Framing Gender: Political Rhetoric, Gender Schemas, and Public Opinion on U.S. Health Care Reform

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Although gender plays an enormous role in structuring personal relationships, society, politics, and culture, we know relatively little about when people's gender ideologies will influence their opinions on issues that do not trade directly on matters of gender. This article presents a theory of "group implication," which defines the conditions under which elite political discourse can lead citizens to perceive and evaluate issues in terms of their gender schemas—their cognitive representations of gender beliefs. I apply this framework to an analysis of the 1993–94 U.S. health care reform effort, and demonstrate how elite frames structured the issue in a way consistent with the gender schema. This structuring was subtle and symbolic, and served to associate people's gender ideology with their thinking about health care reform. The article concludes with consideration of the implication of these findings for our understanding of the political impact of gendered rhetoric, and for our conceptual understanding of the relationship between gender and public opinion.

Given its enormous social and psychological importance, gender can play an important role in political cognition. Just as the racialization of welfare leads racial conservatives to oppose welfare programs and racial liberals to support them (Gilens 1999), political issues can likewise become gendered. This process, which I call "gender implication," leads to polarization, not necessarily between men and women (i.e., a gender gap) but between supporters of traditional and egalitarian gender arrangements. We know that this occurs for issues that impinge directly on gender equality, or for issues—such as abortion or child care—that the public believes affect gender roles or the fortunes

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of women and men differently (Sapiro 2003, 618–19). I argue that another sort of gendering can occur. An issue can be gender-implicated if it is framed in ways that *symbolically* evoke people's ideas about gender. An issue can be gender-implicated if it is framed in ways that symbolically evoke people's ideas about gender, leading people to view the issue through an unconscious "lens of gender" (Bem 1993).

In this article, I argue that the 1993–94 American health care reform debate demonstrates gender implication at work. Before 1993, mass opinion on health care reform was not linked with gender ideology. The politics and rhetoric deployed during 1993–94 brought a change, by linking health care with gender in new ways. These linkages were subtle and symbolic, and they unconsciously associated people's feelings about gender relations with their thinking about health care reform. After reform efforts died, these linkages faded among the public.

This analysis is important for several reasons. First, it expands our understanding of how gender ideology can structure public opinion, even without explicit references to gender. This adds to our understanding of the role of issue frames in shaping opinion. The analysis also draws attention to one of the ways that the "lens of gender" structures political and social cognition. Most broadly, this approach treats gender implication within a general framework that allows analysis of implication among both men and women and that holds the prospect for comparing gendering and racialization.

I begin with a theoretical account of the conditions under which political rhetoric will engage people's ideas about gender, even without any explicit gender references. Next, drawing on secondary accounts of the Clinton administration's 1993–94 health care reform effort, I explore the set of rhetorical frames deployed by supporters and opponents of reform. In this discussion, I demonstrate how these frames were consistent with implicit gender coding. Then I employ survey data from the National Election Studies (NES) to demonstrate that public opinion did become gender-implicated in response to these frames. Finally, I conclude with some observations about the significance of the findings for health care reform specifically, as well as for our understanding of the role of gender in political cognition and politics.

THEORY

"Gender implication" is the process by which opinion on political issues becomes entwined—in political discourse and in citizens' minds—with

considerations of gender. The term "implication" makes clear that the process need not be explicit: The rhetoric need not refer explicitly to gender and individuals may be unaware of gender's impact on their opinions.

Mechanisms of and Conditions Governing Group Implication

The interaction between psychological *schemas* and rhetorical *frames* governs this process. Schemas are "cognitive structure[s] that represent knowledge about a concept" (Fiske and Taylor 1991, 98). They are invoked when we encounter ambiguous phenomena, including political issues, and they play an active role in perception by filling in missing information and by suggesting bases for evaluation. When a person encounters a political issue, some schema is invoked to understand it; that schema then influences the basis for evaluating the issue (Conover and Feldman 1984; Smith 1998).

