5-2011

Gender and Health Care Reform: The Power of Party and Perspective

Alexa McClanahan
College of William and Mary

Gender and Health Care Reform: The Power of Party and Perspective

A thesis submitted in partial fulfillment of the requirement
for the degree of Bachelor of Arts in Government from
The College of William and Mary

by

Alexa Jordan McClanahan

Accepted for _____

_____

_____

_____

Williamsburg, VA
April 15, 2011

TABLE OF CONTENTS

SECTION I: INTRODUCTION

In her article "Enlarging Representation: Women Bringing Marginalized Perspectives to Floor Debate in the House of Representatives," Katherine Cramer Walsh writes that "while women may be adjusting to an institution [Congress] that has been established and developed from a man's point of view, they are, at the same time, transforming it into a body that gives consideration to a broader array of perspectives, and does so with sincerity" (2002, 391). This perspective merges the two dominant schools of thought regarding women in politics: one, that party is everything, and two, that gender is everything. While the first perspective supports the traditional uni-dimensional model of legislator behavior, it ignores the possibility that secondary dimensions, such as gender, could have a meaningful impact on legislators' actions. On the other hand, assuming that gender or other social characteristics are the primary pulls on a legislator ignores the fact that the end goal, of course, is reelection, and this is heavily dependent on party and ideology. This paper seeks to add to the perspective summarized by Cramer Walsh, that while women are still operating within a "man's world," and one dominated by party, gender does make a difference in how they choose to navigate Congress.

Other literature has focused on the impact of gender on specific policy areas; for example, studies that show that men are more hawkish or that women are seen as more competent on "compassion" issues. Although this approach makes it harder to generalize legislators' behavior to other policy areas, it provides a specific and concrete context in which to study gender. I examine the policy area of health care for several reasons: first, because of its contemporary prominence due to the 2009 debate on health insurance

reform; second, because it includes contentious issues such as abortion and reproductive rights as well as traditional "women's issues;" and third, because it is heavily integrated into the agenda and institutional structure of Congress and therefore legislators must act with purpose when working within this policy area. In addition, health care touches on theoretical issues relevant to both feminist theory and political theory, such as the feminization of poverty, the patriarchic nature of the health care industry, and the difference between sex and gender.

The Sex/Gender Divide

The difference between sex and gender has been debated extensively in both feminist and political theory. Though the distinction between sex and gender usually goes unnoted in political research, it is especially relevant to the issue are of health care and particularly to this paper. Generally, political research uses the word "gender" as a blanket term to refer to both one's sex and one's behavior as a socially constructed being; however, important differences exist between the use of the word "sex" and the word "gender." Susan Tolleson-Rinehart (2000, 165) summarizes this difference, in that "sex differences are biological, stemming from differences in reproductive function…but gender differences are contextual; they are the social constructions built upon sex differences."

While biological sex does play a role in constructing health policies for men and women, gender is often the greater factor. For example, men are, biologically, significantly less likely to get breast cancer (Tolleson-Rinehart 2000, 179). However, many other aspects of health policy, such as insurance, social welfare programs and senior citizen care, are more dependent on the fact that "because the sexes are socialized

differently, their life chances are often significantly different" (Tolleson-Rinehart 2000, 179). The issues that more women are uninsured than a decade ago and that female-headed households continue to be poorer than male-headed households — both of which affect health policy — are not "…organic or physiological but, rather, are the direct or secondary results of differential gender role socialization and gender ideology at large in the political culture" (179).

Gender role socialization also extends to political behavior. While this paper posits that male and female legislators act in different ways, it does not assume that these actions derive from any essential characteristics about men and women. Rather, I argue that (at least in the case of health care) legislators act in strategic ways in regard to gender, especially given the fact that there are differences in preferences at both the mass and elite levels. When this is the case, legislators must appeal to their core constituencies, and I argue that this is done through rhetoric on the House floor. In this vein, my paper is also based on theories of gender performance, which combat essentialist arguments and help explain why legislators would make an active choice to act as they do.

With this explanation in mind, I will use the term "gender" periodically throughout this paper to refer to the socialized characteristics of a male or female legislator. In some cases, this may not be the most appropriate term to use according to feminist theory; however, I find it easier to contextualize this work within political theory by using the existing framework of the majority of political research.

Explanation of Analysis

As for the work itself, the following analysis is divided into four sections, each of which explores an aspect of how gender plays out in health care reform. First, I will

provide a brief overview of attempts to reform health care since the 1960s, focusing on the Health Security Act of 1993. Second, I will explore whether men and women appear to possess different interests when it comes to health care and subsequent public opinion surrounding the 2009 health care reform debate, focusing on gender differences. Third, I will look at these preferences at the elite level, through roll call votes cast during the 111th Congress. Finally, I will compare these votes with the rhetoric employed on the floor of the House during the health care reform debate to determine where gender differences arise in public discussion as well as voting behavior.

My main finding is that sex and gender each play a unique role in the determination of behavior and preferences on health care reform; however, neither dimension makes as much of a difference as party or ideology. The findings of this study are significant on two levels: first, that party and ideology continue to surpass secondary dimensions as primary motivators of a legislator's behavior; and second, that sex and gender appear to play out differently based on what aspect of legislating is examined. First, at the mass level, though it would appear that men and women possess different interests regarding health care, we see only a small gender gap in public opinion. At the elite level, an analysis of roll call votes shows significant differences between male and female legislators; however, an examination of the rhetoric used to explain these votes again shows little differences between male and female legislators.

Second, the distinction between sex and gender unfolds as we move from the mass to elite level and the idea of the presentation of self comes into play. At the rhetorical level, legislators appear to use gender in a manner consistent with Fenno's (1977) idea of the presentation of self: that is, they manipulate the social construct of

gender in a strategic way to gain trust and support from their constituencies and therefore work toward the goal of reelection. This suggests that members of Congress, whether male or female, do not simply act on the basis of their sex, but that sex, gender, and party all come together in explaining legislators' behavior at various levels. However, before examining this phenomenon in the context of the 2009 debate on health care reform, it is necessary to examine how gender and party have played a role in past attempts at reform.

SECTION II: A BRIEF HISTORY OF MAJOR CONGRESSIONAL HEALTH REFORM EFFORTS

A look at the history of health care reform, especially the attempt of the Clinton administration to reform health care in the early 1990s, helps us understand the most recent health care reform debate. Theda Skocpol notes in "Is the Time Finally Ripe? Health Insurance Reforms in the 1990s" that "repeatedly during the 20th century, reformers in the United States have been certain that the time had come to enact broad, publicly financed or regulated health insurance" (61). However, as with any sweeping reform effort, the actual enactment of health insurance reform has proved elusive to both policymakers and stakeholders alike. The Kaiser Family Foundation notes six times that major national reform was attempted in the 1900s, from the New Deal to President Bill Clinton's Health Security Act of 1993. Each time, pressures in favor of reform have either faded or resulted in partial steps toward a national insurance system, such as Medicare and Medicaid (Hacker 170).

Medicare and Medicaid became part of the national agenda in 1965, after President Lyndon Johnson made Medicare his highest priority in his bid for the Presidency in 1964; that election also brought a large liberal Democrat majority to Congress. This political environment, combined with Johnson's tactical ability to ensure passage in the Senate, led to the incorporation of Medicare and Medicaid into the Social Security Act in 1965 (Hoffman 2009). Another major push for reform would not come until the Clinton administration almost thirty years later, as the Health Security Act of 1993.

The Clinton Administration and Health Care Reform

Perhaps the most visible reform attempt of the 20th century, President Bill Clinton's push for the Health Security Act in the early 1990s provides a useful framework for understanding the current debate. Until that time, "experts and politicians took it for granted that it just was not politically feasible to talk about governmental reform in health care" (Skocpol 59). However, the inflation of the 1970s, rising health premiums in the 1970s and 1980s, an increasing movement toward managed care, and cutbacks in Medicare decreased the number of insured Americans, most of whom were from low-income families (Hacker 1997, 15). Despite decreasing insurance rates, significant public pressure in favor of reform did not develop until rising health care costs came to the attention of the middle class, a much more politically organized group. In addition, a number of events in the early 1990s created an environment in which enacting national health reform once again became a possibility, such as a Congressional atmosphere that had changed dramatically from that of previous decades and the election of Harris Wofford to the Senate in 1991, who ran on a health-care platform.

One of the changes in the Congressional environment was increased institutional attention to health care. Hacker (1997) notes that one way to estimate changes in the level of congressional attention for an issue is the number of committee and subcommittee hearings held on the topic (24). The number of hearings for health care reform remained high and grew consistently from 1980 to 1991. Together with the volume of health care legislation introduced, these two measurements indicate that the amount of Congressional attention paid to health care peaked in the early 1990s (Hacker 1997).

Given that attention to health care peaked in the early 1990s, what factors were behind this push? The increasing pressure public health programs were placing on state and federal budgets, as well as growing attention from major advocacy groups such as the American Medical Association, created outside demands for reform (Hacker 1997). Internally, the emergence of a revitalized Democratic leadership in the House and the fact that health care issues were now divided among seven major committees with pro-reform chairs created an environment "more supportive of legislative entrepreneurship and less conducive to the formation of entrenched policy subsystems than the oligarchy before it" (Hacker 1997, 30). Despite these factors, the Health Security Act failed to garner enough Congressional support and was eventually defeated.

Why Did the Health Security Act Fail?

