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# No Time to Fight, People Are Dying Out There

*The Impact of Elite Polarization on Developmental Assistance for Health*

ABSTRACT The factors influencing donor countries' overall contributions to developmental assistance for health (DAH) are little known, despite the importance of DAH in improving health conditions in low- and middle-income countries. This study examines how political elite polarization in legislative branches affects DAH commitments and disbursements from country-members of the OECD's Development Assistance Committee. From a world-society perspective, political polarization may decouple DAH contributions from global health funding norms and values. I test the impact of polarization on DAH commitments and disbursements using two-way fixed-effects regression analyses on multiple data sets and a new index of right–left elite polarization. I find that polarization is negatively associated with DAH disbursements but shows no significant relationship with DAH commitments. This suggests that elite polarization in donor countries impedes legislative efficiency, potentially increasing DAH disbursement volatility, and (more broadly) that political dynamics in donor countries can significantly impact the stability of global health financing. These findings have important implications for understanding the challenges in sustaining consistent DAH funding, especially from Development Assistance Committee members. KEYWORDS developmental assistance for health, Developmental Assistance Committee, world society, decoupling, political polarization

Developmental assistance for health (DAH) refers to financial and in-kind transfers from primary development channels, including bilateral agencies, international organizations, and international nongovernmental organizations (INGOs), to low- and middle-income countries to maintain or improve public health (Dieleman et al. 2016). Although the proportion of DAH to GDP is marginal in high-income donor countries, it is a crucial source of funding for the recipient countries. For instance, the average share of external aid in total health spending in low-income countries was 29% as of 2020 (World Health Organization 2022). In recipient countries, these resources enable the construction of new infrastructure for health, establishment of universal healthcare systems, training of people as healthcare providers and for other health-related roles, and the development and distribution of pharmaceuticals and medical technologies.

The Development Assistance Committee (DAC) plays a significant role in DAH. It is an international forum of developed countries under the Organisation for Economic Co-operation and Development (OECD), and its members share the mandate of promoting development cooperation. Following the establishment in 2000 of the Millennium Development Goals, which focused attention on DAH, the contributions of DAC

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members to DAH increased, reaching USD 18.5 billion in 2019 (Micah et al. 2017; Nomura et al. 2021a). But this growth has stagnated since the 2010s, leaving low- and middle-income countries facing uncertainty in arranging and implementing healthcare systems and services (Dieleman et al. 2016).

Despite efforts to mobilize health aid, the determinants of DAH from the donor's perspective remain insufficiently explored. While government failures in recipient countries play an important part in disbursement delay and inefficiency (Leurs 2005; Moitra et al. 2021), administrative challenges and unforeseen political issues on the donors' side have also been identified as causes for disruption in broader budget supports (SPA BSWG 2006). Regarding DAH contributions, scholars have studied the patterns of aid transfer (Dieleman et al. 2016; Nomura et al. 2021a) and priority setting in aid allocations based on political and strategic considerations (Alesina and Dollar 2000; Bermeo 2017; Berthélemy 2006). These studies typically focus on the country as a single observational entity and examine how a donor's characteristics influence its donation behavior. They mostly overlook the internal process of decision-making on DAH contributions. One exception addresses the social construction of aid priorities from a world-society perspective (Baccini, Heinzel, and Koenig-Archibugi 2022), but further exploration is needed of how DAH contributions are determined in donor countries.

Moreover, the factors that influence the size of total DAH contributions remain unclear. Although the aid-allocation approach enables scholars to understand general patterns of "who gives to whom" (Alesina and Dollar 2000), it is unclear why contributions to DAH are stagnating. For instance, Leach-Kemon and colleagues (2012) find that the global financial crisis hindered DAH contributions from 1990 to 2011. Yet Stuckler and colleagues (2011) find no statistically significant association between economic recession and DAH spending. Consequently, while DAH contributions can significantly improve health in low- and middle-income countries, the donor-side determinants of DAH spending, particularly in the context of the decision-making process, are still not well understood.

This study addresses the gap in the literature by analyzing how elite political polarization in DAC countries affects their commitments to and disbursements of DAH. Here, "elite political polarization" refers to political division among officeholders, party officials, policy intellectuals, and activists (McCarty 2019:13). While it is often assumed that the financing of DAH is embedded in world society (Alesina and Dollar 2000; Baccini et al. 2022; Swiss 2011), the decision-makers behind DAH are more directly embedded in national politics. Actors in government and legislatures are tasked with planning global health aid for the short and long term, as well as proposing and deciding actual budget spending in the immediate fiscal year. Given these considerations, this study asks, How does elite polarization within legislatures affect the predictability and stability of global health funding?

In this paper, I examine the process of DAH financing and how elite polarization influences the outbound health aid of a donor country. In the next section, I detail how the data were collected for the variables used in the statistical models and hypothesis tests. Then I present the results of the analysis and discuss their implications.

## BACKGROUND

### Importance of DAH and the Role of the DAC

Health outcomes in any region are influenced by the interconnectedness of global systems (Koplan et al. 2009). Health inequality is intertwined across borders, because current health conditions are often both the consequence of globalization and the cause of global crises. Within this global fabric, DAH has emerged as a pivotal tool to redress health disparities, particularly in low- and middle-income countries. Although DAH constitutes less than 1% of total global health expenditures, it covers more than 50% of health spending for some recipient countries (Dieleman, Micah, and Murray 2019).

Influxes of DAH can increase domestic health expenditure in recipient countries, directly improving health outcomes (Yogo and Mallaye 2015). For instance, stable DAH support enables accessible medical care at local healthcare facilities, which is not otherwise provided (Lane and Glassman 2008). Some scholars find that DAH reduces mortality among children under five by providing health care, especially for the poorest (Bendavid 2014). DAH's contribution to building universal health coverage is also evident in its support for healthcare infrastructure development and policy reforms, which enhance healthcare accessibility and efficiency in underserved areas (Obi et al. 2021). DAH funds often go toward combating high-prevalence diseases such as malaria and tuberculosis, significantly alleviating healthcare burdens on vulnerable populations (Odokonyero et al. 2018).

Among other contributors to global health, the DAC plays an important role in facilitating DAH (Dieleman et al. 2016). Initially established in 1961 as the Development Assistance Group to increase aid resources for the least developed countries (Eyben 2013), the DAC aims to identify and develop practical solutions for global problems and influence global perspectives and actions by monitoring official development assistance, setting standards for development cooperation, and conducting periodic reviews of the policies and programs of other DAC members.

Inclusion in the DAC puts pressure on member countries to contribute more actively to development assistance to low- and middle-income countries. From the world-society perspective (Meyer 2010; Ramirez 2012), donors' decision-making processes for DAH are embedded in social environments that shape the conceptual and normative frameworks among DAC countries as well as other actors in the field, including international organizations, INGOs, and other countries (Baccini et al. 2022). With greater exposure to INGOs (OECD DAC 2011) and enforcement of standards through a peer-review process (Swiss 2012), the aid-allocation process is shaped by global ties to world society in a way that reinforces global norms and practices (Swiss 2017). Priority-setting and aid-allocation decisions are made by actors navigating normative judgments and practical conditions, rather than being solely determined by the burden of disease (Baccini et al. 2022). Greater exposure to world society through the DAC and global ties to INGOs are expected to intensify pressure and re-emphasize ethical imperatives, encouraging more active contributions to overall developmental assistance, including for health.