An issue frame, on the other hand, is "a central organizing idea or story line that provides meaning to an unfolding strip of events, weaving a connection among them. The frame suggests what the controversy is about, the essence of the issue" (Gamson and Modigliani 1987, 143). Frames often suggest explicitly how best to view an issue. I argue that frames can also work unconsciously to evoke a particular schema, which then influences issue perception and evaluation. A frame will evoke a particular schema when the frame is congruent with the schema. Schemas, then, are the psychological analog of rhetorical frames.

Schemas contain attributes that describe the category in question, as well as a structure that positions those attributes in relation to each other and provides a basis for judgments. For example, white Americans' schemas for understanding race contain *attributes* drawn from common cultural stereotypes: that whites are rich, that blacks are athletic, that discrimination occurs against blacks, that whites are hard-working, and so on.[1] For some, this schema includes a structural linkage that suggests that blacks are poor *due to* discrimination; others' racial schemas include a different structural link that suggests whites are rich

1. Patricia Devine shows that high-prejudiced and low-prejudiced people are equally aware of cultural stereotypes (1989).

because they work harder than blacks (Wittenbrink, Gist, and Hilton 1997). This variation in structure leads to variation evaluations of situations perceived in terms of the race schema.

Bernd Wittenbrink and colleagues conducted an intriguing experiment that shows how schematic structure can drive evaluations of situations that are—on their surface—quite removed from the schema (1997). Subjects watched a series of animated videos involving the interaction of a single fish with a larger group of fish. These videos involved conflict between the fish and the group, but were ambiguous as to the individual fish's and the group's motivations. The crucial finding was that subjects' racial schemas affected their interpretations of the videos. Subjects who believe blacks are poor because they do not work hard tended to hold the individual fish responsible for the interactions; those who believe blacks' position is due to discrimination held the group responsible. The structural fit between schema and video was key: Racial schemas did *not* influence interpretation of a different video that did not involve conflict between unequal groups of fish.

This research by Wittenbrink and colleagues demonstrates that a schema can influence evaluation of a situation that bears little or no surface resemblance to the contents of the schema. I extend this argument to gender schemas and to the evaluation of political issues. For a gender schema to drive issue evaluation, the issue rhetoric must frame the issue in a way that is congruent with the structure of the gender schema. That is, the schema and frame must share the same *structure*;[2] when they do, that schema can govern the perception and evaluation of the issue.

Structure of the Gender Schema

The structure of Americans' gender schemas is therefore crucial, because the match—or lack of match—between structure and rhetoric governs gender implication. In this analysis, I focus on three central aspects of the gender schema: the centrality of difference, the importance of power, and variation in the evaluation of difference and power.

First, the idea of difference has been central to theoretical understandings of gender for centuries. The idea of gender difference gives rise to beliefs about appropriate roles and spheres of activity for men and women

2. Work on analogical reasoning makes similar arguments about the role of structure (e.g., Holyoak and Thagard 1995).

and ultimately underlies the distinction between public and private (e.g., Epstein 1988). Most importantly for my purposes, the mass public understands gender in terms of difference. Children learn very young about sex differences and are socialized early and often to understand and respect gender differences (Stockard 1999), and the power of the idea of fundamental gender difference is evident in the resilience of the claim of biological bases for all manner of observed sex differences (e.g., Fausto-Sterling 1992).