The question of why the Health Security Act failed has been a topic of major debate in the scholarly literature. Several competing explanations exist, including Clinton's failure to mobilize adequate support, the manipulation of public opinion by advocacy groups that opposed reform, and the institutional barriers of Congress itself. Other scholars look to the preferences of members of Congress themselves to explain why the Clinton reform plan failed. The traditional approach to examining policymakers' preferences is to assume that they involve only one dimension; however, this approach does not seem plausible in the case of health care reform — assuming multiple dimensions makes analysis more realistic, as more factors than ideology impact a legislator's vote (Hacker 1997, 174). In addition, another problem occurs in determining where policy options and preferences fall on the ideological spectrum. For example, legislators' preferences shifted over the course of the health care reform debate, negating

the argument that the preferences of members of Congress doomed Clinton's plan from the start (Hacker 1997, 174). Hacker argues that many politicians initially supported reform because it was politically advantageous to do so, implying that a solely ideological model fails to totally explain legislators' behavior.

The possibility that dimensions other than ideology influenced the backlash to health care reform is especially evident in the context of gender. For the Clinton administration, increasing public attention to gender and to Hillary Clinton as a divisive political figure additionally complicated the debate over health care reform. Clinton headed the administration's task force and was a volatile figure during the reform period, serving as a public example of the changing gender roles of women and the deluge of women into the career world, especially against the context of both the male-controlled health care industry and political world (Winter 2008). In addition, Clinton defied the traditional role of First Lady by crossing into the policy world. Winter (2008) argues that her association with health care reinforced the gendered implications of the debate, and that public feelings about health care did become associated with feelings about Clinton, which could have contributed to the lack of public support for the Health Security Act. On a larger scale, Winter notes that gendering occurred because the metaphorical frames used by both sides of the debate framed health care reform as interrupting preexisting power relations. These gendered frames also contributed to the lack of mass support for the bill and its subsequent failure.

Despite repeated failure to enact comprehensive health insurance reform, "the right combination of interests, ideas, and leadership can create possibilities for policy innovation where reformers once thought none existed" (Hacker 1997, 182). Using the

lens of gender, I examine preferences at the mass and elite levels that shaped the 2009 debate over health care reform. Following Winter (2008), I investigate how health care reform became gendered and how this phenomenon played out at the mass level and then on the floor of the House.

SECTION III: DIFFERENT INTERESTS, SAME PREFERENCES? THE GENDER GAP AND PUBLIC OPINION

I begin my investigation at the mass level, by examining whether men and women have different interests and/or preferences regarding health care. The issue of health care presents a prime opportunity for studying two related phenomena: first, the inherent gender gap in interests in health care; and second, the gap between interests and preferences when accounting for gender. For reasons of socialization, socioeconomic status, and health needs, the interests of men and women appear to differ significantly when it comes to health care. However, studies on voter and legislative preferences have had mixed results. I investigate the relationship between interests and preferences in this area in two parts: first, by examining the reasons why health care interests may differ by gender; and second, by examining public opinion data for gender differences.

The Gender Gap in Interests in Health Care

Several factors, both micro and macro, lead one to the assumption that men and women have different interests regarding health care. First, on a structural level, any discussion of health care inherently invokes the gender question (Winter 2008). Health care as a policy domain is built on roles and ideas about service providers and recipients, and based primarily on an uneven doctor/nurse relationship that typically governs interactions with health care. Duerst-Lahti and Kelly (1995) describe the health care field as "an industry governed by men but delivered by women," and indeed, despite spending the majority of a visit with a historically female nurse, a patient pays the historically male physician. In addition, all service providers other than physicians (including nurses and midwives) are considered support staff. Duerst-Lahti and Kelly (1995) note that, as of the last major attempt at health care reform, the American Medical Association and

doctors themselves paid little attention to attempts to revise these practices in favor of maintaining institutionalized sexism (243). Looking to the interactional level, the socialization of men and women as a result of their experiences with the health care industry and other gendered institutions differently shape their medical needs and interests.

On this interactional level, most scholarly research looks to socialization, along with modern phenomena such as the feminization of poverty, to explain the gender gap. Previous research has established that a gender gap exists in regard to "compassion" issues; i.e., ones that aid the poor, unemployed, or sick (Price et al 2006, 45). Poggione (2004) presents the explanation that women's experiences and responsibilities in the private sphere influence their attitudes and behavior regarding these issues. Specifically, Swers (2002) notes that "scholars who examine gender-role socialization and its impact on women's attitude and behavior note that women are raised to accept primary responsibility for the care of young children and elderly relatives" (4). As a result, women view themselves in relational terms.

In addition, the feminization of poverty is a major contributing factor to the emergence of different interests for women within the health care issue area. Various risk factors for lacking health insurance show women to be a vulnerable population (Bobinski & Epps, 2001). Women are also less likely than men to be covered by private insurance, though public health programs such as Medicaid may present barriers to accessing necessary reproductive and long-term care services. Changes to social welfare policy over the past decade have also impacted access to Medicaid. In addition to differences in health policy for the poor, research regarding Medicare also suggests different interests

for men and women. Women are negatively impacted by certain limitations of Medicare, such as the lack of coverage for prescriptions and lack of long-term care, because of their unique health needs, including a greater propensity for chronic illness (Bobinski & Epps, 2001). In addition, less than half of women actually receive gynecological health services covered by Medicare. Furthermore, Bobinski & Epps (2001) argue that women's health risks increase in old age as a result of the lifelong strain of acting as caregivers for family and friends, a role that continues to be delegated to women.

These findings suggest that men and women would have different preferences regarding the scope of government involvement in the administration of public services, and thus regarding health care reform. However, Price et al (2006) find that knowledge about health care, strong opinions on health care issues, and health care-related political activity are relatively independent, suggesting that divergent interests may not translate into similarly divergent preferences.

Gender and Policy Preferences at the Mass Level

The above findings paint a complex picture for the relationship between men's and women's interests and preferences. The gendered nature of the health care industry and the abundance of issues within health care that relate exclusively or especially to women and families suggest that male and female voters would express different preferences. The actual effect of gender on voters' preferences, however, is less clear. Shapiro (1986) points out that there is not necessarily a correspondence between the gendered content of policies and the public's perception of these policies — indicating that there may be differences between observed interests and expressed preferences. Complicating the issue, Winter (2008) notes that men and women reacted identically to

gendering rhetoric during the health care reform debate of 1993-1994. Examining public opinion data gathered prior to the 2009 debate on health care reform could shed light on voters' interests and hopefully explain how their preferences were played out.

A small gender gap in public opinion on health care has been documented but not particularly well-studied over the past few decades. From the 1940s to the 1970s there was little evidence that gender played a major role in determining public opinion (Frankovic 1982). Gender differences on "compassion issues," those defined as relating to health care, social welfare, and similar policy areas, first started to appear in the polls in the 1970s (Norrander 2008). The emergence of a gender gap on these issues has generally been attributed to the socialization of women to be more empathetic and the greater likelihood for women to require government assistance (Norrander 2008).

However, until the 1980s, researchers tended to find little to no significant gender differences in choices for government policies, and their findings were generally not reported or publicized (Shapiro & Mahajan 1986). The first major indication that gender was increasingly becoming a dividing feature of the voting public was the election of Ronald Reagan in 1980. Men favored Reagan by a large margin, women did not, and the "gender gap" as it is currently known began to be documented in the literature.

While the Reagan phenomenon brought attention to a gender gap in voting preferences, less attention has been paid to a gender gap in policy preferences (Shapiro & Mahajan 1986). However, policy preferences and public opinion reflect the political knowledge of the voting public on a particular issue and are invaluable in tracking variances in preferences over time. Mueller (1988, 24) notes that "polling is a useful tool both for governing and for gaining office." In addition, polling has increasingly been

employed by women's organizations to gauge the degree of public support for women's issues (Mueller 1988).

Kaufmann and Petrocik (1999) note that the importance of social welfare attitudes to the gender gap, the conservatism of men, and the prominence of social welfare issues to the formation of party differences places are the key issues at the heart of the gender gap. Health care, as a social welfare issue, has been especially susceptible to attention from a variety of fronts, both from policymakers desiring to enact or halt change and voters attempting to understand and form opinions on these efforts. Health care is an interesting site for an investigation of public opinion and gender because it involves fundamental questions about gender, such as the role of the caregiver or who should make health decisions for a family. Because the mass public understands gender in terms of difference, gender differences at the mass level tend to be divided along a traditional/progressive binary that plays out in opinions on health care (Winter 2005).

Gender and Public Opinion on Health Care Reform

Despite the different health care interests of men and women, the effect of gender on public opinion is more complex. In particular, the 1992 to 1994 health insurance reform debate provides important insights into the preferences of men and women regarding health care (Weisman 1998). Before 1993, mass opinion on health care reform was not linked to gender ideology. However, the politics and rhetoric deployed during the debate linked health care with gender in new ways (Winter 2005). The attempt of the Clinton administration to enact national health reform marked one of the most significant divides in public opinion of the decade. In addition, the debate specifically addressed issues that "are generally believed to be of concern to women and to draw women into

social reform" (Weisman 1998, 214). For example, women are more likely to be more dependent on public health insurance, less likely to be insured through their employer, and more likely to be family caregivers. For these reasons, women were expected to be more supportive of reforms that extended insurance coverage, disassociated health insurance from employment, and protected families (Weisman 1998).

