-related revenue-sharing transfers are shaped by mayors' policy decisions and show variation across and within districts over time. See López Accotto et al.

xxxviii Estimated with data from the Ministry of Health, province of Buenos Aires.

xxxix We will use “consultations” for brevity.

xl For details on consultations and data sources, see Appendix B.

xli Gøsta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Princeton: Princeton University Press, 1990).

xlii For measures, data and sources, see Appendix B.

xliii Pritchett and Summers.

xliv Data from the Ministry of Finance, province of Buenos Aires.

xlv Because most mayors from the PJ lack consistent ideological agendas during the period studied here, we do not test for partisanship.

xlvi See Huber and Stephens; Garay. Touchton et al. find that electoral competition is not associated with health outcomes across Brazilian municipalities.

xlvii Garay’s Data Set of Protest. See Appendix B.

xlviii Calculated using <http://www.distanciasentre.com>. See Appendix A, Table A1

xliv Sven E. Wilson and Daniel M. Butler, “A Lot More to Do: The Sensitivity of Time-Series Cross-Section Analyses to Simple Alternative Specifications,” *Political Analysis*, 15:2 (Spring 2007), 101-23.

¹ We assume that the random constants and the independent variables in our data are uncorrelated. Cheng Hsiao, *Analysis of Panel Data* (Cambridge: Cambridge University Press, 2003). We also ran a Hausman test to evaluate if random effects were more accurate than fixed effects and concluded that a random effects model is more appropriate.

^{li} We did a Breusch-Pagan Lagrange Multiplier (LM) test and concluded that a random effects model is more appropriate for this data.

^{lii} Nathaniel Beck, “Time-Series–Cross-Section Data: What Have We Learned in the Past Few Years?” *Annual Review of Political Science*, 4 (June 2001), 271-93.

^{liii} See Brady and Collier.

^{liv} Tax collection reflects not only wealth but actual capacity or willingness to create, set rates for, and collect local taxes.

^{lv} See Chiara et al, 2000; Gustavo Badia and Martina Saudino, “La construcción Político-Administrativa del conurbano Bonaerense,” in Gabriel Kessler, ed., *El Gran Buenos Aires* (Buenos Aires: Unipe-edhasa, 2015), 121; Szwarcberg.

^{lvi} See Figure A1, Appendix A.

^{lvii} Ministry of Health, SISA.

^{lviii} 2001 census data from INDEC; population from Chiara et al, 2000, 84.

^{lix} Szwarcberg.

^{lx} www.juntaelectoral.gba.gov.ar

^{lxi} See www.josecpaz.gov.ar (accessed 01/2017).

^{lxii} Interview, councilmember of opposition PJ faction, July 6, 2017. See Szwarcberg.

^{lxiii} Interview, May 16, 2017.

^{lxiv} Data on spending is not publicly available and local government officials refused to provide it. Data for 2010 from Observatorio UNGS, and for 2016 provided by an opposition councilmember.

^{lxv} Interviews: district’s secretary of health and municipal hospital director, July 6, 2017.

^{lxvi} José C. Paz was the second-poorest Conurbano district in 2001 and the fourth-poorest in 2010.

^{lxvii} *La Nación* September 12, 2006.

^{lxviii} *Ibid*; *La Nación* November 1, 2006 and March 26, 2003. Interview, secretary of health.

^{lxi} Calculated with data from Chiara et al. 2000, 78 and INDEC.

^{lxx} Data for 1995 from Chiara et al 2000, 80; data for 2015 from Ministry of Health, province of Buenos Aires.

^{lxxi} Calculated with data from Presupuesto General de Gasto Municipal, 1996-2010.

^{lxxii} Calculated with data from Presupuesto General de Gasto Municipal, 1996 and 2010.

^{lxxiii} See *La Nación* September 6, 2012.

^{lxxiv} Magdalena Chiara, Mercedes De Virgilio, Javier Moro, Ana Airiovich, Carlos Jiménez, “La política sanitaria local en el municipio de Malvinas Argentinas” *Documento de Trabajo # 1* (Buenos Aires: UNGS, 2010)

^{lxxv} Communication with Graciela Ocaña, former head of PAMI (2004-07) and Minister of Health (2007-09), March 28, 2014.