Second, a central point of feminist theorizing is that gender is more than mere difference; it is fundamentally also about power and dominance. Catharine MacKinnon argues that "construing gender as a difference, termed simply the gender difference, obscures and legitimizes the way gender is imposed by force. . . . [T]he idea of gender difference helps keep the reality of male dominance in place" (1987, 3). Gender is "deeply embedded in the politics of family relations" (Goldner et al. 1998, 556)—it defines appropriate roles, behavior, and power within the family sphere, and also between the public and private spheres. In turn, dominance relationships in the family sphere both reflect and support dominance relationships in politics and society (e.g., Phillips 1991, 102–4). This dominance is codified and enforced in laws and in the design and implementation of public policy (Epstein 1988, Chapter 6; Fraser 1989; Mettler 1998; Skocpol 1992; Tolleson Rinehart and Josephson 2000, Section II). Moreover, people's lived experience of gender serves to normalize structures of power, dominance, and inequality (e.g., Goffman 1977; West and Zimmerman 1987).

The third element of the gender schema turns on an evaluation of the first two: (1) the centrality of individual differences and the articulation of these differences into appropriate spheres of conduct, and (2) the power relationships that operate within and between these differences. Analysts have long noted the centrality of prescription in gender beliefs: These are beliefs not just about how men and women differ but how they *should* differ (Fiske and Stevens 1993). For supporters of traditional gender arrangements, the difference between men and women is fundamental (whether its basis is divine or biological), and gender hierarchy is a natural and necessary outgrowth of that difference. In contrast, gender progressives believe that "the artificial division [of gender] is neither fair nor functional and that it promotes an unfair and unjust system" (Sigel 1996, 15). MacKinnon (1987, 21) characterizes these opposing interpretations of gender difference in contrasting her perspective with Phyllis Schlafly's:

> We both see substantial differences between the situations of women and of men. She interprets the distinctions as natural or individual. I see them as fundamentally social. She sees them as inevitable or just—or perhaps inevitable *therefore* just—either as good and to be accepted or as individually overcomeable with enough will and application. I see women's situation as unjust, contingent, and imposed.

The public is also divided along this axis. Despite liberalization in gender norms, there is still considerable public debate about gender equality and especially about changes in actual gender arrangements (Huddy, Neely, and LaFay 2000; Sanbonmatsu 2002). Moreover, this axis of disagreement structures political conflict over explicit gender issues, including the Equal Rights Amendment (Mansbridge 1986) and abortion (Luker 1984), and serves as an organizing principle for both liberal and conservative women's organizations (Dworkin 1983).

There are several reasons to expect men and women to share a common gender schema structure. Both undergo similar socialization (boys and girls are taught to assume different *positions* in the gender system, but they are socialized to the same system), are immersed in essentially the same culture, and watch largely the same media. Moreover, the fact that the social structure puts men and women in close and intimate contact with each other should limit the degree to which they develop radically different understandings of what gender *is*.[3] Men and women may differ in their average location on the evaluative continuum, but they should share the same basic schematic structure.[4]

To summarize, the gender schema consists of three interconnected elements: (1) beliefs about the centrality of individual differences and the articulation of these differences into appropriate spheres of conduct; (2) beliefs about the power relationships and hierarchy; and (3) a dimension of evaluation of the first two. Gender traditionalists fall at one end of this dimension; they believe that the differences are natural and the hierarchy is appropriate, and they therefore oppose change. Gender egalitarians fall at the other end; they believe that the differences are socially constructed and that the hierarchy is inappropriate. Others fall somewhere in the middle.

3. This is in contrast to modern race relations, where spatial and task segregation leads blacks and whites to different understandings of race (Jackman 1994; Sigelman and Welch 1991).

4. This construction of gender develops in important ways out of the structural relationship between *white* women and men (Collins 1990; Higginbotham 1992; Hurtado 1989). Unfortunately, the limited number of nonwhite respondents in the data prevent me from exploring racial differences in this analysis.

People may draw on this schema to understand political issues—even issues that have nothing to do with gender—when those issues are framed to fit the gender schema. The key is not an explicit reference to gender; it is in the *structure* of the appeal: the invocation of difference, of power relations, and of appropriate roles within and across spheres.