However, public opinion data gathered during these years presents a more complex picture of the impact of gender on policy preferences. The polls did not reveal significant differences between men and women on support for specific reform proposals. In addition, many reports of polling results did not present breakdowns by gender due to the lack of significant findings (Weisman 1998). While single items from various polls identified gender differences, these differences are scattered and the differential is usually small. For example, in polls conducted in 1993 and 1994, women were consistently more likely to favor the Clinton plan, but the average gender difference was only 4.4 percentage points (Weisman 1998). One of the larger gender differences occurred in a 1994 Gallup poll, in which 82% of women and 68% of men reported that ensuring that American has health insurance was a "very important" issue (Weisman 1998).[1] Overall, with few exceptions, researchers failed to find significant latitudinal or longitudinal gender differences.

In addition, party identification played a significant role in dividing men and women on health issues in the early 1990s. Weisman (1998) notes that various health care financing proposals, which tapped into ideological differences about the role of government, probably divided women as much as men along partisan and socioeconomic lines, a finding consistent with the general literature. Similarly, a survey conducted in

[1] Gallup polled 1,519 adults over January and February 1994 for the American Medical Association.

1993 by the Harvard School of Public Health found that men, conservatives, and Republicans, as well as the well-educated and upper-income, favored a managed-competition approach to health care. [2]On the other hand, women, liberals, and Democrats, along with the less-educated and lower-income subgroups, were significantly more likely to prefer government rate settings (Blendon et al 1994).

After the Clinton reform effort failed, researchers continued to measure public opinion on health care, to varying effects. Differences between men and women in these surveys are generally not large, but show a consistent pattern of women taking a more liberal position (Bardes & Oldendick 2000). For example, in the 1996 General Social Survey, 73% of women gave a liberal response to questions regarding government spending on social welfare issues, including health care. On the other hand, 62% of men gave a liberal response.[3] The survey also showed the general public to be divided on whether the country should have a government insurance plan. When asked whether the government in Washington should guarantee medical care for people who don't have health insurance, 69% of women and 58% of men agreed.[4] Compared with men during this time period, women were more supportive of programs to guarantee quality health care and meet basic human needs (Center for American Women and Politics 1997).

More recent polls reflect the continued existence of a small but consistent gender gap. Norrander (2008) notes that the gender gap in percentages favoring more government services peaked around 2000, but after 2002 was beginning to converge

[2] Data derived from a survey conducted 18-25 March 1993 by the Harvard School of Public Health and the polling firm Marttila & Kiley.
[3] The researcher collected data from four spending questions on the 1996 General Social Survey: whether we are spending too much money, too little money, or about the right amount, on four social welfare issues, one of which is the nation's health.
[4] Data gathered by CBS/*New York Times*, February 1996.

slightly. Women are still slightly more likely than men to be dissatisfied with the "availability and affordability" of health care, at 70% vs. 64% (Simmons 2000). Furthermore, women are more likely than men to say that the system has major problems or is in a state of crisis (76% vs. 64%) (Simmons 2000).

In addition to being evident in polling data on the role of government in health care, a gender gap is also present in the context of public opinion evaluating presidential candidates and their policies. Simmons (2000) finds that "while most Americans are concerned about all aspects of health care, women, the elderly, and the poor tend to say they are more concerned about the issue than other groups." For example, while 76% if men say that health care is "very" or "extremely" important in influencing their vote for president, 89% of women say that this issue area has high importance.

Notably, public opinion on some health-related issues reveals underlying partisan alignments or ideologies that may supersede gender. For example, Norrander (2008) identifies abortion as case in which the general literature on the gender gap fails. She finds that, on the abortion question on the National Election Study from 1980 to 2004, a gender gap occurs in four out of the twelve years. However, women are more likely to be more traditional on abortion, stating that it is never justified, while men are more likely to fall into situationalist categories; this finding goes against previous literature on women as more liberal on social welfare issues. In addition, no consistent gender gap exists for pro-choice categories. Norrander (2008) determines that, generally, men and women do not differ significantly in response to the abortion question, indicating that other factors, such as party, are more important. In addition, public opinion on health-related issues such as abortion may depend more on a divide between traditional and egalitarian views

regardless of one's status as a man or a woman, rather than a gender gap between the sexes (Winter 2005).

Overall, the literature on public opinion on health care reveals small but persistent trend in gender differences. First, the finding that women are likely to be more liberal on social welfare issues remains true in this issue area. Second, public opinion on health care follows the general historical pattern of the gender gap and helps explain how the gender gap plays out in specific issues. Third, data on gender differences in preferences in this issue area helps answer the question of the previous section, whether men and women have different interests but convergent preferences on health care. It appears that, after accounting for political knowledge and partisan identification, the gender gap in public opinion on health care is not as significant as one would estimate. However, a general difference in preferences does exist, and shows no signs of disappearing in the near future, especially in the context of the recent health reform debate. To shed more light on the current state of gender differences in health care at the elite level, I examine survey data from the 2008 National Election Study.

Public Opinion on Health Care Reform in 2008

I conducted a regression of the 2008 National Election Study, which gauges pre- and post-election public opinion on a range of issues, to determine whether mass opinion on the most recent push to reform health care mirrors the scholarly literature on other reform efforts. The ANES conducts surveys both pre- and post-election; all data in this study was gathered pre-election and was weighted to reflect its status as pre-election data. The independent variables chosen express various demographic characteristics that may impact public opinion on health care: gender (male or female); race (black coded as 1,

otherwise as 0); age; family income; insurance coverage (1 for insurance, 0 for no insurance); ideology (7-point scale ranging from very liberal (1) to very conservative (7); and party identification (7-point scale ranging from strongly Democrat (1) to strongly Republican (7). For the dependent variable, I used a question regarding the respondent's position on universal health care, which was coded on a seven point scale from "favor a great deal" to "oppose a great deal." I regressed this question against the independent variables of gender, race, age, family income, whether the respondent was insured, political ideology, and party identification. Table 4.1 shows the results of this regression. I expect to see significant results for variables such as age, family income, and insurance coverage, and less significant results for gender (in accordance with the scholarly literature).

As demonstrated, age, income and ideology provide powerful explanations for why the respondent did or did not support universal health care. However, the impact of gender is more subtle. The result of a two-tailed test fall short of statistical significance: women are less likely to be opposed to universal health care, but the effect is not large or quite statistically significant. However, in a one-tailed regression test with the expectation that women will be more inclined to favor health care reform, the result reaches significance. Overall, we see a marginal effect for gender. In addition, the question used is a general question regarding preferences on health care reform. This question is useful within the broad context of the ANES study; however, if more refined questions that that touched on specifically gendered issues had been available we may have seen different results. However, this result confirms that gender differences in mass

opinion regarding health care leading up to the 2009 reform effort mirrored those documented in the existing literature.

Table 4.1: Regression of Support for Universal Health Care

Gender	-.317
Black	-.0385
Age	.0117**
Family Income	.0305*
Insurance	.347
Ideology	.217***
PartyID	.471***
Constant	-.05

*** Statistically significant at the .01 level.
** Statistically significant at the .05 level
*Statistically significant at the .1 level
Number of observations is 701 (smaller because only a portion of the sample was asked this health care question).
Sample is weighted.
R squared is .3181.

SECTION IV: GENDER AND ROLL CALL VOTES ON HEALTH CARE IN THE 111TH CONGRESS

With the knowledge that only a marginal gender gap occurred in 2008 public opinion on health care reform, I turn to the elite level to examine gender differences in legislators' preferences and to determine whether a similar effect occurs with legislators' votes. Most of the research on gender and elite preferences has focused on roll call votes. Though no research on roll call voting indicates that "we should discount ideology as the dominant voting cue …[roll call votes] do imply that our complex beliefs about gender roles and a growing gender consciousness may also structure decision making in this policy arena" (Norton 1999, 66). In addition, Norton (1999) notes that a simple, one-dimensional voting model may not explain the entire pattern of congressional voting for legislation that affects women; in fact, research about the growing gender consciousness in national and state legislatures suggests that a voting model should account for more complexity, especially on women's issues. In fact, a single model cannot be applied to gendered and non-explicitly gendered issues, as the literature indicates that female legislators use different cues to make decisions in each of these policy areas, both of which will be discussed below.

In a one-dimensional voting model, ideology is the main factor in determining what preference a legislator will express. However, a growing body of research argues that secondary dimensions should not be set aside as unimportant, but are sometimes basic elements of legislative voting patterns (i.e. Norton 1999; Ansolabehere, Snyder, & Stewart 2001). Though much previous research has focused on women in state legislatures, these findings are also useful in constructing a basis for understanding women legislators' voting behavior at the Congressional level. In comparison to men,

female legislators at the state level are more liberal and more committed to legislation incorporating issues of traditional concern to women, including education, health, and welfare (Swers 2001).

Furthermore, on non-women's issues, women are considered to be slightly more liberal than are men (i.e. Frankovic 1977, Swers 2001). However, similar to patterns in mass opinion, while women do have slightly more liberal voting patterns, with few exceptions these voting patterns do not differ significantly from those of male legislators (Vega & Firestone 1995). In addition, like research on public opinion, research on the gendered voting preferences of legislators has provided mixed results. For example, Frankovic (1977) found significant gender differences in male and female representatives' voting patterns. However, she could not determine if these differences were due to the impact of gender or to the fact that women were more likely than men to represent urban and minority districts (Swers 2001). Welch (1985) and Burrell (1994) both found that, while party is the most significant predictor of a liberal voting record, female legislators are more liberal than their male colleagues within the same party.