^{lxxvi} Chiara et al., 2010.

^{lxxvii} Municipal budgets, 1996–2007. Similar data for 2008-2015 are not available in municipal budgets.

^{lxxviii} Chiara et al., 2010,16.

^{lxxix} *Ibid* fn 71.

^{lxxx} See Figure A2, Appendix A.

^{lxxxi} The margin of victory ranged from 18.5 to 38 percent across elections, with the exception of 2007, when it was 9.2 percent.

^{lxxxii} Interview, councilmember, July 12, 2017; *Ibid* fn 73.

^{lxxxiii} See www.Sanisidro.gov.ar

^{lxxxiv} San Isidro, several years and Foro Civico San Isidro, n/d.

^{lxxxv} Interview, top politician #1, May 10, 2017.

^{lxxxvi} Ibid.

^{lxxxvii} Interview, top local official #2, May 18, 2017.

^{lxxxviii} *ibid* fn 85.

^{lxxxix} According to our estimates with municipal data, health insurance payments represent close to 10 percent of annual health expenditures.

^{xc} The margin of victory ranged from 18 to 44 percent between 1995 and 2015.

^{xcⁱ} Authors' database of hospitals, Conurbano 1995-2016.

^{xcⁱⁱ} Vicente López, another wealthy district, has provincial hospitals and also provides broad local health services.

^{xcⁱⁱⁱ} Local Council, Avellaneda, Session of December 11, 2014 (https://www.ivoox.com/sesion-hcd-avellaneda-del-11-diciembre-del-audios-mp3_rf_3848660_1.html)

^{xc^{iv}} *La PoliticaOnline*, August 7, 2014.

^{xc^v} *El Sindicalista Radio Podcast*, November 7, 2014 (https://www.ivoox.com/entrevista-medicos-del-hospital-wilde-audios-mp3_rf_3710909_1.html).

^{xc^{vi}} Ibid.

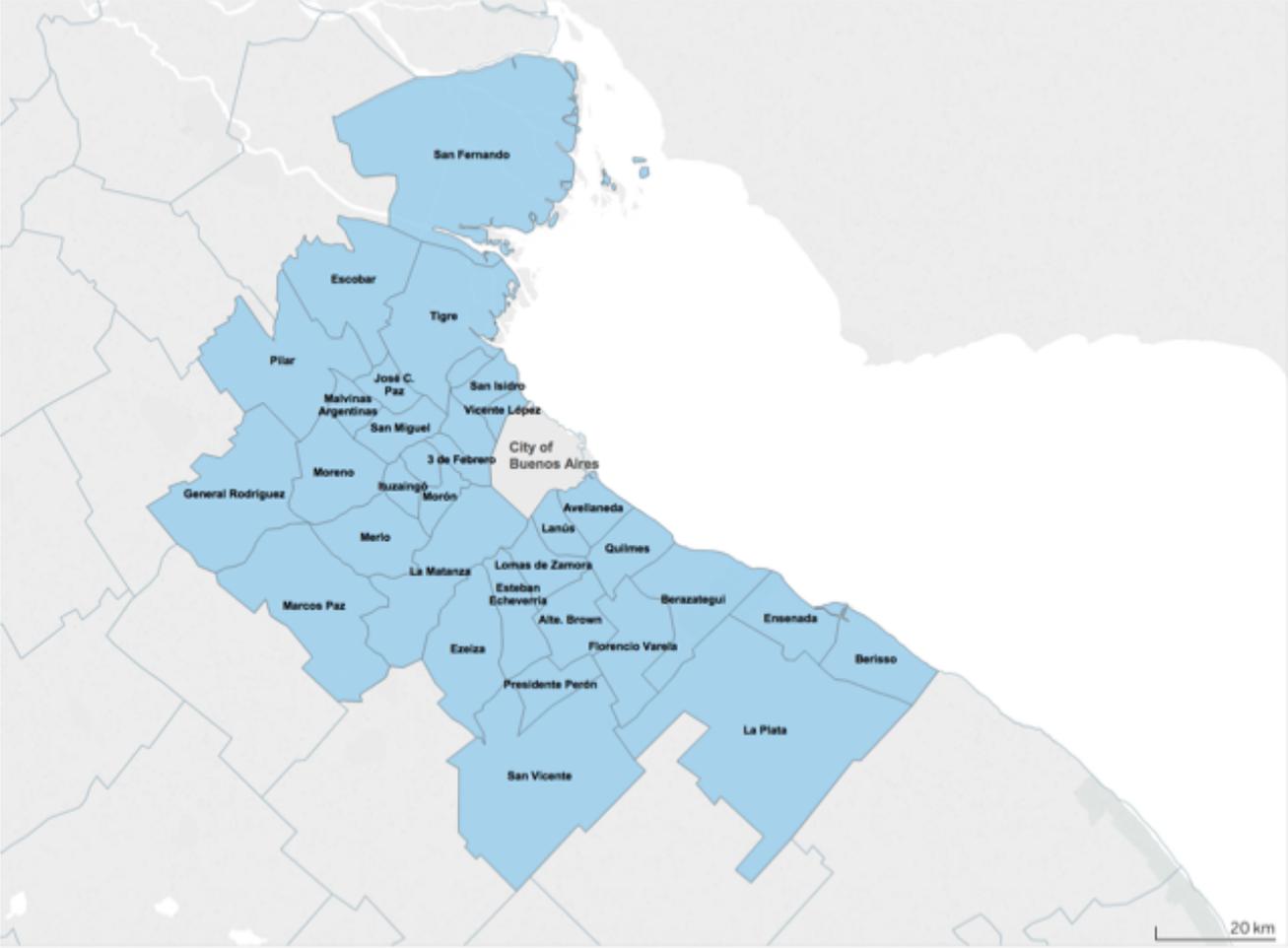
^{xc^{vii}} *CICOP Prensa*, August 15, 2014 (<http://cicop.org.ar/prensa/cicop-a-favor-de-la-provincializacion-del-hospital-de-wilde/>)