The start of the twenty-first century is considered a golden age in global health (Micah and Dieleman 2019). The amount of foreign aid quadrupled during the 1990s and peaked

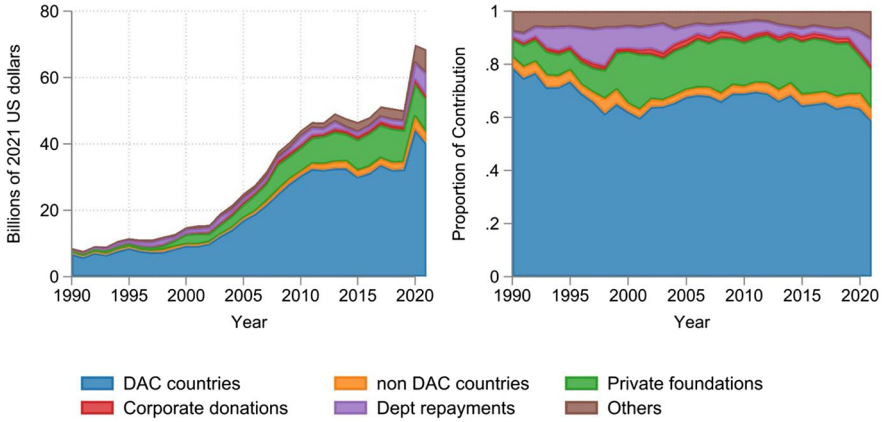


FIGURE 1. Total and percentage of development assistance for health by funding source, 1990–2021.
Source: Author's analysis of data from the Development Assistance for Health database of the Institute for Health Metrics and Evaluation (IHME 2023).

in 2017. This increase in DAH was mainly driven by the DAC countries (Figure 1). Until 2021, the DAC countries consistently contributed at least 60% of global DAH, except in 2001. The lower percentage in 2021 might have been due to COVID-19 (World Health Organization 2022). Excluding the fluctuations in 2020 and 2021, DAC countries have driven the overall increase and stagnation in DAH (Knox 2020).

## Decoupling of DAH

The amount of bilateral health aid can be measured in two ways: commitments and disbursements (Van de Maele, Evans, and Tan-Torres 2013). Commitments are donors' stated intentions to aid a specific recipient country's health sector. In bilateral aid, commitments represent the "promise" of a donor country to provide specific amounts of money through an aid project in a particular year or during subsequent years. In contrast, disbursements are the release of funds to or the purchase of goods or services for a recipient; they represent the actual payments recorded each year. Persistent gaps between commitments and disbursements commonly arise, not only because commitments include sums pledged for future years, but also due to failures to disburse funds as initially planned. These gaps can be exacerbated by a lack of readiness from either the donor or the recipient, which can delay disbursement.

As agencies within DAC member countries make decisions on commitments and disbursements, *decoupling* is possible (Meyer 2010; Meyer et al. 1997). This often manifests as policy–practice decoupling, where formally stated goals are not realized in practice (Bromley and Powell 2012). Membership in the DAC suggests increased motivation for contributions due to nominal accountability under the DAC mandate (OECD 1991) and social pressure from involvement in expert and advocacy networks (Baccini et al. 2022). But contributions are influenced by many factors, including the quality of institutions, infrastructure, economic and policy environments, and the nature

of the aid (Chang et al. 2019; Moitra et al. 2021). Admittedly, recipient countries' administrative competence and economic and political stability are important factors (Ernst 2013; Martínez Álvarez and Acharya 2012), but lack of accountability among donors crucially threatens DAH contributions (Leurs 2005; Sridhar 2010).

The exact reasons for decoupling in global health funding remain unclear. Studies suggest that administrative conditions and political problems on the donor's side are the primary impediments to the effective deployment of DAH (Eifert and Gelb 2008; Hudson 2013; SPA BSWG 2006). Yet these studies, primarily based on expert documentation, have not identified which aspects of these political issues significantly contribute to the decoupling of DAH promises from actual contributions. I propose that the legislative process is critical, as it is where DAH commitments and disbursements are formulated and ratified.

DAH can be decoupled from the goals of DAC members in two ways. One way is that a donor country may fail to meet the DAC's primary goal by making a smaller commitment than the average year, or smaller than expected. This can happen if its current or anticipated capacity shrinks due to domestic challenges, such as changes in public support or administrative norms.[1] Because recipient countries heavily rely on DAH for health policy and planning (Sridhar 2010), a smaller commitment will force them to reassess their long-term goals, with health and general developments postponed due to insufficient resources (Farag et al. 2009).

The other way of decoupling is that the donor country may fail to realize its commitments, delaying or even canceling disbursements. Volatility in DAH disbursements can create critical problems in recipient countries by hampering resource allocation and services essential for maintaining health. For instance, it may compromise recurring costs such as salaries, drugs, and transport and undermine long-term efforts in building health systems (Moon and Omole 2017).

### Domestic Political Polarization and DAH Contributions

In most, if not all, democratic countries, any budget must be approved by the respective legislative bodies to be planned and executed. Donors bound by the DAC are no exception. The legislative branch is a significant factor in DAH decoupling, given its authority to allocate funds across different areas, including DAH schemes. Although extensive research indicates that political processes influence domestic public health expenditures (Clemente, Lazaro, and Montanes 2016; Hartwig and Sturm 2014; Hitiris and Posnett 1992; Liang and Mirelman 2014; Okunade, Karakus, and Okeke 2004; Patterson and Veenstra 2016), the impact of political turmoil on DAH remains under-investigated.

A country's political situation, especially political polarization, can impair its DAH contribution in several ways. First, political polarization can cause legislative gridlock and prevent the legislature from passing new bills (Lee 2015).[2] When a political stalemate emerges, it impairs legislative productivity (Kistner 2015; McCarty 2011), which also directly impacts DAH financing. Moreover, in the negotiation between politicized legislators to break the gridlock, DAH often becomes a primary target for budget cuts. In the political negotiation process, global health, categorized as "low politics," is often considered less crucial than "high politics," such as security and military spending, and often sacrificed in exchange for other resources (Fidler 2009; Sridhar 2010).

Second, political polarization politicizes people's understanding of health and science, undermining the rationale for DAH (Rekker 2021). Political scientists find that political polarization fosters the politicization of science, leading to an emphasis on the inherent uncertainty of science and casting doubt on scientific consensus (Bolsen and Druckman 2015:748). The imperative of DAH relies on understanding the historical roots of global health, which emerged during colonial times as a mechanism for protecting colonial interests rather than advancing equitable health outcomes (Greene et al. 2013). From this historical awareness arises a moral imperative—particularly for former colonial powers—to address the global health disparities that their past actions helped to create (Paxton and Knack 2012). The case for DAH is further supported by evidence of the effectiveness of foreign aid in improving health outcomes in lower-income countries (Hynes and Scott 2013). However, when health and science become politically salient, politicized discourse often results in motivated disbelief regarding science and health (Campbell, Leister, and Zenou 2019; Taber and Lodge 2006), which leads to more controversy and weaker support for DAH among decision-makers. This is worrisome because the politicization of an issue can be irreversible (Jones-Jang and Noland 2022; Zeitlin, Nicoli, and Laffan 2019), and recovering DAH once it has been compromised by this mechanism is difficult.

Finally, political polarization, especially in recent years, strengthens nationalism and right-wing populism, which often oppose DAH ideologically. Recent political polarization has further entrenched conservative ideologies, as observed in developed countries with stable democracies (Hankins, Hoover, and Pecorino 2017; Rydgren 2007). When policymakers endorse more right-wing politics, they are more likely to oppose foreign aid, including DAH (Paxton and Knack 2012).

Moreover, the emergence of right-wing populism in many DAC members (Andersen and Bjørklund 2000; Breeze 2019; Hafner-Burton, Narang, and Rathbun 2019; Lee, Wu, and Bandyopadhyay 2020) has increased the ethnocentrism and anti-globalism in their political agendas (Bonikowski 2017). In addition, the anti-globalist reaction from political leaders can promote the idea that noncompliance with global regimes is prevalent, which undermines the impact of world society driven by the DAC (Carnegie and Carson 2019).

In sum, this paper examines whether political polarization in DAC member countries affects their DAH contributions to developing countries. If the politicization of science and health, coupled with the rise of right-wing populism, weakens the pressure from world society to mobilize DAH, then *commitments* are likely to diminish as the polarization intensifies. On the other hand, if increased polarization leads to legislative instability by causing gridlock and delaying legislative processes—a factor that cannot be predicted when commitments are made—then it could reduce *disbursements*. These considerations suggest two hypotheses.