In addition, Norton (1999, 65) notes that "we should not assume that voting cues for legislation regarding gender equity, pregnancy, family leave, childcare, abortion, and family planning are necessarily the same voting cues used for legislation like the strategic defense initiative, clean air, or a balanced budget." Indeed, other research indicates that gender exerts a significant effect on voting for specific gender-related concerns such as abortion and women's issues (Swers 2001). An additional body of research examines whether women express more liberal preferences on these issues and whether the importance of gender varies with the consequences of a vote for women as a group (i.e.

Swers 2001, Norton 1999). Research on women's mass political behaviors shows that women are more concerned with legislation that directly affects the lives of women and children, and studies of female legislators in the late 1980s and 1990s similarly reveal that women are more interested in working and voting for legislation concerning women, children and the family (Norton 1999). Much of this research has focused on abortion and reproductive policy, and party does seem to play a significant interactive effect in these policy areas. In a study of women's issue roll-call voting in the 103rd and 104th Congresses, Swers (2001) found Democratic women to be the most active supporters of liberal positions on women's issues; Democratic men were also highly supportive. Republican women registered the most dramatic change in their voting behavior on these issues: when Republicans held the majority, Republican women reduced their support for liberal positions by an average of almost 50%.

Health care as an issue area incorporates several of the concerns and findings discussed in the above research. Though little research has been conducted specifically on gender and health care votes, a study of the 103rd Congress by the Center for American Women and Politics provides a foundation for possible findings of this study. CAWP found that women in the 103rd Congress, as a group, voted differently from their male colleagues on numerous bills, including various health care proposals. For example, half of Republic women voted against the majority position of their party on the Family and Medical Leave Act, which proposed the continuation of health insurance coverage during times of leave, and the Hyde abortion amendment, which prohibits the use of federal funds for abortion services. In addition, Democrats had gender gaps of ten

percentage points or more in numerous roll call votes regarding health care, including the above bills.

Health Care Votes of the 111th Congress

With the above foundation in mind, I investigate whether a gender gap persisted in votes on health care in the 111th Congress. I focus on three important votes: the House passage of the Affordable Health Care for America Act, the Stupak-Pitts abortion amendment, and the House passage of the conference report on health care in 2011. The Affordable Health Care for America Act, passed by the House on November 7, 2009 by a vote of 220-215, proposed an overhaul of the health insurance industry and an expansion of health insurance coverage to more uninsured Americans. The Stupak-Pitts abortion amendment, passed by the House on November 7, 2009 by a vote of 240-194, proposed to amend the Affordable Health Care for America Act to prohibit the use of federal funds for abortion. It was not included in the Senate version of the bill. Finally, the conference report of the House and Senate health care bills passed the House on March 21, 2010, by a vote of 220-211; All 178 Republicans and 33 Democrats voted against the bill.

Because the legislative histories of these bills are complex, it is helpful to briefly explain what the votes were about and how they related to one another over time. The push to reform health care in the 111th Congress started with H.R. 3200, The America's Affordable Health Choices Act of 2009. However, the bill was unsuccessful and was eventually replaced by The Affordable Health Care for America Act, or H.R. 3962. This bill was introduced in the House on October 29, 2009, with the goal of making several changes to current health insurance practices to cover more of the uninsured. Key provisions included a government-run insurance exchange, a public insurance option, and

changes to rate policies. The bill was passed by the House on November 7, 2009. However, the bill was never passed by the Senate, which debated a similar bill entitled The Patient Protection and Affordable Care Act. This bill passed the Senate on December 24, 2009. During the reconciliation process, the House abandoned H.R. 3962 in favor the Senate bill, and the reconciliation bill became the Health Care and Education Reconciliation Reform Act of 2010.

The Stupak-Pitts Amendment was introduced as an amendment to H.R. 3962. Its purpose was to prohibit the use of federal funds for abortions not in cases of rape, incest, or potential harm to the mother. Though the amendment passed the House, it was not included in the final version of the bill. The vote discussed here is the initial House vote that occurred on November 7. Though the Stupak-Pitts amendment explicitly discusses a gendered issue, both the House bill and the reconciliation bill also included women's issues, such as how to treat preexisting conditions and the regulation of disproportionately higher insurance rates for women. With this foundation in mind, I examine gender differences in roll call votes for the House bill, the Stupak-Pitts Amendment, and the final conference report.

The Gender Gap in Roll Call Voting Patterns

An examination of legislators' voting behavior on these three bills reveals large and statistically significant gender differences, especially for Democratic women. In fact, gender was a predictive factor in the vote and a pivotal factor in passage; if more members of Congress had been male, the Affordable Health Care for America act might not have been passed. Since almost all Republicans voted the same way on these roll call votes, only Democratic behavior can be explored. A breakdown of the votes is shown in

Table 4.1, with the top entry being the number of votes and the percentage. Significant gender differences exist in all three votes, but especially on the Stupak-Pitts Amendment, with female legislators less likely to support the amendment. In addition, female legislators were more likely to vote for the initial House passage of the health care reform bill and also for the final version that came out of conference committee in March. Table 4.1 shows the breakdown of these votes by gender.

Table 4.1: Vote Breakdown by Gender

	Abortion		Passage		Conference	
	Y	N	Y	N	Y	N
Male	62	141	167	36	165	33
	30.5	69.5	82.3	17.7	83.3	16.7
Female	2	53	52	3	54	1
	3.6	96.4	94.6	5.5	98.2	1.8

The possibility does exist that the differences in the roll call behavior of Democratic men and women were actually due to differences in their overall ideologies. If female lawmakers tend to be more liberal than their male counterparts, than these votes may actually result from ideological differences rather than gender. To investigate this possibility, I use the standard measure of Congressional ideologies, the DW-NOMINATE scores developed by Keith Poole and Howard Rosenthal. I use this ideological rating system to divide Democratic House members into thirds: the most liberal third, a middle group, and finally the least liberal third of the House Democratic Caucus. Table 4.2 explores these results.

As Table 4.2 shows, differences by gender still hold for all three votes, even when controlling for ideology. Indeed, these differences are also statistically significant when a

regression analysis is conducted (Probit, with appropriate controls for constituency, partisanship, and ideology), reaffirming that gender did make a difference on the floor of the House of Representatives among Democratic legislators during the 2009-2010 debate over health care reform. Most significantly, did the presence of the 55 female House Democrats in March 2010 basically determine the outcome of the vote to pass health care reform? The answer may be yes.

Since almost all the members in the most liberal and moderate ideological groups voted yes on the conference report, I focus on the least liberal third, where many House Democrats, especially males, voted against party position. This category included 10 of the 55 women, 90 percent of whom voted to pass the bill. If they had voted for health care reform at the same percentage rate as their male counterparts, however, then only 5 or 6 of them would have voted yes, meaning, most likely, 3 or 4 fewer votes for the passage of the health care reform conference bill. The final vote on the conference report was 219-212, so if 4 votes had switches from yes to no, the final version of the bill would not have passed. The presence of so many female members in the House Democratic Caucus may have been pivotal to the outcome of the vote.

Table 4.2: Vote Breakdown by Ideology

		Abortion	Passage	Conference
Most	Male	8.5%	98.3%	100%
Liberal	Female	0	100%	100%
Middle	Male	20.8%	100%	97.2%
Group	Female	6.7%	100%	100%
Least	Male	58.3%	51.4%	55.1%
Liberal	Female	10%	70.0%	90.0%

The above results show that a gender gap does exist in the preferences of male and female legislators, especially on moral issues such as abortion and compassion issues such as health care (i.e. Frankovic 1977, Norton 1999, Swers 2001). However, as Michele Swers (2001, 218) notes, "analyses of roll-call voting only scratch the surface of potential gender differences in legislative participation." An analysis of the use of rhetoric on the floor of the House may shed more light on the relationship between position-taking and vote preference, and also on the ways in which gender and sex differ in terms of behavior on the floor of the House. We see a transition from acting for women, as in the roll call votes discussed above, to using gender as a performative tool with the end goal being a specific "presentation of self."

SECTION V: WHAT MAKES A DIFFERENCE? GENDER AND VALUES LANGUAGE

With the knowledge that analyses of roll call votes may not provide a full explanation of legislators' behavior, I next examine the ways in which both male and female legislators explain these votes to their constituencies and to their colleagues in the House. This topic has been the subject of extensive scholarly debate focused on the manner in which female legislators act and present themselves on the floor (i.e. Gerrity et al. 2007, Osborn and Morehouse 2002, Swers 2002, Reingold 2000). Studies on women in Congress tend to take one of two approaches: either investigating whether female legislators act in the specific interests of women through their legislative actions, or examining the representative ways in which female legislators do or do not present themselves as feminine on the House floor.

An important method for analyzing either of these topics is through the study of rhetoric. When studying rhetoric, we must consider that like their male counterparts, female legislators are generally not single-issue legislators: they, too, act under the pressures of various groups (such as their party), "meaning they have a host of electoral and policy concerns to address through their floor speeches" (2). In addition, it is of vast importance to note that just because female legislators have generally been studied as a group, they may not share the same policy concerns or even the same beliefs about their representational role. Researchers increasingly agree that divisions as well as commonalities exist among women legislators (e.g. Carroll 2000, Swers 2002). This acknowledgment is potentially of great significance in determining the impact that women have on Congress, especially when it is filtered through party identification. For example, Swers (2002) notes that an especially conservative freshman class of women in

the 1994 Congress were explicitly anti-feminist, and did not desire to be seen as feminist legislators. In addition, party leadership on the left and right deploys female legislators in different ways, based on the position of women as a core constituency or the desire to expand appeal among women, respectively (Swers 2002). If we acknowledge that female legislators, like their male counterparts, are driven by multiple factors, then the motivations for their actions on the floor become more complicated than simply advancing women's-issue legislation.