^{xc^{viii}} Touchton and Wampler; Touchton et al.

^{xc^{ix}} Ewig, Cristina, "Reform and Electoral Competition. Convergence towards Equity in Latin American Health Sectors," *Comparative Political Studies*, 49: 2 (2016), 184-218.

Appendix A. Figures and Tables

Figure A1. Map of Conurbano Municipalities



Elaborated with Tableau Desktop Professional Edition.

Table A1. Conurbano Municipalities, Population and Distance from the City of Buenos Aires

| Municipality | Population (2010) | Distance (in km) |
|---------------------|------------------------------|-----------------------------|
| Almirante Brown | 552,902 | 26 |
| Avellaneda | 342,677 | 7 |
| Berazategui | 324,244 | 29 |
| E. Etcheverría | 300,959 | 40 |
| Ezeiza | 163,722 | 37 |
| Florencio Varela | 426,005 | 27 |
| San Martín | 414,196 | 21 |
| Hurlingham | 181,241 | 29 |
| Ituzaingó | 167,824 | 34 |
| José C. Paz | 265,981 | 44 |
| La Matanza | 1,775,816 | 36 |
| Lanús | 459,263 | 11 |
| Lomas de Zamora | 616,279 | 32 |
| Malvinas Argentinas | 322,375 | 42 |
| Merlo | 528,494 | 42 |
| Moreno | 452,505 | 42 |
| Morón | 321,109 | 28 |
| Quilmes | 582,943 | 23 |
| San Fernando | 163,240 | 30 |
| San Isidro | 292,878 | 27 |
| San Miguel | 276,190 | 40 |
| Tigre | 376,381 | 32 |
| Tres de Febrero | 340,071 | 24 |
| Vicente López | 269,420 | 14 |
| Berisso | 88,470 | 63 |
| Ensenada | 56,729 | 59 |
| Escobar | 213,619 | 54 |
| General Rodríguez | 87,185 | 58 |
| La Plata | 654,324 | 58 |
| Marcos Paz | 54,181 | 58 |
| Pilar | 299,077 | 61 |
| Presidente Perón | 81,141 | 56 |
| San Vicente | 59,478 | 58 |

Source: Population from the National Institute of Statistics and Censuses (INDEC), 2010 Census; Distance calculated with <http://www.distanciasentre.com>