Relationship with Other Work on Gender and Political Behavior

This article differs in important ways from two major lines of research on gender and opinion. The first is work on the gender gap (Sapiro 2003, 605–10). The idea of gender implication arises from a fundamentally different assumption, namely, that gender can influence public opinion for both men and women, and that it can operate similarly for both. Of course, insofar as men and women differ in their average support for traditional or egalitarian gender arrangements, gender implication can give rise to a gender gap, but this need not be the case.

A second major approach has focused on people's understanding of their *own* gender and its impact on political beliefs and behavior. Much of this work has explored the roles played by gender identification and consciousness among women (Conover and Sapiro 1993; Gurin, Miller, and Gurin 1980; Tolleson Rinehart 1992). Though important for opinion, especially among women, identification and consciousness are *theoretically* orthogonal to beliefs about appropriate gender arrangements, although they are likely to be related empirically, with identified or conscious women likely to fall at one extreme or the other of the gender ideology scale (Tolleson Rinehart 1992, Chapter 4; for an overview of work in this vein, see Sapiro 2003). My approach to gender implication differs in that it allows for the analysis of women's and men's opinion in a single framework. Whereas identification and consciousness are clearly very different theoretical constructs among women and men (Fiske and Stevens 1993), cognitive *beliefs* about proper gender roles may operate similarly among men and among women. As a theoretical approach, gender implication lets us explore gender-opinion connections among both men and women, and also see how beliefs about gender can serve as a symbolic template for interpreting political issues far from the domain of gender itself. I argue in the following section that this occurred during the health care reform debate in the United States.

HEALTH CARE REFORM

After making comprehensive national health care reform a major campaign issue in 1992, the Clinton administration organized a large task force to construct and promote a plan for health care reform. Led by Hillary Rodham Clinton, the task force put together a complex and comprehensive plan, which sought to guarantee universal coverage and contain costs. In September 1993, the White House launched the Health Security proposal; after a year of intense debate, comprehensive health care reform was essentially politically dead by September 1994.

Rather than work closely with cabinet officials, interest groups, and Congress, the administration developed the policy within the White House and engaged in a campaign to sell the plan to the public, in order to create pressure for its passage.[5] In response to the administration's "public opinion" strategy, a wide range of players who had been closed out of the task force process also tried to shape opinion, including various interest groups, Democrats and Republicans in Congress, and others. All sides of the debate focused on crafting and disseminating appeals to the public, which meant that the public was awash in communications campaigns relating to health care reform, creating good conditions for changes in framing to influence the structure of public opinion. In the sections that follow, I note the gendered character of health care policy, and then review the frames that both sides deployed during 1993–94, focusing on the ways that these frames—unlike those that came earlier—should have engaged the public's gender schemas.

Health Care as a Gendered Policy Domain

Social policy generally is built on gendered assumptions about the roles of service providers and recipients (Sapiro 1986). In the medical realm, this is reinforced by the fact that women and men have different medical needs—some due to biological difference, many more due to the effects of gendered differences in socialization, insurance coverage, poverty, and other social and economic resources (e.g., Tolleson Rinehart and Josephson 2000). Health care is *symbolically* gendered as well. Linda Gordon

5. On the genesis of the administration strategy and the ensuing political struggle, see Jacobs and Shapiro (2000) and Skocpol (1997). For a more policy-oriented discussion of the genesis of the reform plan itself, see Hacker (1997); broader accounts include Navarro (1994), which sets 1993 in the context of other reform efforts, and Oberlander (2003), which lays out the larger political context of the federal government's involvement in health policy administration.

argues that "in establishing themselves as professionals with cooptive authority to admit or exclude others, doctors made particular use of their power over women" (Gordon 1990, 157).[6] This symbolic gendering continues today. As Mary Ellen Guy describes:

> Gender power relations in medicine are an exaggeration of [gendered] power relations embedded in the political culture. Patients spend more time with nurses but pay physicians. . . . Most reimbursement schedules are predicated on whether the physician orders the services of the ancillary professional. (1995, 243)[7]

This symbolic gendering extends, finally, to the doctor–patient relationship itself, as doctors maintain a sort of paternalistic control, as the only professional in the system qualified to assess the patient's best interest.