The relationship between the desire of female legislators to express a unique viewpoint and the need for reelection remains unclear, and will be investigated in further detail in my study. As a legislator's primary goal, the drive for reelection influences his or her actions and rhetoric on the floor, leading to position-taking, defined by Mayhew (1974) as the public enunciation of a judgmental statement on anything likely to be of interest to political actors. As a position-taker, the member of Congress is a speaker rather than a doer; the symbolic action of taking a position both allows the member of Congress to claim credit for doing so and to communicate a position to his/her party and constituents. Mayhew notes that rhetoric, especially on the floor, is an important vehicle for position-taking, and the scholarly literature agrees that symbolic activity, such as speech making, is electorally motivated (i.e. Hill and Hurley 2002, Sinclair 1986). A specific body of research examines the importance of rhetoric, specifically political values, and position-taking to the legislator with the rational goal of being reelected.

Rhetoric and Politics

The literature on political values language is based on the assumption of a relationship between political values and political party, with values being "powerful and

reliable weapons in the persuader's arsenal" (Nelson and Garst 2005, 490). A value is defined as an abstract belief about desirable end states or behaviors that transcends specific situations and guides evaluations and behavior (Schwartz 1994). Core political values reflect abstract, prescriptive beliefs about humanity, society, and public affairs (Feldman 1988, Kinder 1998).

Nelson and Garst (2005) find that the power of values-based political messages depends on recipients having shared values with the speaker (personal identity match), shared political party identifications with the speaker (social identity match), and/or previously held expectations about values traditionally associated with different political parties. In their study, participants especially rejected messages from rival party members when the speaker evoked unexpected values — meaning it makes political sense for a member of a certain party to evoke the values associated with that party. In addition, the literature establishes a binary between egalitarian and humanitarian values (i.e. Nelson and Garst 2002, Hart 2000, Ladd & Lipset 1980), with Democrats traditionally associated with egalitarian values and Republicans with individualistic values (Hart 2000). However, the fit between party and values is not perfect, and considered within the context of gender, this relationship becomes even more complicated.

Implications for My Study

As discussed above, previous research on women legislators has focused on roll-call votes as a method of position-taking. However, I am interested in also investigating how party, sex and gender come into play when the action in question is performative, rather than simply one of casting a vote. I examine whether gender matters for the act of position-taking in a way that it didn't in previous parts of my study. There are several

potential reasons for this difference, such as the facts that all legislators, not just women, present themselves in deliberate ways and that though women may act for women through roll-call votes, speaking for them may be more difficult given the need to appeal to all members of the constituency and succeed within the patriarchal institutional makeup of Congress. In addition, I examine the continued interactional role of party, with the expectation of a significant party divide between egalitarian values language and individualistic values language, with women using more egalitarian values language regardless of party identification.

Finally, the issue area of health care reform is key to this investigation for several reasons: first, it invokes inherently gendered questions of power and access to resources; second, health care is highly integrated into the Congressional agenda and connected with social welfare programs such as Social Security; and third, health care is traditionally considered a "soft" issue so this may influence how women choose to address it.

Research Design and Methodology

The data used in this study is floor debate conducted in the 111th Congress (2009-2010), specifically in the House of Representatives. The data was collected from the Congressional Record, available online. For this study, I focused on floor speeches made during the debate over H.R. 3962 (previously H.R. 3200), the Affordable Health Care for America Act. The study was limited to the week in late October and early November in which the bill was unveiled by Speaker Nancy Pelosi, debated on the floor, and then voted on. Therefore this study spans from Thursday, October 29, when the bill was introduced, to Saturday, November 7, when the bill and two amendments were voted on by the House. I included this Congress and specific week in the sample to make the

analysis as current as possible and to examine a bill in which gendered and non-gendered issues would both be present. To analyze the speeches, it was first necessary to determine which floor speeches would be included. I deemed any floor dialogue with a Congressional Record label relating to H.R. 3962 as relevant to be included in the study. To determine what length of speech would be included, I deemed all one-minute speeches, special orders, and floor statements of approximately a paragraph or more to be relevant. Following this, I did not include interjections, requests to reserve time, or statements by the chair or Speaker.

I then developed a manual coding system to determine which speeches contained values language. Drawing from Osborn and Morehouse (2002), I developed a list of values terms that, based on previous literature, were likely to be present in the speech. These terms included words such as "fairness," "security," "liberty," and "freedom." All values terms coded had to meet Schwartz's (1994) definition of a value. Based on this list of terms, I developed a coding binary between egalitarian/humanitarian values language and individualistic/Protestant values language (egalitarian/humanitarian = 1). Finally, I determined the degree of values language in the speech — whether it contained no/very little values language, a moderate amount of values language, or was highly valued (0 = none, 1 = very little (1 term), 2 = moderately (2 terms), 3 = highly valued (3 or more terms). Following Gerrity and Osborn (2007), values language is considered to be moderately used if it is repeated twice in the body of a remark.

Employing these categories to the week of debate which comprises the study yields 326 cases (speeches), of which 259 are by men and 67 are by women. There are 112 speeches given by Democrats, with 214 given by Republicans. Because the unit of

analysis is the speech, not the legislator, some legislators are counted more than once in the body of the sample, depending on when and how many times they spoke. My primary dependent variables are the degree of values language used in the speech and values orientation, as discussed above. I chose to use variables related to the speeches themselves, rather than the legislator, to acknowledge the possibility that legislators do not express similar preferences on different issues, or that their preferences always follow the same pattern.

My primary independent variable is gender (women = 1), with several other variables serving as controls on the primary variable, most notably party (Democrat = 1), following the notion that party may be an intervening variable in gender differences (that there are differences by gender for one party but not the other). Therefore, this control also acknowledges the possibility that there are differences by gender for one party or not the other. Second, I control for the type of speech being analyzed, because of previous literature on one-minutes being used as a vehicle for position-taking (Swers 2002, Morris 2001) and because of the hypothesized possibility that the type of speech most common for men is the 1-minute, while for women it is the special order, because of the possibility that women's issues are still tokenized and grouped within special-issue debate (Kanter 1977, Swers 2002).

Finally, I control for whether the speech is a women/family issue or not (women/family issue = 1). This issue has proved controversial in the existing literature because of the difficulty of determining what a women's issue is explicitly and what is not. Osborn and Mendez (2007) acknowledge the difficulty of determining a women's issue from a neutral issue, as several issues relate directly to women even if not in an

explicitly gendered context, such as education and health care. Because of the nature of health care as an issue in which women's issues are already acknowledged to be present, I determined that a speech would be coded as a women/family issue if it directly referenced women's health, or issues that pertain especially to women such as breast cancer or abortion. For most of these speeches, the Congressional Record designates them such as women/family issues by the title given, reducing the possibility for incorrectly categorizing a speech.

Analysis of Data

The results of my rhetorical analysis reveal that explaining male and female legislators' voting behavior is more complex than simply putting them on a binary or reducing explanations of behavior to a legislator's sex. The overwhelming finding is that although female Democrats behaved differently in roll call votes, they explained their behavior to the voters and the public via their floor statements in much the same way as men. This finding reinforces the facts that appealing to voters and achieving reelection continue to be the primary drivers for a legislator, regardless of gender, and that gender as a social construct is performative and strategic: female legislators seem well aware of their gender when speaking on the House floor.

Differences between Genders

The overall results of my rhetorical analysis show small, if any, differences between men and women when controlling for party. Tables 5.1 and 5.2 show the relationship between gender and degree of values language and values orientation, respectively, when party is not a consideration. Without controlling for party, women are slightly more likely than men to use egalitarian/humanitarian language (35% vs. 29%). In

addition, without controlling for party, women are less likely than men to fall into the highest degree of values language usage, meaning, percentage-wise, they give more speeches that are less valued. However, this result may also be due to the fact that men gave the overwhelming majority of one-minute speeches, which tend to be more ideologically extreme, which will be discussed.

Table 5.1: Gender and Degree of Values Language in Speech

Gender of Speaker	Degree of Values Language in Speech				
	0	1	2	3	Total
0	6	35	27	24	92
	6.52	38.04	29.35	26.09	100.00
1	0	12	11	7	30
	0.00	40.00	36.67	23.33	100.00
Total	6	47	38	31	122
	4.92	38.52	31.15	25.41	100.00

Table 5.2: Gender and Values Orientation

Gender	Values Orientation		
	0	1	Total
0	61	26	87
	70.11	29.89	100.00
1	20	11	31
	64.52	35.48	100.00
Total	81	37	118
	68.64	31.36	100.00

Differences for Democrats

However, once we control for party, the gender differences in floor behavior between men and women blur. We see slight differences in values orientation, with Democratic women more oriented toward egalitarian language and messages; however, no gender differences are evident within the Republican Party. Table 5.3 shows the relationship between gender and values orientation for Democrats. Eighty-six percent of Democratic men and 92% of Democratic women used egalitarian messages; reversed, about 14% of Democratic men and about 8% of Democratic women evoked individualistic language. However, this difference is not large and the relationship is even smaller within the Republican Party. Table 5.4 shows the relationship between gender and values orientation in the GOP. We see that women are actually slightly more likely to follow their party's ideological orientation and use individualistic language. Overall, I find that party, more than gender, influences how legislators speak on the floor.