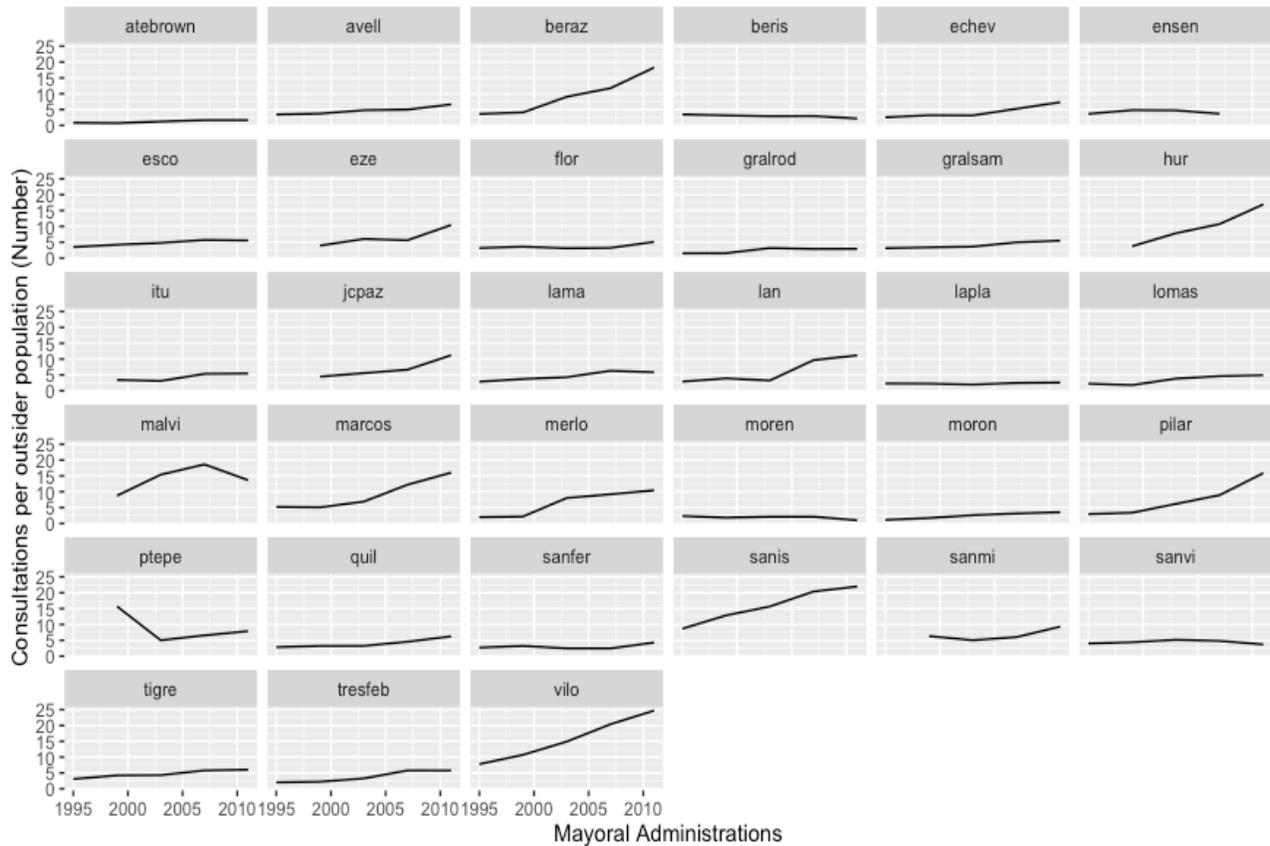
Table A2. Mayors' Alignment with the Governor, Conurbano Municipalities, 1995-2015