None of this guarantees that health care opinion will be gender-implicated among the public without frames that engage the gender schema. As we shall see, the gendered character of health care policy and delivery provide fertile ground for these sorts of frames.

Health Care During the 1992 Presidential Campaign

During 1992, the Clinton campaign emphasized universal health coverage and cost limitations. The Bush campaign emphasized free-market principles, with tax incentives to expand coverage and increased efficiency to cut costs. In his July 3 radio address, George H. W. Bush said: "We would lower costs for patients and providers alike by keeping high taxes, costly litigation, and big bureaucracies off their backs. . . . The biggest story of our time is the failure of socialism and all its empty promises, including nationalized health care and government price-setting."

Others have shown that Clinton's emphasis on costs and universal coverage evoked considerations of equality among the public (Jacobs and Shapiro 2000; Koch 1998); we would also expect that the Republican framing would evoke concerns about the scope of government. In short, during 1992, health care was framed in terms of the traditional post–New Deal alignment, with Democrats calling for greater government effort to promote equality and Republicans championing a more limited government role.

6. See Luker (1984, 27–39) for a similar argument in the context of abortion policy.

7. This presumes, of course, that doctors are men and nurses women. This is symbolically true, and was literally the case during the nineteenth century. Even in 2004, 92% of nurses are women, and 71% of doctors are men (U.S. Department of Labor, Bureau of Labor Statistics 2005).

The Clinton Administration's "Health Security" Frame

This changed in 1993. The administration feared that discussing cost controls would frighten middle-class voters who had health coverage, and that emphasizing universal coverage would draw attention to the poor (Skocpol 1997, 117–20). Therefore, they focused on two different themes: *security* and *personal impact*. Their consulting team advised that in discussing the plan, "*the dominant goal should be health security*. . . . [T]here is also an emotion in security (lacking in cost) that empowers our rationale for bold change." They advised that discussion of the plan should focus on "personal, human impact," and on "you and your family" (quoted in Skocpol 1997, 117; emphasis in original). Thus, "security" was the first of five principles that President Clinton articulated in his September 1993 speech that launched reform, and that speech included frequent references to the health care woes of ordinary families.

Opponents' Frames: Big Government and Private Decision Making

Opponents focused on two frames: that the plan would create giant new government bureaucracies and that it would project the government into the private realm of health care provision. Opponents believed "that support for Clinton's plan could be eroded by accentuating and arousing Americans' dread of government and the personal costs of health reform" (Jacobs and Shapiro 2000, 130). For example, Representative Dick Armey (R-TX) suggested in an October 1993 letter to the *Wall Street Journal* that the "Clinton health plan would create 59 new federal programs or bureaucracies, expand 20 others, impose 79 new federal mandates. . . . [T]he Clinton plan is a bureaucratic nightmare that will ultimately result in higher taxes, reduced efficiency, restricted choice, longer lines, and a much, much bigger federal government" (quoted in Skocpol 1997, 144–45).

Opponents coupled these standard invocations of bureaucracy run amok with claims that those bureaucrats would intrude in the private health care realm. Images of intrusion built upon existing images of health care provision; the implicitly private "doctor–patient relationship" has been an icon of health care discussion since the American Medical Association (AMA) worked to kill "socialized" health care in the 1930s (e.g., Patel and Rushefsky 1995, 21–22). More recently, in the aftermath of failed health care reform, for example, the AMA described that relationship this way:

> The patient-physician relationship must ultimately be one of trust, but all too often trusting relationships are disrupted not because of dissatisfaction between patient and physician but because of choices made by the patient's employer, a health insurance plan, or both. (Dickey and McMenamin 1999)

Kathleen Jamieson and Joseph Capella (1994) found that bureaucratic control and diminished doctor choice were two of the major themes that appeared in commercials that opposed reform. The most famous example were the "Harry and Louise" spots, which portrayed a fictitious 40-something couple discussing their concerns about the administration's plans. One major theme was the impending intrusion of the federal government into a traditionally private domain: "'There's got to be a better way' Harry and Louise opined for the cameras, as they discovered the horrible possibilities of bureaucrats choosing their health care plan" (Skocpol 1997, 137). Although they received only moderate airplay, their influence was magnified by extensive media coverage.