To further examine the potential differences among Democratic legislators, I divided the Democratic legislators in my sample that did use individualistic language into the ideological thirds I also used to analyze the roll call votes in the previous section. However, the legislators (of which there were 5, all men) that used individualistic language were positioned within different ideological thirds. In addition, I examined whether the Democratic members of this sample voted for or against the initial House passage of the bill and the Stupak-Pitts amendment. However, all members of this group, though they used individualistic language, voted for both bills, implying that male legislators as well as female legislators feel the need to send a specific ideological

message to their constituencies. It is also possible to observe the impact of party and ideology in speeches on women and family issues.

Table 5.3: Gender and Values Orientation, Democrats

Gender of Speaker	Values Orientation		
	0	1	Total
0	4	24	28
	14.29	85.71	100.00
1	1	11	12
	8.33	91.67	100.00
Total	5	35	40
	12.50	87.50	100.00

Table 5.4: Gender and Values Orientation, Republicans

Gender of Speaker	Values Orientation		
	0	1	Total
0	57	2	59
	96.61	3.39	100.00
1	19	0	19
	100.00	0.00	100.00
Total	76	2	78
	97.44	2.56	100.00

Women and Family Issues

Women and family issues, most notably abortion, provide the greatest example of party intervening in the gendered use of values language. Within women/family issues that relate to reproductive rights (of which there are 20), 100% of legislators, regardless of gender, use language that corresponds with their party's values. It appears that when it comes to women/family issues (often meaning abortion), party and party values become more important than gender: all speakers on women/family issues fell within the hypothesized values categories. This could speak to the controversial nature of abortion, the use of speeches on abortion to take positions and to communicate an electorally important message back to the constituency, or the possibility that abortion is an issue of conscience rather than of gender. This data supports findings by Osborn and Mendez (2010) that women and men give comparatively the same percentages of speeches on abortion. They note that this could be that abortion is a "wedge issue" that legislators wish to avoid, or that the issue may be of religious or moral importance rather than of specific importance to women.

Discussion of Findings

I will discuss several interesting findings in the data, with the intention of explaining differences by gender given legislators' behavior and actions on the floor. First, I will examine the conclusion that party, more so than gender, influences how legislators speak on the floor. Second, I will discuss differences among women legislators that, although present but not significant in my study, are beginning to be explored in the literature. Third, I discuss the possibility that women, though they frame their floor comments in the same manner as their male colleagues, are still considered a special

interest to Congress. Finally, I discuss the relationship between these findings, the analysis of roll-call votes, and the literature on public opinion to form final observations about how sex and gender operate in the health care policy area.

The Importance of Party

The results of the rhetorical analysis show that although women Democrats behaved differently, they explained their behavior to the voters and other members of the public via their floor statements in generally the same manner as did their male colleagues. This finding supports the observation that legislators, regardless of gender, have reelection as their primary goal. Female legislators need their public statements to appeal to voters of both genders in order to be reelected, meaning their voting behavior and floor behavior diverge. In addition, this finding supports the conclusion that women must emulate masculine characteristics and speaking styles in order to advance in Congress (i.e. Cramer Walsh 2002, Winsky Mattei 1998, Huddy & Terkildsen 1993). Duerst-Lahti and Kelly (1995) note that women must enter politics "within ideological terms of masculine norms;" the "masculine norm" here being language that is less empathetic and more aggressive and assertive (Huddy & Terkildsen 1993).

In addition, as floor debate gives legislators the opportunity to perform for their colleagues as well as constituencies, framing debate in a way similar to men, despite casting different roll call votes, may help women advance in the House and gain superior positions. This drive for legitimacy may be magnified in the context of health care reform, as health care has traditionally been considered a "compassion issue" and is relegated to the back-burner of the policy arena (Mueller 1986). In addition, Cramer Walsh (2002) note that, through debate, female members of Congress prove that they can hold their

own, which is especially important given the fact that women in Congress are still relatively new. Research on Congress has suggested that new members try to adapt to the norms of the institution. In order to be taken seriously, new female members might emulate the behavior of men (Cramer Walsh 2002).

In addition, the practice of emulating men on the floor may be useful for reelection purposes, since some research has suggested that voters prefer masculine characteristics. For example, Winsky Mattei (1998, 504) finds a preference for masculine characteristics at higher levels of office; she notes that "women candidates may succeed at the polls because they manage to convince voters that…they possess desirable masculine political strengths." In addition, she acknowledges that "female legislators are probably correct in assuming that voters punish candidates who lack typical masculine traits." Regarding speaking to the public, Cramer Walsh (2002, 390) notes that "floor debate is an arena in which women demonstrate their competence on a wide range of topics, which increases the possibility that the public and other members will not discount female candidates or representatives by virtue of their sex."

Overall, these findings support conclusions in the scholarly literature that women legislators must appeal to voters of both genders to achieve reelection, and that they do this by putting party first and potentially by mirroring the rhetoric of their male colleagues. Does this mean that the potential to espouse unique experiences or perspectives is completely removed from the reality of being a female member of Congress? No. The qualitative findings of this study support the assertion that "women are framing debates in ways similar to their male colleagues, yet they speak on behalf of

marginalized constituencies more than men, and talk about their experience in roles that only women can represent" (Cramer Walsh 2002, 379).

The idea that women do perform uniquely on the House floor takes on two forms: first, in the acknowledgment that women of different political parties do not perform in the same way; and second, in the possibility that women's issues are still considered a special interest in Congress.

Differences among Women: The Case of Party Line

Though the differences between Democratic and Republican female legislators in this study are slight, I believe they deserve examining within the context of the scholarly literature. The findings mirror Shogan's (2001) assertion that Democratic and Republican women talk about different issues when they discuss women's interests. For example, both Democratic and Republican women expressed concerns about abortion. However, while Democratic women focused on reproductive rights, gender discrimination in insurance coverage, and equal access for women to health care, Republican women focused on the traditional role of women in the family as administrators of health care. In addition, because of Republican women's stricter adherences to party values orientation, my data supports the argument that Republican women are more traditional and more interested in party positions than Democratic women (Sapiro and Farah 1980).

To provide a specific example, I turn to a one-hour special order held on November 2, 2009, entitled "Health Care for Women in America." The special order was headed by Congresswoman Marsha Blackburn (R-TN). Congresswoman Blackburn and her colleagues both promoted alternative Republican proposals (written by men) and highlighted their experiences as wives and mothers and extended these to the

demographic of women in general. For example, another participant in the special order, Congresswoman Judy Biggert (R-IL), explained that "as a mom and a grandmother, I've always been very concerned about health care, and I want to make sure that my family has the best that's possible."

Fundamentally, as Shogan (2001) notes, women represent women in different ways; thus, Democratic and Republican women use different rhetoric on the floor. My research also confirms that Democratic women are still considered the standard-bearers for women's issues; while Republican women do not avoid discussion about women's issues, they are greatly overshadowed by Democratic women. As Shogan (2001, 141) notes, this is instructive to the Republican Party, either to elect more Republican women to the House or to place more female legislators in the House in positions to engage in floor rhetoric about women's issues. If not, the Democratic Party will continue to be perceived as the party of women, despite a greater effort by the Republican Party to incorporate women into its public image.

Women: A Special Interest?

Despite the incorporation of women into the floor debate of both parties, I observed that women are still treated as a special interest on the floor of the 111th Congress. Women's issues are treated as special-interest issues, even though public opinion data indicates that women in the general public do not express health care concerns very different from men, and in fact, men tend to be more liberal than women on issues such as abortion. In my study, both Republican and Democratic women spoke on traditional women's issues; however, the issues on which they chose to focus were vastly different, highlighting the interactive effect of party on gender. For example,

"Healthcare for Women in America," the Republican one-hour special order discussed above, explored the role of women as the primary health care decision-makers for the nuclear family, whereas Democratic women spearheaded a pro-choice debate over the Stupak amendment on November 7. These differences support the assertion that simply focusing on women as a category ignores the multiplicity of perspectives women bring to politics, based on their socialization, values, and party identification. In addition, the possibility that women are treated as a special interest sheds light on the relationship between female legislators, their votes, and their floor rhetoric: they cast votes based on individual or women's preferences, but to achieve reelection they must appeal to both genders. In a legislative world still overwhelmingly dominated by men, this compromise appears to take the form of special orders that remain, content-wise, separate from general debate.

Gender Implications for the Use of One-Minute Speeches

Another way in which I see women's issues as still being considered a special interest in health care is in the structure, rather than simply the content, of floor debate. The gender discrepancies apparent in the types of speeches given on the House floor reflect more the strategic preferences of the party leadership than a desire to accurately represent women, and limit women's opportunities to engage in general floor debate and decrease the likelihood that they could speak as women. Though Swers (2002) acknowledges elements of tokenism in the parties' strategic use of congresswomen (27), I find that the attitude that women are a special interest is alive and well in the 111th Congress. Women may, and do, speak on policy concerns outside the realm of women's issues; however, women's issues within healthcare are generally condensed within

special orders or planned debate. The phenomenon of one-minute speeches being dominated by men (83.15% given by men) — in contrast to the few special orders centered on women — suggests that even when female legislators emulate men, men have more leeway in their ideological positions and that the male voice is still dominant in the House.