| Mayoral Administration | | | | | |
|-------------------------------|----------------|------------------|----------------|----------------|----------------|
| Municipality | 1995-99 | 1999-2003 | 2003-07 | 2007-11 | 2011-15 |
| Almirante Brown | Aligned | Aligned | Aligned | Aligned | Non-Aligned |
| Avellaneda | Aligned | Non-aligned | Non-Aligned | Aligned | Aligned |
| Berazategui | Aligned | Aligned | Non-Aligned | Aligned | Aligned |
| E. Etcheverría | Aligned | Non-Aligned | Non-Aligned | Aligned | Aligned |
| Ezeiza | Aligned | Aligned | Aligned | Aligned | Aligned |
| Florencio Varela | Aligned | Aligned | Aligned | Aligned | Aligned |
| San Martín | Aligned | Non-Aligned | Non-Aligned | Non-Aligned | Non-Aligned |
| Hurlingham | Aligned | Non-Aligned | Non-Aligned | Aligned | Non-Aligned |
| Ituzaingó | Aligned | Aligned | Aligned | Aligned | Aligned |
| José C. Paz | Aligned | Aligned | Aligned | Aligned | Aligned |
| La Matanza | Aligned | Aligned | Aligned | Aligned | Aligned |
| Lanús | Aligned | Aligned | Non-Aligned | Aligned | Aligned |
| Lomas de Zamora | Aligned | Non-Aligned | Non-Aligned | Non-Aligned | Aligned |
| Malvinas Argentinas | Aligned | Aligned | Non-Aligned | Non-Aligned | Non-Aligned |
| Merlo | Aligned | Aligned | Aligned | Aligned | Non-Aligned |
| Moreno | Aligned | Aligned | Aligned | Aligned | Aligned |
| Morón | Aligned | Non-Aligned | Non-Aligned | Non-Aligned | Aligned |
| Quilmes | Aligned | Non-Aligned | Aligned | Aligned | Aligned |
| San Fernando | Aligned | Aligned | Non-Aligned | Aligned | Non-Aligned |
| San Isidro | Non-Aligned | Non-Aligned | Non-Aligned | Non-Aligned | Non-Aligned |
| San Miguel | Aligned | Aligned | Non-Aligned | Aligned | Non-Aligned |
| Tigre | Non-Aligned | Non-Aligned | Non-Aligned | Aligned | Non-Aligned |
| Tres de Febrero | Aligned | Aligned | Non-Aligned | Aligned | Aligned |
| Vicente López | Non-Aligned | Non-Aligned | Non-Aligned | Non-Aligned | Non-Aligned |
| Berisso | Aligned | Aligned | Aligned | Aligned | Aligned |
| Ensenada | Aligned | Aligned | Aligned | Aligned | Aligned |
| Escobar | Non-Aligned | Non-Aligned | Non-Aligned | Aligned | Non-Aligned |
| General Rodríguez | Aligned | Aligned | Aligned | Aligned | Aligned |
| La Plata | Aligned | Aligned | Aligned | Non-Aligned | Aligned |
| Marcos Paz | Aligned | Aligned | Non-Aligned | Non-Aligned | Aligned |
| Pilar | Aligned | Non-Aligned | Aligned | Aligned | Non-Aligned |
| Presidente Perón | Aligned | Aligned | Non-Aligned | Aligned | Aligned |
| San Vicente | Aligned | Aligned | Non-Aligned | Aligned | Aligned |

Source: Elaborated with secondary literature, newspaper clippings, and candidate information.

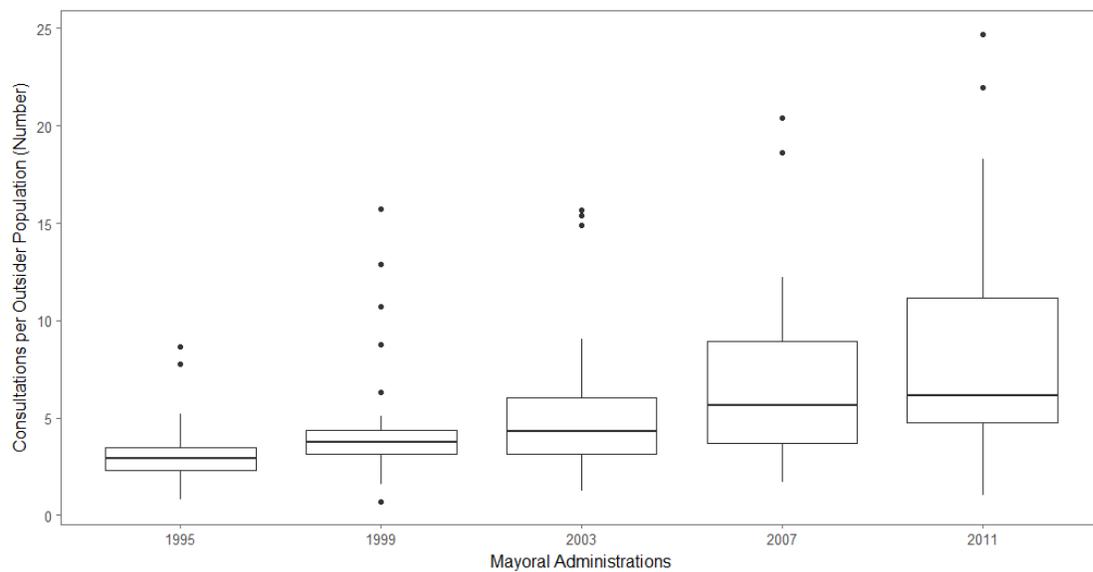
Note: The *Conurbano* expanded its reach over time. The nine districts listed last here became part of the region in the 2000s (Provincial Law 13473/06).