H1. Greater political polarization in the legislative body will decrease DAH commitments in DAC member countries.

H2. Greater political polarization in the legislative body will decrease DAH disbursements in DAC member countries.

## METHODS

### Dependent Variable

I use four dependent variables for DAH, using different data sources to address the limitations of each. First, I use the OECD's Creditor Reporting System (CRS) data set for both commitments and disbursements. The CRS data begin in 2002 and use self-reports—the most straightforward data source. However, when publishing its yearly data, CRS updates past contributions in two ways. A donor can provide updated information for any past reporting year; and the OECD removes information on past recipient countries that become donors (AidData 2017). Because of its self-reporting format, DAH flows may be omitted or double-counted in the CRS data (IHME 2023).

To address those limitations, I use AidData's Core Research Release Version 3.1 (AidData 2017) as a third dependent variable. Instead of reflecting updated information on past commitments, AidData uses an additive model that leaves the previous year's data unchanged and updates only the new year's. AidData is based on CRS but enhances data quality by incorporating other donor documents, including annual reports and official websites, to estimate commitments more accurately (Tierney et al. 2011). As a result, AidData contains historical information for longer periods than CRS. However, it has not been updated since 2012 and only includes data up to 2009.

Finally, I use the Development Assistance for Health Database 1990–2021 from the Institute for Health Metrics and Evaluation (IHME) to measure disbursements. IHME uses diverse methods to provide more accurate estimates from bilateral donors by tracking comprehensive donor and recipient data, ensuring no duplications or omissions (Grépin et al. 2012; IHME 2023). For instance, IHME collects health-related project-level data and calculates weighted averages to get more precise estimates for each project, especially for the less reliable items in the CRS database.

When assessing DAH contributions across all data sets, I consider DAC member countries only after their accession to the committee. This is because DAC members are the most influential and active contributors to DAH. Also, due to the DAC's mandate and peer review process, DAC membership is enough for a donor country to feel pressure to make an effort toward DAH contributions. Consequently, commitments and disbursements made by countries prior to their joining the DAC are excluded from this study. The DAC has 31 country members (see Table A1 in the appendix), but each model uses a different number of countries and years due to data availability. To improve comparability between models, I use the same list of recipients and aid sectors across all three data sets. I limit the recipients to the World Bank's category of low- and middle-income countries (Dieleman et al. 2016). For the aid sectors, because the CRS and AidData data sets contain other aid sectors along with health, I use general health, basic health, and population programs. CRS is collected as official development assistance in all channels in constant 2021 US dollars.

The AidData and IHME data sets use 2009 and 2021 constant US dollars, respectively. Although AidData uses different baselines for the constant dollars, I do not change its currency since it will not change the significance of the relationship in the analysis.

Finally, I transform all dependent variables into the natural logarithm of DAH contribution as a percentage of GDP. GDP is derived from the World Bank Databank API using constant 2015 US dollars (NY.GDP.MKTP.KD). With log transformation, DAH contribution measures approximate the normal distribution.

I conduct robustness checks using both logged and unlogged dependent variables, as well as alternative model specifications to account for different distributions of the dependent variable. In fixed-effects regression models, the log transformation does not alter the relationships between variables. Fixed-effects Poisson regression models on unlogged dependent variables produced results consistent with those of the main models. Finally, fixed-effects negative binomial models on both formats failed to achieve concavity. This issue likely arises from the characteristics of the dependent variable, which represents a proportion of DAH spending per GDP rather than a count. Overall, changes in the format of the dependent variables and model specifications do not significantly alter the main finding, whereas regression models with logged dependent variables best satisfy the model assumptions. See Appendix B for details of the model selection and robustness checks.

### Political Polarization

Political polarization has been measured in various ways for cross-national comparisons. Azzimonti (2013) used the monthly count of polarization-related words in newspapers to measure polarization in the public sphere. Another study used the percentage of voters supporting anti-political-establishment parties (Casal Bértoa and Rama 2021). The Varieties of Democracy (V-Dem) project surveyed experts on whether societies are polarized into antagonistic political camps (Coppedge et al. 2019). However, these measures do not clearly specify the domains they assess, such as public or elite polarization (Fiorina and Abrams 2008). Dalton (2008) proposed a measure of party system polarization using data from the Comparative Study of Electoral Systems. His index intends to measure the distribution of parties on a scale of ideological position, and their influence in the legislative branches. Although it enables cross-country comparisons of polarization in two-party and multiparty systems, Dalton's method includes only five waves of CSES from 1996 onward, leaving significant gaps due to limitations in data availability.

To address the limitations of previous measures, I construct a new scale, the Elite Political Polarization Index (EPPI), to measure elite political polarization in the legislative branch. This index is constructed by adapting Dalton's (2008) polarization-index formula to the RILE index (also known as the Right-Left scale), which measures the ideological position of political parties in the election manifestos collected by the Manifesto Research on Political Representation (MARPOR) project. By analyzing the content of election manifestos, MARPOR estimates each party's political stance, including attitudes on foreign relations, freedom and democracy, governmental decentralization, economy, social welfare, traditional norms, and inclusion of minorities (Budge 2013; Budge and Laver 2016; Volkens et al. 2013). RILE ranges from –100 (perfectly left-wing) to 100 (perfectly right-wing); I rescale it to range from 0 to 10 for compatibility with Dalton's formula.

Specifically, I apply Dalton's polarization index to RILE this way:

$$\text{EPPI} = \sqrt{\sum \left[ \text{VoteShare}_i \left( \frac{\text{RILE index}_i - \text{mean RILE index}}{5} \right)^2 \right]}$$

where *i* indicates individual parties, and "RILE index" refers to the right–left position of each party, rescaled to range from 0 to 10. The deviation of the RILE index is divided by 5 to make EPPI fall between 0 and 10, where 0 indicates all parties have the same position in the election, and 10 means all parties are split between two extreme sides (Dalton 2008). Strictly speaking, because the MARPOR data are based on election records, we can only calculate the index on an election date. However, I assume that the political distribution of a legislative body will not significantly change during the session. Therefore, each year between elections is coded with the value from the previous election. In election years, the date a new legislative body convenes to open a new session is used as a weighted point. For example, if a new session starts on February 21, the 52nd day of the year, the index of the previous legislative body will be weighted as 51 / 365 = 0.1397, and that of the new legislative body as 314 / 365 = 0.8603.

EPPI has several advantages over other metrics. First, because it uses political positions estimated directly from parties' declared attitudes, it more accurately reflects the political distribution of a legislative body. Second, by including vote share, it also reflects each party's political influence. For instance, if a party has an extreme ideological position, but does not get enough votes to wield any influence in the legislative body, its influence on political polarization should also be minuscule. Third, because it uses the sum of polarized scores, it can be applied in both two-party and multiparty systems.

I conduct robustness checks using the political polarization indicator from the V-Dem data set as an alternative measure for the independent variable. However, this measure showed no significant association with the dependent variables. This may be due to the nature of the V-Dem indicator, which is based on experts' subjective assessments of polarization in broad social contexts rather than on objective, domain-specific metrics, such as my legislature-focused measure. If DAH spending is influenced by a specific type of political polarization, but the measurement captures a broader notion of polarization, this could lead to construct validity issues due to conceptual overgeneralization. This result highlights the need for a new measure that focuses on elite polarization in the legislature. For details, see Appendix B.

### Control Variables

I use several control variables that may be associated with both DAH and political polarization. GDP per capita, in constant 2015 US dollars, is included to account for the potential spurious relationship arising from donor countries' economic development. Research suggests that countries with higher GDP per capita tend to contribute more DAH (Dieleman et al. 2015). Also, higher GDP per capita corresponds to less political polarization in European countries (Akdede 2012). The data are from the World Bank Databank API (NY.GDP.PCAP.KD) and natural-logged to address skewness.