In addition, Maltzman and Sigelman (1996) find that unconstrained floor time, such as one-minute speeches, is used mainly for policy rather than electoral purposes. One-minutes are used by party leadership to communicate the party's views on a specific piece of legislation or the "message of the day" (Morris 2001). Given the visibility of one minutes and their partisan nature, it is intriguing that party leadership does not deploy more women in this form of speech. If the one-minute speeches given in the morning are said to set the tone for that day of legislation, excluding women from this particular form of rhetoric suggests that women's interests are excluded as well. The exclusion of women from one-minutes could be a strategic decision by a party leadership desiring to establish firm party line, a decision by the female legislators themselves not to be associated with a highly partisan form of position-taking, or simply a result of what remains an overwhelmingly unequal Congress in seniority and leadership (Swers 2002, 25).

The Unique Position of Abortion as a Gendered Issue

Finally, as discussed in the scholarly literature, abortion provides a unique example of party interacting with gender on a women and family issue. When speaking about abortion (which occurred 20 times in my study), 100% of legislators used language that corresponded with their party's values. This result could have been skewed by the discussion of the Stupak-Pitts abortion amendment, which was the subject of heavy

public debate and was discussed in value-laden language by both Democrats and Republicans. Regardless, this data supplements the discussion of abortion as an unusual case in the field of gender and politics. Osborn and Mendez (2010) note that abortion does not follow their categorization of women's issues; unlike other issues, female Senators do not give significantly more speeches on abortion than men, though they do not theorize why. Swers (2002) also notes that abortion does not follow typical patterns of floor behavior.

The strength of party values orientation when it came to abortion could be a result of several factors, such as the desire to avoid unnecessary attention on the issue, especially on a highly visible piece of legislation in a midterm election year, which may have deterred more liberal Republicans from speaking. In addition, this study did not control for party leadership or committee membership; these factors could have had an effect on who was able to speak about abortion and thus on their position on the matter.

Connections between Mass Preferences and Elite Performance

Lastly, I discuss the relationship between these findings, the analysis of roll-call votes, and my analysis of public opinion to form final observations about how sex, gender and party operate in the health care policy area. The different needs of men and women regarding health care suggest that female legislators would wish to speak to these interests on the House floor; however, as in mass opinion, few gender differences exist in elite rhetoric about health care. Rather, we do see gender differences in roll call votes on health care, suggesting that while female legislators may look to women's interests when casting votes, they understand the need for their behavior on the floor to appeal to both their constituencies and to the powers-that-be in Congress. In addition, it appears that

female legislators do speak for women within the boundaries allotted them; that is, special orders that encapsulate a variety of women's perspectives and experiences into a single program. This approach, combined with the fact that male legislators make a disproportionate amount of one-minute speeches, suggests that women's issues are still considered a "special interest" by Congress, even within an issue area historically deemed a "feminine" compassion issue. My research suggests that while female legislators do bring marginalized perspectives to floor debate, party and the need for reelection continue to be the primary drivers of floor behavior for members of Congress of either gender. Furthermore, this research suggests that sex and gender do not operate in the same way, or play the same roles in different areas of legislative action. We see that gender matters for the performative actions of a legislator in a way that it doesn't for less public actions, such as casting a roll call vote. Essentially, we observe that a legislator's gendered behavior is not fixed, but rather adapts to the environment in which that behavior is carried out.

SECTION VI: CONCLUSION

In this study, I examine how gender interacted with party at both the mass and elite levels in the 2009 health care reform debate. Using regressions of public opinion data, roll call votes, and rhetoric on the House floor, I was able to determine where gender made an impact and where party prevailed. First, I researched the interests and preferences of men and women at the mass level, examining where gender differences arose. I discovered that, prior to the 2009 debate on health care reform, few gender differences existed in public opinion regarding health care. Next, I investigated how this played out at the elite level, through the study of key health care roll call votes in the 111th Congress. Here, I discovered that gender did make a difference: the votes of female legislators were crucial to the passage of the Affordable Health Care for America Act.

However, I also wanted to examine how female legislators, through rhetoric, explained their behavior on the floor of the House. I studied values language used during the week of debate of the House bill and the Stupak-Pitts abortion amendment and discovered that, although gender differences appeared in the casting of roll call votes, women explained their actions to their constituencies in much the same way as men. These results suggest that while female legislators may cast votes in the interests of women, they recognize the need to appeal to both genders and to the institutional makeup of Congress in order to achieve reelection and garner favor within the chamber. As other researchers have observed, Congress continues to be an institution dominated by both men and a historically masculine perspective; perhaps as a reflection of this institutional structure, voters in the constituency also respond better to masculine characteristics. In

turn, female legislators frame their dialogue about votes on the House floor in a manner similar to men and governed particularly by party.

Most importantly, this study affirms the notion that female legislators do not act in a certain way by virtue of their sex. Rather, a variety of electoral and policy concerns guide female legislators. In addition, female members of Congress must juggle several seemingly conflicting roles: they must acknowledge the unique needs of women, they must appeal to constituencies that comprise both men and women, and they must actively work to succeed in an institution that continues to be dominated by a masculine perspective. By successfully filling multiple roles, female legislators prove that, rather than being fixed or immutable, gender is both fluid and strategic. In addition, the distinction between sex and gender comes into play when examining different aspects of legislators' behavior, further proving that gender is a social, performative construct rather than an unchangeable concept. When looking at interests and preferences, sex may be the operative concept; for example, men and women have different biological propensities that gender health care policy. However, when looking at rhetoric, it becomes evident that gender as a presentation of self, rather than any innate characteristic, governs legislators' behavior.

In addition, this study adds to the body of scholarly research on health care as an issue area. Though more research is needed to determine whether the results of this study extend to other issue areas as well, these results suggest that at least in the 2009 passage of health care reform Democratic female legislators did vote for women. This finding complicates the discussion of whether or not women display different voting patterns from men, and on which issues. While some research finds few roll-call differences

between men and women (i.e. Frankovic 1977, Vega & Firestone 1995), other research does find that women are more liberal than men within the same party (i.e. Welch 1985). At least in the case of the Democratic Party, I found the latter to be true for health care reform. It seems that, within an environment of increasingly diverse representatives and constituencies, the traditional uni-dimensional voting model no longer explains a legislator's behavior in all issue areas, and that secondary dimensions such as gender do play a role in determine a legislator's vote. In addition, health care as an issue encompasses both historically women's issues, such as child care and reproductive health, and non-gendered issues such as the budget, making it useful for my study but perhaps unique of other issue areas. It would be an interesting next step to compare the roll-call votes and rhetoric studied in this analysis to votes and rhetoric concerning a traditionally more masculine issue area, such as defense or economic policy.

This research is unique in that it provides a comparative analysis of different aspects of legislative behavior within the same issue area and provides new insights into how gender and party operate in the policy area of health care. In addition, this research provides a foundation for further inquiries into how gender continues to impact Congress in the 21st century. Further studies might control for committee membership or constituency ideology to further pinpoint how gender operates for female legislators. It is my hope that with the aid of further research, Congress will transform to not only acknowledge the possibility that women's interests should be fully integrated into House discourse but also embrace the fact that men and women use gender to perform in strategic ways to achieve both policy goals and reelection.

SECTION VII: REFERENCES

Ansolabehere, S., Snyder, Jr., J. M., & Stewart III, C. (2001). The effects of party and preferences on Congressional roll-call voting. *Legislative Studies Quarterly, 26*(4), 533-572.

Bardes, B. A., & Oldendick, R. W. (2000). Public opinion on social welfare issues. In *Public opinion: measuring the American mind* (pp. 122-142). Belmont, CA: Wadsworth Pub.

Barnello, M. (1999). "Gender and roll call voting in the New York State Assembly." Women and Politics 20: 77-94.

Blendon, R. (2011). Women's perspectives on health care policy. In *American public opinion and health care* (pp. 451-472). Washington, D.C.: CQ Press.

Blendon, R. J., Marttila, J., Benson, J. M., Shelter, M. C., Connolly, F. J., & Kiley, T. (1994). The beliefs and values shaping today's health reform debate. *Health Affairs, 13*(1), 274-284. doi: 10.1377/hlthaff.13.1.274

Blumenthal, D. (1995). Health care reform: Past and future. *New England Journal of Medicine, 322,* 465-68.

Bobinski, M., & Epps, P. G. (2001). Women, poverty, access to health care, and the perils of symbolic reform. *The Journal of Gender, Race, and Injustice,* (5), 233-265.

Box-Steffensmeier, J. M., De Boef, S., & Lin, T. (2004). The dynamics of the partisan gender gap. *American Political Science Review, 98*(03).

Carpini, M., & Keeter, S. (2005). Gender and political knowledge. In S. Tolleson-Rinehart & J. J. Josephson (Authors), *Gender and American politics: women, men, and the political process* (2nd ed., pp. 21-47). Armonk, NY: M.E. Sharpe.

Carroll, S.J. (2002). "Representing women: Congresswomen's perceptions of their representational roles." In *Women Transforming Congress*, ed. Cindy Simon Rosenthal. Norman: University of Oklahoma Press, 50-68.

Cramer Walsh, K. (2002). Enlarging representation: Women bringing marginalized perspectives to floor debate in the House of Representatives. In C. S. Rosenthal (Author), *Women transforming Congress* (pp. 371-396). Norman, OK: University of Oklahoma Press.