Figure A2. Medical Consultations in Conurbano Municipalities, 1995-2015



Source: elaborated with consultations data from the Dirección Provincial de Estadísticas de la Provincia de Buenos Aires and with health coverage data from the National Institute of Statistics and Censuses (INDEC), *Censo Nacional de Población* (1991, 2001, and 2010).

Figure A3. Medical Consultations across Mayoral Administrations, Conurbano, 1995-2015



Source: elaborated with consultations data from the Dirección Provincial de Estadísticas de la Provincia de Buenos Aires, and with health coverage data from the National Institute of Statistics and Censuses (INDEC), *Censo Nacional de Población* (1991, 2001, and 2010).

Note: Years indicate the beginning of mayoral administration terms.

Appendix B. Quantitative Analysis

Variables, Data, and Sources

Our data set contains information on thirty-three municipalities in the metropolitan area surrounding the city of Buenos Aires. This area, known as the Conurbano, is located within the province of Buenos Aires, holds about one-third of the country's population, and contains a broad range of socioeconomic conditions, including high levels of marginality. It should be noted that the Conurbano has grown over time, expanding from twenty-four to thirty-three districts in the 1990s.¹ When we run our tests with the earlier twenty-four municipalities, the results are substantively similar.

Local provision of health care services: Our indicator of service provision is municipal medical consultations (*consultas médicas municipales*) per outsider population (i.e., population without health insurance). Data come from the Dirección Provincial de Estadísticas de la Provincia de Buenos Aires, *Rendimientos de Establecimientos con y sin Internación de Dependencia Provincial, Municipal y Nacional por Región Sanitaria* (annual data from 1995 through 2015). For several years we obtained the data from publicly available documents; for other years we obtained those documents from provincial offices. We also use data on hospital beds from the same sources. For details on consultations, see Dirección de Estadísticas e Información de Salud (DEIS), *Consultas Ambulatorias en Establecimientos Oficiales* (Buenos Aires: Ministerio de Salud, 2013).

The outsider population was calculated as the total share of the population without health insurance coverage with data from the National Institute of Statistics and Censuses (INDEC), *Censo Nacional de Población* (1991, 2001, and 2010). Data were interpolated to produce annual estimates.

Municipal hospitals: To identify and track local hospitals and clinics, we created a database with information from the above sources as well as from newspaper articles, websites, and municipal and hospital documents. We collected information on opening dates, the construction of new hospital buildings as well as the transfer of local hospitals to provincial authorities if applicable.

Alignment of mayor with governor: Districts are coded 1 if mayor is aligned, 0 if not aligned. Data came from analyses of newspapers, electoral ballots, and secondary literature, including journalistic reports and books.

District wealth: We use gross geographic product (GGP) per capita to measure a district's wealth. Data were provided by the Dirección Provincial de Estadística, Ministerio de Economía de la Provincia de Buenos Aires (several years). Population data came from INDEC.

Electoral competition: We measure competition as the margin of difference between the leading candidate and runner-up. Data were obtained from the Junta Electoral de la Provincia de Buenos Aires (<http://www.juntaelectoral.gba.gov.ar/mapa-provincia-bsas.php>).