I also looked at GDP growth and unemployment, to control for economic recession (see Appendix B). However, these variables are insignificant, suggesting that recessions do not impact DAH spending (Stuckler et al. 2011) while in some cases producing contradictory results without significantly affecting the main findings. This may suggest further research on the association between recessions and DAH spending, but it lies beyond this study's scope. Therefore, I exclude these variables to maintain model parsimony.

I also include variables concerning general welfare generosity and domestic health status. If elite polarization undermines the rationale for health investment, as H1 suggests, it is likely to reduce domestic health status, budgets, and DAH contributions. Moreover, while public health spending reflects general welfare generosity (Brady and Burroway 2012), it may also reflect donors' altruistic or egoistic aid allocation and can affect DAH contributions. For example, Switzerland and most Nordic countries show altruistic aid allocation, which prioritizes recipients' needs and merits, while Japan and the United States exhibit the most egoistic aid allocation, which links aid to the self-interest of the donors (Berthélemy 2006). To account for the confounding effects of governments' general support of healthcare, data on public health spending—that is, current expenditures (as a share of GDP) for government/compulsory health schemes from all providers—is obtained from the health expenditure and financing statistics within OECD Stats. Also, infant mortality per 1,000 live births is obtained from the World Bank API (SP.DYN.IMRT.IN) and included in the models as a proxy measure of overall population health and development (Reidpath 2003).

To control for the political context of donor countries, I include data on democracy and legislative corruption from V-Dem. The quality of democratic systems is recognized as a key factor in aid priorities (Bermeo 2017). Democratic countries tend to allocate their aid to democratic recipients (Alesina and Dollar 2000; Berthélemy 2006). While a minimum level of democracy is necessary for political polarization to exist (McCarty 2019), excessive polarization is known to threaten democracy (Arbatli and Rosenberg 2021) and hinder decision-making, as mentioned. Moreover, less democracy is often correlated with more corruption, leading to the misuse of public resources for private gains (Bauhr and Grimes 2021; Kubbe and Engelbert 2018). On the other hand, corruption is associated with higher government health expenditures in developed countries (Liang and Mirelman 2014). In any case, corruption may have a significant relationship with DAH contributions. My democracy variable is calculated as the mean of five high-level democracy indices—electoral, liberal, participatory, deliberative, and egalitarian—on a scale from 0 (least democratic) to 1 (most democratic). Legislative corruption is on a scale where 0 means most legislators allegedly engage in corrupt activities, such as accepting bribes, and 4 indicates they never or hardly ever do.

Finally, I control for the total number of INGOs to account for national ties to global institutions. The data are from the Union of International Associations' *Yearbook of International Organizations* (Shorette 2022).[3] Peer influence from the world society affects the conceptual and normative frameworks of aid policymakers and influences the funding priorities for DAH (Baccini et al. 2022). If more exposure to overlapping networks puts more pressure on legislators to abide by the global health script, it may

lead to efforts to expand DAH contributions. Political polarization may accelerate the decoupling from the global health script, but this moderating effect lies beyond the scope of this study. In the analyses, I divide the number of INGOs by 1,000 to aid interpretation.

## Methods

I use a two-way fixed-effects ordinary least squares regression model with clustered robust standard errors in Stata 17.0. I use country and year as panel-level variables.

There are several reasons to use a two-way fixed-effects model for this study. First, the panel structure of the data violates the assumption of ordinary least squares regression that all observations are independent. Second, two-way fixed-effects regression analysis is commonly used in global perspective studies to control potential heterogeneity bias (e.g., Bhandari and Burroway 2023). This method allows control over omitted variables through temporal and country-specific unobserved factors. Therefore, the two-way fixed-effects model approximates exogeneity in analyses (Bailey 2021). Third, by conducting two-way fixed-effects regression, I intend to measure the general impact of political polarization on DAH across country- and time-specific variations. Although decision-making processes on DAH are embedded in the world society, it can be assumed that the decoupling effects of political polarization are relatively independent of the decision-making processes of other DAC member countries. Finally, in all models, a Hausman specification test indicated that the random-effects specification is not appropriate for panel-level effects. In sum, the two-way fixed-effects model enables the isolation of both country-specific and time-specific variances, allowing us to evaluate changes within countries over time and focus on the effects of political polarization on DAH contributions.

I consider linearity, multicollinearity, autocorrelation, heteroskedasticity, and outliers for robustness checks. I log-transform the dependent variables to ensure a linear relationship between independent and dependent variables. The variance inflation factor is calculated using pooled ordinary least squares regressions equivalent to the models. The means and the variance inflation factors do not exceed 3, which implies that multicollinearity would not be a problem (Daoud 2018). Next, I use a Wooldridge test to check for autocorrelations in the dependent variables. While CRS commitments and AidData have no significant autocorrelations, CRS disbursements and IHME do. This result follows the understanding that commitments typically fluctuate more than disbursements (Van de Maele et al. 2013). White's test and the Breusch-Pagan/Cook-Weisberg test are used for heteroskedasticity using the pooled ordinary least squares models. In all models, White's tests do not reject homoskedasticity, but Breusch-Pagan/Cook-Weisberg tests suggest heteroskedasticity. I conduct fixed-effects regression models with clustered robust standard errors to estimate heteroskedasticity and autocorrelation-consistent analyses for all models (Hoechle 2007). Finally, I check outliers using standardized residuals. Except for the CRS disbursements model, all models have two to five outliers; however, their exclusion does not significantly alter the results. The details can be found in Appendix B.

The four models used in this study are not strictly comparable, because each uses a different list of donor countries and years. However, I use the same set of recipient countries and aid sectors to standardize measurements across the dependent variables. Also, using two-way fixed-effects models, I estimate relationships between variables while controlling for year- and country-specific unobserved factors. Although some years or countries are not included in the AidData or IHME data sets, the general relationship between the variables of concern should remain consistent with the counterpart CRS models. I considered an alternative set of models using the same observations for all models—that is, with no missing values in all dependent and independent variables. However, this gives us only 251 observations from 22 countries between 2002 and 2013, limiting the information significantly, especially in the 1990s and later 2010s. But while the smaller sample may have less statistical power, making it more difficult to achieve significance, the direction of the main variable associations remains consistent, suggesting that the core relationship is robust.

## RESULTS

Table 1 provides descriptive statistics for the four data sets I used. Each section presents mean and standard deviations for each analytic sample. The years covered are restricted mainly by data availability for the dependent variable.

Figure 2 shows the EPPI scores of selected countries. The United States, a two-party system, shows the strongest fluctuation. Generally, EPPI decreases when one political party controls both the House and Senate, and increases during divided control, indicating the possibility of political gridlock. Denmark had the highest mean EPPI, while South Korea had the lowest. A country's EPPI appears to be influenced by the ideological distance between dominant parties, with fluctuations reflecting election trends. For example, Denmark's landslide election of 1973 reduced the score, while, in South Korea, the diversification of political parties and the decline of the dominant two-party system in 2008 increased it. The Netherlands has the median EPPI; it is relatively stable and slowly decreasing. The reduced influence of the three largest parties since the 1980s and the rise of minor parties may have contributed to this trend.

Table 2 presents the main findings of the study. In Model 1 (CRS commitments), the coefficient for political polarization is positive, but it is not statistically significant. Only GDP per capita has a marginally significant coefficient, suggesting that increasing GDP is associated with more generosity in DAH commitments.

In Model 2 (AidData commitments), the coefficient for political polarization is statistically insignificant. Models 1 and 2 do not support H1, because they do not show an effect of political polarization on DAH. Other aspects of Model 2 show slightly different patterns from Model 1. Infant mortality is negatively associated with commitments, which aligns with the assumption that a healthier country commits more to global health funding. The coefficient for corruption is highly significant ($p < 0.001$), suggesting that worse corruption is associated with larger DAH commitments. The implication of this finding will be discussed later.