Dodson, D. (1995). *Voices, Views, and Votes: The Impact of Women in the 103d Congress.* Center for American Women in Politics.

Duerst-Lahti, G., & Kelly, R. (1995). On governance, leadership, and gender. In G. Duerst-Lahti & R. Kelly (Eds.), *Gender Power, Leadership, and Governance*. Ann Arbor: University of Michigan Press.

Feldman, S. (1988). "Structure and consistency in public opinion: The role of core beliefs and values." *American Journal of Political Science* 32(2): 416-40.

Frankovic, K. A. (1977). Sex and voting in the U.S. House of Representatives 1961-1975. *American Politics Quarterly, 5*(3), 315-330.

Frankovic, K. A. (1982). Sex and politics: New alignments, old issues. *PS, 15*(3), 439-448.

Garst, J., & Bodenhausen, G. (1996). ""Family values" and political persuasion: Impact of kin-related rhetoric on reactions to political campaigns." Journal of Applied Social Psychology 26(13): 1119-137.

Gerrity, J, Osborn, T., & Morehouse Mendez, J. (2007). Women and representation: A different view of the district? *Politics & Gender* 3(2): 179-200.

Goren, P. (2005). Party identification and core political values. *American Journal of Political Science* 49(4): 881-96.

Hacker, J. S. (1997). *The road to nowhere: the genesis of President Clinton's plan for health security*. Princeton, NJ: Princeton University Press.

Hart, R. P. (2000). *Campaign talk: Why elections are good for us*. Princeton, NJ: Princeton UP.

Hill, K., & Hurley, P. (2002). "Symbolic speeches in the U.S. Senate and their representational implications." *The Journal of Politics* 64(1): 219-31.

Hoffman, C. (2009). *National health insurance: A brief history of reform efforts in the U.S.* Kaiser Family Foundation.

Huddy, L., & Terkildsen, N. (1993). The consequences of gender stereotypes for women candidates at different levels and types of office. *Political Research Quarterly, 46*(3), 503-525. doi: 10.2307/448945

Jamieson, K. H. (2000). The gender gap in political knowledge: Are women less knowledgeable than men about politics? In *Everything you think you know about politics --: and why you're wrong* (pp. 83-89). New York: Basic Books.

Jordan Brooks, D. (2003, January 21). Healthcare coverage: Who's responsible? *Gallup*. Retrieved from http://www.gallup.com/poll/7636/Healthcare-Coverage-Whos-Responsible.aspx

Kanter, R.M. (1977). Some effects of proportions on group life: Skewed sex ratios and responses to token women. American Journal of Sociology 82(5): 965-90.

Kathlene, L. (1995). Alternative views of crime: Legislative policymaking in gendered terms. The Journal of Politics 57(3): 696-723.

Kaufmann, K. M., & Petrocik, J. R. (1999). The changing politics of American men: Understanding the sources of the gender gap. *American Journal of Political Science*, *43*(3), 864-887.

Kenski, K. (2003). Testing political knowledge: Should knowledge questions use two response categories or four? *International Journal of Public Opinion Research, 15*, 192-200.

Kinder, D. (1998). Opinion and action in the realm of politics. *Handbook of Social Psychology*. Ed. Anthony R. Pratkanis, Stephen J. Breckler, and Anthony G. Greenwald. 4th ed. Hillsdale: Lawrence Erlbaum, 778-867.

Klein, E. (1985). The gender gap: Different issues, different answers. *The Brookings Review*, *3*(2), 33-37.

Maltzman, F., & Sigelman, L. (1996). "The Politics of talk: Unconstrained floor time in the U.S. House of Representatives." *The Journal of Politics* 58(3): 819-30.

Mattei, L. W. (1998). Gender and power in American legislative discourse. *The Journal of Politics*, *60*(2), 440-461.

Mayhew, D. (1974). *Congress: The electoral connection.* Yale University Press, New Haven.

Morris, J. (2001). "Reexamining the politics of talk: Partisan rhetoric in the 104th House." *Legislative Studies Quarterly* 26(1): 101-121.

Morone, J. A., & Belkin, G. S. (1994). *The politics of health care reform: lessons from the past, prospects for the future*. Durham: Duke University Press.

Mueller, C. M. (1986). Nurturance and mastery: Competing qualifications for women's access to high public office? In G. Moore & G. D. Spitze (Eds.), *Women and politics: activism, attitudes and office-holding*. Greenwich, CT: JAI Press.

Mueller, C. M. (1988). The empowerment of women: Polling and the women's voting bloc. In *The Politics of the gender gap* (pp. 16-36). London: Sage publ.

Nelson, T., & Garst, J. (2005). Values-based political messages and persuasion: Relationships among speaker, recipient, and evoked values." *Political Psychology* 26(4): 489-516.

Norrander, B. (1999). The evolution of the gender gap. *The Public Opinion Quarterly*, *63*(4), 566-576.

Norrander, B. (2008). The History of the Gender Gaps. In L. D. Whitaker (Author), *Voting the gender gap* (pp. 9-30). Urbana: University of Illinois Press.

Norton, N. (1999). Uncovering the dimensionality of gender voting in Congress. *Legislative Studies Quarterly*, *24*(1), 65-86.

Osborn, T, & Mendez, J. (2002). Speaking as women: Women and floor speeches in the Senate. *Journal of Women, Politics & Policy* 31(1):1-21.

Price, V., David, C., Goldthorpe, B., Roth, M. M., & Cappella, J. N. (2006). Locating the issue public: The multi-dimensional nature of engagement with health care reform. *Political Behavior, 28*(1), 33-63.

Reingold, B. (2000). *Representing women: Sex, gender and legislative behavior in Arizona and California*. University of North Carolina Press, Chapel Hill.

Sapiro, V. (1986). The gender basis of American social policy. *Political Science Quarterly, 101*(2), 221-238.

Sapiro, V. (2003). Theorizing gender in political psychology research. In D. O. Sears, L. Huddy, & R. Jervis (Eds.), *Oxford Handbook of Political Psychology* (pp. 601-634). Oxford: Oxford University Press.

Sapiro, V., & Farah, B. (1980). New pride and old prejudice. *Women & Politics* 1: 13-36.

Schwartz, S. (1994). Are there universal aspects in the structure and contents of human values? *Journal of Social Issues* 50(4): 19-45.

Shapiro, R. Y., & Mahajan, H. (1986). Gender differences in policy preferences: A summary of trends from the 1960s to the 1980s. *The Public Opinion Quarterly, 50*(1), 42-61.

Shogan, C. (2001). Speaking out: An analysis of Democratic and Republican woman-invoked rhetoric of the 105th Congress. *Women and Politics* 23: (1/2): 129-146.

Simmons, W. W. (2000, September 28). Health care an important issue this year. *Gallup*. Retrieved from http://www.gallup.com/poll/2503/Health-Care-Important-Issue-Year.aspx

Sinclair, B. (1986). Senate styles and Senate decision making, 1955-1980. *The Journal of Politics* 48(4): 877-908.

Skocpol, T. (1993). Is the time finally ripe? Health insurance reforms in the 1990s. *Journal of Health Politics, Policy and Law*, *18*(3), 531-550.

Swers, M. (2001). Understanding the policy impact of electing women: Evidence from research on Congress and state legislatures. *PS: Political Science and Politics, 34*(2), 217-220.

Swers, M. (2002). *The difference women make: The policy impact of women in Congress.* University of Chicago Press, Chicago.

Tannen, D. (1990). *You just don't understand: Women and men in conversation*. New York: Morrow.

The gender gap: Attitudes on public policy issues (Publication). (1997). Rutgers University, NJ: Center for American Women and Politics.

Thomas, S. (1989). Voting patterns in the California assembly: Role and gender. *The Journal of Women, Politics & Policy* 9(4): 43-56.

Tolleson-Rinehart, S. (2000). "Women get sicker, men die quicker": Gender, health politics, and health policy. In S. Tolleson-Rinehart & J. J. Josephson (Authors), *Gender and American politics: women, men, and the political process* (pp. 160-182). Armonk, NY: M.E. Sharpe.

Tolleson-Rinehart, S. (2005). "Women Get Sicker; Men Die Quicker": Gender, Health Politics, and Health Policy. In S. Tolleson-Rinehart & J. J. Josephson (Authors), *Gender and American politics: women, men, and the political process* (2nd ed., pp. 171-197). Armonk, NY: M.E. Sharpe.

Vega, A., & Firestone, J. M. (1995). The effects of gender on Congressional behavior and the substantive representation of women. *Legislative Studies Quarterly, 20*(2), 213-222.

Weisman, C. S. (1998). Transforming women's health care policymaking. In *Women's health care: activist traditions and institutional change* (pp. 214-231). Baltimore: Johns Hopkins University Press.

Welch, S. (1985). Are women more liberal than men in the U.S. Congress? *Legislative Studies Quarterly, 10*(1), 125-134.

Winter, N. G. (2005). Framing gender: Political rhetoric, gender schemas, and public opinion on U.S. health care reform. *Politics & Gender, 1*(03), 453-480. doi: 10.1017/S1743923X05050130

Winter, N. J. (2008). Gendering of health care reform. In *Dangerous frames: how ideas about race and gender shape public opinion* (pp. 119-140). Chicago: University of Chicago Press.

Wirls, D. (1986). Reinterpreting the gender gap. *Public Opinion Quarterly, 50*, 316-330.