¹ See Gabriel Kessler, ed., *El Gran Buenos Aires* (Buenos Aires: UNIPE-Edhasa, 2015); Rodrigo Zarazaga and Lucas Ronconi, eds., *Conurbano Infinito* (Buenos Aires: Siglo XXI editores, 2017).

Mayor reelection: We code an administration as 1 if the mayor was reelected to a consecutive term, and 0 if the incumbent is not serving a consecutive term. We used the variables *mayor name* and *political party of winning mayoral candidate* from a data set of mayoral elections in Buenos Aires municipalities (1995–2011) created by Felicitas Brú, who kindly shared it with us. For the period 1991–1994 we obtained data from the Junta Electoral de la Provincia de Buenos Aires (<http://www.juntaelectoral.gba.gov.ar/mapa-provincia-bsas.php>).

Protest: We use Garay’s Data Set of Protest (2016), which counts protests by unemployed workers from 1996 to 2010 by province and municipality. For the 2011–2015 administrations, we interpolate data from 2007–2010. See Candelaria Garay, *Social Policy Expansion in Latin America* (New York: Cambridge University Press, 2016).

Outsider municipality: We code districts 1 if outsiders—residents without health insurance—constitute at least 51 percent of the population the year the mayor assumes office, and 0 if they do not.

Distance from the City of Buenos Aires: We calculate the distance from the center of each district to the center of the city of Buenos Aires using the website <http://www.distanciasentre.com>.

Appendix C. Sensitivity Test

In this table we show the results of our sensitivity test, in which we run the models using the average number of consultations during each administration as our dependent variable instead of using the number of consultations in the final year of each administration. The results are similar across models using different dependent variables.

Table C1. Determinants of Medical Consultations per Outsider Population, Random-Effects Regressions (average medical consultations per outsider population in each administration)

| | Model 1 | Model 2 | Model 3 | Model 4 |
|---|----------------------|-----------------------|-----------------------|-----------------------|
| Alignment | -2.942*** (0.610) | -3.107*** (0.613) | -3.122*** (0.630) | -2.798*** (0.615) |
| GDP_pc | 0.0000 (0.0000) | 0.0001*** (0.0000) | 0.0001*** (0.0000) | 0.0001*** (0.0000) |
| Mayor Reelection | 0.714 (0.618) | 0.712 (0.626) | 0.745 (0.623) | 0.714 (0.614) |
| Electoral Competition | 0.023 (0.018) | 0.019 (0.019) | 0.020 (0.019) | 0.015 (0.018) |
| Outsider Municipality | -0.461 (0.678) | - | - | - |
| Protest | - | -0.014 (0.026) | - | - |
| Distance from CABA | - | - | 0.003 (0.019) | - |
| Provincial Consultations (per outsider pop.) | - | - | - | -0.347*** (0.152) |
| N | 148 | 149 | 149 | 149 |
| Adj. R Squared | 0.15 | 0.17 | 0.17 | 0.20 |

*** $p < .01$; ** $p < .05$; * $p < .1$

Appendix D. Qualitative Data

We analyzed government documents, articles from national, provincial, and local newspapers and media outlets, publications from health workers' unions, and transcriptions and recordings of local council meetings. We triangulated data from these sources with open-ended interviews with politicians, health experts, and officials involved in provincial and local health care services. Our interviews, which were carried out between 2016 and 2018, include municipal councilmembers of the incumbent and opposition parties, secretaries of health and/or social assistance in the districts studied, and officials from the provincial and national government. These interviews helped us to uncover the motivations and perceptions of the local political actors behind the development of local health care services.²

² On qualitative research, see Henry Brady and David Collier, eds., *Rethinking Social Inquiry: Diverse Tools, Shared Standards* (Lanham, MD: Rowman & Littlefield Publishers, 2004); Andrew Bennett and Jeffrey T. Checkel, eds., *Process Tracing: From Metaphor to Analytic Tool* (Cambridge: Cambridge University Press, 2015); Tasha Fairfield and Andrew Charman, "Explicit Bayesian Analysis for Process Tracing: Guidelines, Opportunities, and Caveats," *Political Analysis*, 25(3) (2017), 363–380; Lana Mosley, ed., *Interview Research in Political Science* (Ithaca: Cornell University Press, 2013).