TABLE 1. Descriptive Statistics

| | CRS commitments | | AidData commitments | | CRS disbursements | | IHME disbursements | |
|---|---|---|---|---|---|---|---|---|
| | Mean | SD | Mean | SD | Mean | SD | Mean | SD |
| CRS commitments | 1.8 | 1.96 | | | | | | |
| AidData commitments | | | 2.5 | 2.77 | | | | |
| CRS disbursements | | | | | 1.7 | 1.70 | | |
| IHME disbursements | | | | | | | 5.6 | 5.01 |
| Political polarization | 3.6 | 1.50 | 3.8 | 1.50 | 3.6 | 1.53 | 3.6 | 1.47 |
| GDP per capita | 10.6 | 0.44 | 10.5 | 0.36 | 10.6 | 0.47 | 10.6 | 0.40 |
| Public health spending | 6.9 | 1.62 | 6.1 | 1.28 | 7.1 | 1.67 | 6.7 | 1.61 |
| Infant mortality | 3.8 | 1.19 | 5.7 | 2.70 | 3.5 | 1.04 | 4.3 | 1.51 |
| Legislative corruption | 0.1 | 0.09 | 0.1 | 0.07 | 0.1 | 0.09 | 0.1 | 0.07 |
| INGOs | 2,958.9 | 785.67 | 2,424.6 | 955.35 | 3,053.6 | 815.85 | 2,866.3 | 836.09 |
| Democracy | 0.8 | 0.06 | 0.8 | 0.04 | 0.8 | 0.07 | 0.8 | 0.04 |
| Year | 2009.3 | 7.79 | 1997.6 | 10.84 | 2012.4 | 5.73 | 2006.3 | 9.09 |
| Countries | 29 | | 27 | | 29 | | 23 | |
| Years included | 1995–2021 | | 1973–2013 | | 2002–2021 | | 1990–2021 | |
| *N* | 616 | | 606 | | 484 | | 667 | |

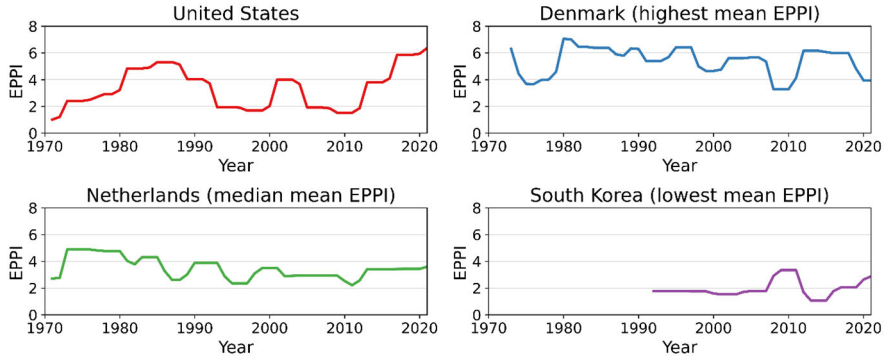


FIGURE 2. EPPI scores for selected countries, 1970–2020.

In Model 3 (CRS disbursements), the coefficient for political polarization is again positive but not significant. But here the coefficient for GDP per capita is significant ($p < 0.05$), suggesting that wealthier countries are more generous with DAH.

In Model 4 (IHME disbursements), the coefficient for political polarization is negative and significant ($p < 0.05$), suggesting that greater political polarization in the legislature is reduces DAH disbursements. More specifically, a one-unit increase in EPPI

TABLE 2. Two-Way Fixed-Effects Models of DAH Commitments and Disbursements

| | Model 1 CRS commitments | Model 2 AidData commitments | Model 3 CRS disbursements | Model 4 IHME disbursements |
|---|---|---|---|---|
| **Political polarization** | **0.018** | **0.002** | **0.010** | **−0.046*** |
| | **(0.045)** | **(0.056)** | **(0.040)** | **(0.017)** |
| GDP per capita (logged) | 4.941+ | 2.331 | 6.992* | 1.690** |
| | (2.619) | (1.555) | (2.744) | (0.594) |
| Public health spending | 0.090 | 0.097 | 0.019 | 0.085** |
| | (0.067) | (0.083) | (0.060) | (0.027) |
| Infant mortality | −0.441 | −0.531** | −0.118 | −0.006 |
| | (0.408) | (0.154) | (0.361) | (0.102) |
| Corruption | 0.037 | 19.855*** | 1.923 | −0.434 |
| | (4.858) | (4.474) | (4.139) | (1.724) |
| INGOs (thousands) | 0.242 | −0.013 | 2.370 | 0.060 |
| | (0.219) | (0.181) | (1.541) | (0.095) |
| Democracy | −1.525 | 2.694 | −1.419 | 2.769+ |
| | (2.308) | (9.100) | (1.780) | (1.598) |
| Constant | −58.211* | −29.426 | −87.882** | −28.133*** |
| | (27.457) | (18.117) | (29.627) | (6.052) |
| Observations | 616 | 606 | 484 | 667 |
| Countries | 29 | 27 | 29 | 23 |
| Within-$R^2$ | 0.2486 | 0.4840 | 0.3707 | 0.5096 |
| Years included | 1995–2021 | 1973–2013 | 2002–2021 | 1990–2021 |

+$p$ < 0.1; *$p$ < .05; **$p$ < .01; ***$p$ < .001 (two-tailed tests); standard errors in parentheses.

is associated with a 0.96% decrease in DAH disbursements as a percentage of GDP, holding all else constant. Although Models 3 and 4 yield different findings regarding the effect of political polarization on DAH disbursements, the results of Model 4 are more reliable thanks to better data. Therefore, Model 4 presents suggestive evidence that stronger political polarization is associated with smaller DAH disbursements, all else being equal. This model also has a significant coefficient for GDP per capita ($p$ < 0.01), in line with Models 1 and 3. Public health spending is significantly associated with disbursements ($p$ < 0.01), and so is democracy, but with only marginal significance ($p$ < 0.1). Although there is no strong assumption of a relationship between democracy and disbursements, we are seeing a possible link.

In summary, the models vary in their results, particularly with respect to the direction and significance of the impact of political polarization. This could be due to the differing

nature of the data sources, as discussed in the next section. However, a positive association of GDP per capita with DAH is seen in multiple models.

To illustrate the practical effect of political polarization on DAH contributions, I provide two anecdotal cases, from Australia and the United States, respectively. In Australia, the conservative coalition government integrated AusAID into the Department of Foreign Affairs and Trade, resulting in significant budget cuts and reallocations of funds to national defense (Anderson 2014; Wood, Burkot, and Howes 2015). Moreover, faced with fiscal constraints and public demands for economic responsibility, the liberal Labor Party prioritized immediate humanitarian needs, such as aiding refugees from Papua New Guinea, rather than restoring funding for long-term development projects (ABC News 2013). Amid ideologically polarized priority-setting—where each party sought to promote its political agenda and respond to its constituency—the share of aid spending in the national budget sharply declined over four years, reducing DAH disbursements from USD 826 million in 2012 to 319 million in 2017 (IHME 2023). Thus a shift in political priorities driven by political polarization significantly reduced DAH contributions.

In the United States, the President's Emergency Plan for AIDS Relief, the largest initiative targeted specifically at HIV/AIDS globally, has long been maintained with bipartisan support. However, in 2023, a conservative think tank and a Republican representative challenged the plan's legitimacy, alleging (without evidence) that it supported abortion-related activities abroad (Moss and Kates 2023). While the program was successfully reauthorized, this case illustrates how misinformation and ideological polarization can undermine bipartisan support for global health initiatives, threatening their long-term stability and effectiveness.

## DISCUSSION

My models suggest that greater political polarization is associated with smaller DAH disbursements (but not commitments) from DAC member countries. They also indicate complex and varied effects from other factors. The differences are likely to stem from the nature of the data sources.

First, commitments generally fluctuate more than disbursements (Van de Maele et al. 2013), making them unpredictable. Commitments are a promise of future spending, so they increase when more promises are made, but the disbursement will happen over the next several years. Disbursements are more predictable than commitments, as they represent annual planned spending over extended periods, tied to the donor's national budget (Dieleman et al. 2016; Van de Maele et al. 2013). On the other hand, the predictability of the disbursements raises concerns about volatility. They are considered more susceptible to the specific context than commitments, because the distribution of funding is tied to the political, economic, and administrative contexts of the donor and recipient (Nomura et al. 2021b). Commitments may exist as an envisioned blueprint, mapping out future goals with relative independence from the potential and imminent problems in DAC members' domestic politics. Because disbursements are measured by

legislative decision-making, political polarization and subsequent legislative obstacles may be more directly reflected in the volatility of disbursements.

Second, the discrepancy in the results could be derived from the quality of the self-reported CRS data. The IHME data set is estimated by adjusting the CRS data to overcome two main challenges: aid activity is underreported in the CRS compared to what is reported to the DAC, and disbursements are underreported compared to commitment data (Dieleman et al. 2016). Also, AidData is known to correct problematic variables, including dollar amounts and coding schemes (Grépin et al. 2012). Estimating more accurate DAH amounts aims to reduce measurement errors in the data set. The higher *R*-squared values in the AidData and IHME models versus the CRS models further support this interpretation of smaller unexplainable errors. Therefore, the AidData and IHME data sets may offer more reliable estimates in this study as well.

Given all this, I suggest, first, that elite polarization, as measured by weighted ideological distance and vote share in legislative bodies, has a negative relationship with the DAH disbursements of DAC member countries, as estimated by IHME. Given that these are central to global health financing (Dieleman et al. 2016), it appears that elite political polarization in high-income countries can threaten the stability of health aid to developing countries and thus their health status. Although I did not measure this directly, the exacerbated political polarization around the world after 2005 (McCoy et al. 2022) may be partially responsible for the stagnation of DAH contributions since 2010.

Second, I see no significant association between the number of INGOs and DAH contributions. This paper draws on the world-society literature, which posits that pressure from world society, especially exposure to INGO networks, should increase DAH contributions. However, I find no support for this proposition. This may be due to a data limitation, where I use a generalized count of INGOs instead of counting only health-focused INGOs. Alternatively, it could arise from the data set's frame, which only includes the years after countries joined the DAC. Since the observations are constrained to the cases under social pressure by peer review and monitoring, INGOs' influence may be limited. Further research into how DAC membership and involvement in expert networks through INGOs interact could enhance our understanding of DAH funding from a world-society perspective.

Finally, in the AidData model, corruption is correlated with DAH commitments. This trend aligns with previous findings that corruption is associated with greater government health expenditures (Liang and Mirelman 2014). The literature explains this general relationship by suggesting that corruption increases health expenditure through corrupt money-making schemes in healthcare or by reducing healthcare productivity, which necessitates increased spending. However, the association between corruption and commitments does not extend to CRS commitment (Model 1) or the disbursement models (Models 3 and 4). This is especially interesting given that donors can update CRS data at a later time. This result might indicate that greater corruption in high-income countries leads to larger commitments, which are not subsequently fulfilled. This phenomenon, the potential exploitation of commitments as impression management, could be significantly explored within the framework of world society and decoupling.

This study contributes to the literature in several ways. First, I investigate the potential determinants of gross DAH contributions from high-income countries. The determinants of total health aid from donor countries (Baccini et al. 2022) have received less academic attention than the distribution of funding in recipient countries (Bendavid 2014; Bermeo 2017; Moitra et al. 2021) or the mismatch between the burden of disease and funding allocation (Kim et al. 2022; Moon and Omole 2017). Although enhancing effectiveness by allocating funding to the right places and focus areas is essential to improving health in developing countries, a greater overall amount of DAH will still be needed to achieve the health Sustainable Development Goals (Buffardi 2018). This suggests a dependency on DAH disbursements from DAC members and points to the need for more focus on the factors influencing DAH contributions from high-income countries.

This study also contributes by using the neo-institutional framework to understand the role of political polarization in determining DAH contributions. It is widely acknowledged by world-society scholars that joining global institutions, such as the DAC (Swiss 2011), and being embedded in the world society through INGOs (Baccini et al. 2022) put pressure on governmental actors toward isomorphism (Meyer 2010). With this pressure to contribute to DAH, commitments suggest short-term goals to be achieved through the execution of disbursements settlements, but polarization in the legislature blocks the way with legislative gridlock, the politicization of health and science, and the rise of right-wing populism. This finding expands the world-society perspective of previous research, indicating that global health funding is socially constructed (Baccini et al. 2022; Swiss 2011, 2017). This study also points to the significance of decoupling, which can lead to volatility that jeopardizes health conditions in recipient countries.

Finally, this paper suggests a new way of calculating political polarization by combining MARPOR's RILE and the polarization index. EPPI is a yearly estimate of legislative polarization, considering the ideological positions and voting share of parties in the legislature. Using this, I can measure polarization based on the latest election. This enables maximized observations from the yearly data sets commonly used in global perspective studies, which is not possible with the original polarization index (Dalton 2008). The new index is also suitable for comparative studies, as it can be applied to both two-party and multiparty systems. Finally, since it is derived from standardized indicators, including manifesto contents and voting shares, it has a more specific operational definition and greater content validity than indices based on experts' responses (Coppedge et al. 2019).

This study has some limitations related to the applicability of EPPI as a measurement of party positions. First, because RILE uses political parties' election manifestos, some doubt its validity as a measure of party policy (Mölder 2013). But it remains the standard for measuring the right–left political position of parties (Budge 2013; Hall and Evans 2019). Second, again because RILE is based on manifestos, it might not reflect political actions after the election. Third, it cannot capture a change in a party's political position during the incumbency. Fourth, it does not fully consider the nature of election systems that are bicameral or that replace only some of the legislature in each election, such as in Australia and the United States. Still, the combined EPPI index can estimate the yearly level of elite polarization in the legislature, updated with every election. Moreover, by

using two-way fixed-effect models, I can account for both country-specific and annual variances arising from the relationship between DAH contributions and the EPPI.

Transitioning away from health aid dependency and building locally accountable health financing should be the ultimate goal for a sustainable and equitable global health environment (Adeyi 2023; Obi et al. 2021). However, this will undoubtedly be a prolonged process. The current stagnation indicates that the problem extends beyond the lack of adequate funding or the absence of regionally sustainable healthcare systems—pointing instead to deeper issues, particularly on the donor side (Labonté 2015; Ottersen et al. 2017). I believe that studying the determinants of overall DAH contributions on the donor's side will enhance our understanding of global health financing.

In conclusion, this study suggests that the vulnerability of health funding in developing countries may be an unintended consequence of political power struggles in high-income countries. Exacerbated polarization in developed countries' elite politics not only threatens domestic democracy but also undermines sustainable health systems in developing countries. In short, when political leaders remain divided, the resulting disruption of health aid puts vulnerable populations in developing countries at serious risk. More attention needs to be paid to constructing reliable health aid that is resilient to political disputes in donor countries. ■

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## NOTES

1. While external factors like global norms, inter-institutional pressure, or economic instability might influence DAH commitments, the persistent need for health resources in developing countries and the increasing complexity of INGO networks suggest that global societal expectations continue to drive commitments. Also, economic recessions seem to have no impact on commitments or disbursements (Stuckler et al. 2011).

2. While gridlock is most extensively studied in the American bicameral, presidential, and two-party system (Binder 1999), similar phenomena have been observed in unicameral systems (Mo 2001), parliamentary governments (Bäck and Carroll 2018), and multiparty systems (Hiroi and Renno 2014).

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## APPENDIX A. THE DEVELOPMENT ASSISTANCE COMMITTEE

TABLE A1. Development Assistance Committee Member Countries

| Country | Joined | Country | Joined |
|---|---|---|---|
| Australia | 1966 | Austria | 1965 |
| Belgium | 1960 | Canada | 1960 |
| Czech Republic | 2013 | Denmark | 1963 |
| Estonia | 2023 | Finland | 1975 |
| France | 1960 | Germany | 1960 |
| Greece | 1999 | Hungary | 2016 |
| Iceland | 2013 | Ireland | 1985 |
| Italy | 1960 | Japan | 1960 |
| (South) Korea | 2010 | Lithuania | 2022 |
| Luxembourg | 1992 | Netherlands | 1960 |
| New Zealand | 1973 | Norway | 1962 |
| Poland | 2013 | Portugal* | 1960, 1991 |
| Slovakia | 2013 | Slovenia | 2013 |
| Spain | 1991 | Sweden | 1965 |
| Switzerland | 1968 | United Kingdom | 1960 |
| United States | 1960 | | |

* Portugal joined in 1960, left in 1974, and rejoined in 1991.

Note: Estonia and Lithuania are excluded from the data sets due to their recent accession to the DAC. Similarly, AidData excludes Hungary. Ireland is also not included in AidData, as records of the number of INGOs for Ireland only begin in 2015, resulting in a lack of overlapping data. The IHME data set merges countries that joined after 2013 into "other countries," so they are not included in the analysis.

## APPENDIX B. ADDITIONAL STATISTICAL ANALYSES AND MODEL DIAGNOSTICS

TABLE B1. Two-Way Fixed-Effects Regression Models with Unlogged Dependent Variables

| | Model 1 CRS commitments | Model 2 AidData commitments | Model 3 CRS disbursements | Model 4 IHME disbursements |
|---|---|---|---|---|
| **V-Dem polarization** | **0.007** | **0.108**$^{+}$ | **0.002** | **−0.036**$^{***}$ |
| | **(0.005)** | **(0.063)** | **(0.003)** | **(0.009)** |
| GDP per capita (logged) | 0.114 | 5.832$^{***}$ | 0.167$^{*}$ | 1.084$^{***}$ |
| | (0.116) | (1.709) | (0.084) | (0.229) |
| Public health spending | 0.029$^{***}$ | 0.177 | 0.015$^{**}$ | 0.034$^{**}$ |
| | (0.007) | (0.153) | (0.005) | (0.013) |
| Infant mortality | 0.028 | 0.142 | 0.008 | 0.021 |
| | (0.018) | (0.125) | (0.019) | (0.026) |
| Corruption | −0.530 | 8.735 | −0.104 | −0.821 |
| | (0.351) | (7.658) | (0.220) | (0.808) |
| INGOs (thousands) | 0.078$^{*}$ | 0.230 | 0.410$^{***}$ | −0.002 |
| | (0.031) | (0.299) | (0.076) | (0.043) |
| Democracy | −0.080 | 4.365 | −0.056 | 0.298 |
| | (0.221) | (6.378) | (0.139) | (0.590) |
| Constant | −1.417 | −63.887$^{***}$ | −2.779$^{**}$ | −11.135$^{***}$ |
| | (1.226) | (17.934) | (0.945) | (2.354) |
| Observations | 616 | 614 | 484 | 667 |
| Countries | 29 | 27 | 29 | 23 |
| Within-$R^2$ | 0.1465 | 0.2726 | 0.2461 | 0.4055 |
| Years included | 1995–2021 | 1973–2013 | 2002–2021 | 1990–2021 |

$+p < 0.1$; $^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$ (two-tailed tests); standard errors in parentheses.

Note: Due to the scale of the coefficients, DAH spending is measured per thousand GDP (in constant dollars).

TABLE B2. Two-Way Fixed-Effects Poisson Regression with Unlogged Dependent Variables

| | Model 1 CRS commitments | Model 2 AidData commitments | Model 3 CRS disbursements | Model 4 IHME disbursements |
|---|---|---|---|---|
| **Political polarization** | **0.036** | **0.031** | **0.002** | **−0.037**** |
| | **(0.033)** | **(0.039)** | **(0.028)** | **(0.012)** |
| GDP per capita (logged) | 1.267 | 1.197 | 1.753 | 1.577** |
| | (1.026) | (0.866) | (1.209) | (0.606) |
| Public health spending | 0.096* | 0.146*** | 0.030 | 0.063* |
| | (0.043) | (0.044) | (0.038) | (0.025) |
| Infant mortality | 0.287 | −0.174 | 0.206 | −0.041 |
| | (0.271) | (0.106) | (0.212) | (0.133) |
| Corruption | −5.771 | 5.610 | −1.501 | −0.981 |
| | (4.456) | (6.736) | (4.239) | (2.671) |
| INGOs (thousands) | 0.838 | 0.077 | 2.047** | 0.164 |
| | (0.550) | (0.263) | (0.672) | (0.161) |
| Democracy | −1.568 | 0.571 | −1.053 | 1.800 |
| | (2.551) | (7.598) | (2.413) | (1.931) |
| Observations | 616 | 609 | 484 | 667 |
| Countries | 29 | 22 | 29 | 23 |
| Log-pseudo-likelihood | −0.3549 | −0.5027 | −0.2355 | −1.2536 |
| Wald chi-squared | 27911.46*** | 896.45*** | 1030.51*** | 827.14*** |
| Years included | 1995–2021 | 1973–2013 | 2002–2021 | 1990–2021 |

+$p < 0.1$; *$p < .05$; **$p < .01$; ***$p < .001$ (two-tailed tests); standard errors in parentheses.

TABLE B3. Two-Way Fixed-Effects Models with V-Dem Polarization Index as the Independent Variable

| | Model 1 CRS commitments | Model 2 AidData commitments | Model 3 CRS disbursements | Model 4 IHME disbursements |
|---|---|---|---|---|
| **V-Dem polarization** | 0.095 | 0.387 | −0.048 | −0.058 |
| | (0.199) | (0.232) | (0.186) | (0.119) |
| GDP per capita (logged) | 4.756$^{+}$ | 2.049 | 6.819$^{*}$ | 1.905$^{**}$ |
| | (2.651) | (1.480) | (2.779) | (0.650) |
| Public health spending | 0.081 | 0.059 | 0.027 | 0.081$^{*}$ |
| | (0.070) | (0.086) | (0.064) | (0.034) |
| Infant mortality | −0.435 | −0.520$^{***}$ | −0.134 | 0.000 |
| | (0.416) | (0.133) | (0.387) | (0.100) |
| Corruption | −0.254 | 21.443$^{***}$ | 2.100 | −0.258 |
| | (4.769) | (5.263) | (4.311) | (1.793) |
| INGOs (thousands) | 0.210 | −0.195 | 2.463 | 0.099 |
| | (0.212) | (0.243) | (1.630) | (0.080) |
| Democracy | −1.421 | 2.674 | −1.737 | 2.793$^{+}$ |
| | (2.395) | (8.549) | (1.989) | (1.604) |
| Constant | −56.069$^{+}$ | −26.316 | −86.085$^{**}$ | −30.776$^{***}$ |
| | (27.852) | (16.987) | (30.400) | (6.712) |
| Observations | 616 | 614 | 484 | 667 |
| Countries | 29 | 27 | 29 | 23 |
| Within-$R^2$ | 0.2463 | 0.5003 | 0.3654 | 0.5008 |
| Years included | 1995–2021 | 1973–2013 | 2002–2021 | 1990–2021 |

$+p < 0.1$; $*p < .05$; $**p < .01$; $***p < .001$ (two-tailed tests); standard errors in parentheses.

TABLE B4. Two-Way Fixed-Effects Models with Additional Economic Recession Variables

| | Model 1 CRS commitments | Model 2 AidData commitments | Model 3 CRS disbursements | Model 4 IHME disbursements |
|---|---|---|---|---|
| **Political polarization** | **0.031** | **0.026** | **0.016** | **−0.041*** |
| | **(0.040)** | **(0.055)** | **(0.041)** | **(0.017)** |
| GDP per capita (logged) | 3.918 | 0.249 | 5.246+ | 1.303+ |
| | (2.338) | (1.551) | (2.569) | (0.681) |
| **Unemployment rate** | **−0.034** | **−0.064** | **−0.070*** | **−0.022+** |
| | **(0.041)** | **(0.038)** | **(0.033)** | **(0.011)** |
| **GDP growth** | **−0.009** | **0.050*** | **−0.043*** | **−0.003** |
| | **(0.028)** | **(0.021)** | **(0.020)** | **(0.012)** |
| Public health spending | 0.096 | 0.127 | −0.001 | 0.078** |
| | (0.066) | (0.093) | (0.052) | (0.026) |
| Infant mortality | −0.451 | −0.542*** | −0.184 | −0.022 |
| | (0.411) | (0.132) | (0.352) | (0.104) |
| Corruption | 0.814 | 21.435*** | 2.159 | −0.539 |
| | (4.585) | (4.886) | (3.619) | (1.682) |
| INGOS (thousands) | 0.226 | −0.138 | 2.459 | 0.044 |
| | (0.215) | (0.243) | (1.465) | (0.098) |
| Democracy | −0.955 | 4.472 | −1.192 | 2.700+ |
| | (2.357) | (8.132) | (1.700) | (1.529) |
| Constant | −47.764+ | −10.126 | −69.074* | −23.742** |
| | (24.402) | (17.565) | (27.200) | (6.690) |
| Observations | 614 | 592 | 482 | 665 |
| Countries | 29 | 27 | 29 | 23 |
| Within-$R^2$ | 0.2574 | 0.5001 | 0.3962 | 0.5106 |
| Years included | 1995–2021 | 1973–2013 | 2002–2021 | 1990–2021 |

+$p$ < 0.1; *$p$ < .05; **$p$ < .01; ***$p$ < .001 (two-tailed tests); standard errors in parentheses.

TABLE B5. Hausman Test Results for Primary Models

| | Model 1 | Model 2 | Model 3 | Model 4 |
|---|---|---|---|---|
| Chi-squared | 55.52 | 217.04 | 49.54 | 23.24 |
| Degrees of freedom | 13 | 24 | 13 | 13 |
| *P* | 0.0000 | 0.0000 | 0.0000 | 0.0388 |

TABLE B6. Variance Inflation Factors for Multicollinearity Diagnostics

| | Model 1 | Model 2 | Model 3 | Model 4 |
|---|---|---|---|---|
| Political polarization | 1.05 | 1.12 | 1.05 | 1.12 |
| GDP per capita (logged) | 1.83 | 1.46 | 2.01 | 1.50 |
| Public health spending | 1.56 | 2.22 | 1.54 | 1.75 |
| Infant mortality | 1.07 | 2.36 | 1.03 | 1.35 |
| Corruption | 2.28 | 1.49 | 2.52 | 1.59 |
| INGOs (thousands) | 1.46 | 2.35 | 1.46 | 1.80 |
| Democracy | 1.78 | 1.77 | 1.83 | 1.49 |
| **Mean VIF** | **1.58** | **1.82** | **1.63** | **1.52** |

TABLE B7. Wooldridge Test for Panel Autocorrelation

| | Model 1 | Model 2 | Model 3 | Model 4 |
|---|---|---|---|---|
| *F*-stat | 4.062 | 3.094 | 21.460 | 29.055 |
| *P* | 0.0535 | 0.0932 | 0.0001 | 0.0000 |

TABLE B8. Heteroskedasticity Diagnostic Tests

| | Model 1 | Model 2 | Model 3 | Model 4 |
|---|---|---|---|---|
| *Breusch–Pagan/Cook–Weisberg test* | | | | |
| Chi-squared | 200.29 | 119.33 | 344.85 | 16.19 |
| df | 1 | 1 | 1 | 1 |
| *P* | 0.0000 | 0.0000 | 0.000 | 0.0001 |
| *White's test* | | | | |
| Chi-squared | 616.00 | 614.00 | 484.00 | 667.00 |
| df | 616 | 614 | 484 | 666 |
| *P* | 0.4924 | 0.4924 | 0.4915 | 0.4818 |

TABLE B9. Outlier Robustness Check Excluding Residuals beyond Three Standard Deviations

| | Model 1 CRS commitments | Model 2 AidData commitments | Model 3 CRS disbursements | Model 4 IHME disbursements |
|---|---|---|---|---|
| **Political polarization** | **0.011** | **0.003** | **0.010** | **−0.044*** |
| | **(0.042)** | **(0.058)** | **(0.040)** | **(0.017)** |
| GDP per capita (logged) | 4.701+ | 1.643 | 6.845* | 1.710** |
| | (2.634) | (1.429) | (2.777) | (0.587) |
| Public health spending | 0.097 | 0.099 | 0.021 | 0.084** |
| | (0.066) | (0.083) | (0.061) | (0.026) |
| Infant mortality | −0.434 | −0.532*** | −0.129 | −0.007 |
| | (0.412) | (0.133) | (0.364) | (0.103) |
| Corruption | −0.098 | 16.618** | 2.017 | −0.567 |
| | (5.043) | (5.358) | (4.169) | (1.669) |
| INGOs (thousands) | 0.000 | −0.000 | 0.002 | 0.000 |
| | (0.000) | (0.000) | (0.002) | (0.000) |
| Democracy | −1.389 | 1.110 | −1.483 | 2.546 |
| | (2.289) | (9.160) | (1.788) | (1.530) |
| Constant | −55.874+ | −21.415 | −86.253** | −28.134*** |
| | (27.542) | (17.038) | (29.998) | (6.016) |
| Observations | 614 | 610 | 484 | 661 |
| Countries | 29 | 25 | 29 | 23 |
| Within-$R^2$ | 0.2340 | 0.4909 | 0.3653 | 0.5128 |
| Years included | 1995–2021 | 1973–2013 | 2002–2021 | 1990–2021 |

+$p < 0.1$; *$p < .05$; **$p < .01$; ***$p < .001$ (two-tailed tests); standard errors in parentheses.

TABLE B10. Robustness Check Using a Consistent Sample across All Analyses

| | Model 1 CRS commitments | Model 2 AidData commitments | Model 3 CRS disbursements | Model 4 IHME disbursements |
|---|---|---|---|---|
| **Political polarization** | 0.074 | −0.009 | 0.074 | −0.009 |
| | (0.043) | (0.038) | (0.043) | (0.038) |
| GDP per capita (logged) | 6.731*** | 8.951*** | 6.731*** | 8.951*** |
| | (1.411) | (2.292) | (1.411) | (2.292) |
| Public health spending | −0.027 | −0.003 | −0.027 | −0.003 |
| | (0.102) | (0.096) | (0.102) | (0.096) |
| Infant mortality | 0.654* | 0.250 | 0.654* | 0.250 |
| | (0.255) | (0.230) | (0.255) | (0.230) |
| Corruption | 4.049 | 8.593 | 4.049 | 8.593 |
| | (4.680) | (7.377) | (4.680) | (7.377) |
| INGOs (thousands) | 2.041* | 1.488 | 2.041* | 1.488 |
| | (0.828) | (1.076) | (0.828) | (1.076) |
| Democracy | 8.375 | 6.992 | 8.375 | 6.992 |
| | (6.448) | (5.008) | (6.448) | (5.008) |
| Constant | −95.613*** | −114.471*** | −95.613*** | −114.471*** |
| | (15.178) | (26.262) | (15.178) | (26.262) |
| Observations | 251 | 251 | 251 | 251 |
| Countries | 22 | 22 | 22 | 22 |
| Within-$R^2$ | 0.2426 | 0.3560 | 0.2426 | 0.3560 |
| Years included | 2002–2013 | 2002–2013 | 2002–2013 | 2002–2013 |

+$p < 0.1$; *$p < .05$; **$p < .01$; ***$p < .001$ (two-tailed tests); standard errors in parentheses.