Conservative activists also saw the debate as an opportunity to mobilize opinion against Democratic social programs generally. Republican operative William Kristol warned in 1994 that the administration plan would "relegitimize middle class dependence for 'security' on government spending." He argued that Republicans should oppose *any* reform and should advance a broader antigovernment agenda (Skocpol 1997, 145). Kristol advocated exploiting this opportunity by focusing on *personal fears* and the *intrusion of the government* into the private sphere.

Skocpol shows how this strategy turned into a veritable blizzard of media coverage and grassroots mobilization against the plan. For example, in December 1994, the conservative Heritage Foundation's *Policy Review* warned that "we [will be] forced to purchase health care insurance through our regional alliances," and that "a basic concern is whether they will be able to keep their own doctors under the Clinton plan." This emphasis on large government bureaucracy and private intrusion spread to the popular media. For example, a March 1994 *Reader's Digest* article emphasized that "they are taking away our choice of doctor" (both cited in Skocpol 1996, 147–49).

Other interest groups also employed these two frames. On their Website, Washington group Patient Advocacy put it this way: "What qualifies a bureaucrat—whether it be a federal one or a private sector one—to make medical decisions? These decisions should be left to the patient and his or her doctor" (1999).

Of course, criticism of government bureaucracy is nothing new. As I discussed earlier, the Bush campaign employed this frame in 1992, and as Skocpol notes, "1994 is hardly the first time that political conservatives and business groups have used lurid antistatist rhetoric to attack Democratic-sponsored social security initiatives" (1997, 164). What was new to the health care debate was the way this frame was combined with the focus on personal, private-realm interference. Health care was gender-implicated by the prospect of vigorous government effort to meddle with private health decisions and disrupt established power relationships within health provision.

Hillary Rodham Clinton as a Gendered Image

Hillary Rodham Clinton's close association with reform further reinforced the gendering effect of these frames. Of course, as a woman, Clinton would have raised the salience of the gender schema among the public due to her prominent participation (Huddy and Terkildsen 1993). More importantly, as head of the administration task force, "violate[d] the traditional separation of the masculine sphere and the feminine domestic sphere that ha[d] previously defined the role of First Lady" (Burrell 1997, 18). Consequently, she became the focus of public debate on changing gender roles in 1993 and 1994. Moreover, her role put a woman in charge of reforming the traditionally male-controlled health care industry (Burden and Mughan 1999; Burrell 1997). As Skocpol argues:

> Hillary Rodham Clinton could easily appear "too strong" in relation to a husband many thought was "too weak." She also symbolized the increasing presence and assertiveness of career women, whom many people—including men in elite, professional positions—secretly or not so secretly fear and hate. . . . Cartoonists and talk radio hosts could ridicule the Clinton plan for its alleged governmental overweeningness—and in the process subliminally remind people how much they resent strong women. (1997, 152–53)

Her association thus served to reinforce the gender implication inherent in the issue rhetoric over reform.

Hypotheses

My expectation is that the frames deployed during the reform debate influenced opinion on health care reform. Specifically, I anticipate that

the 1994 debate made Americans much more likely to evaluate health care reform through a gender schema. I hypothesize that opinion on health care was more strongly associated with gender ideology in 1994 than in other years. I expect that in 1994, Americans who held traditional gender views would oppose reform more (or support it less) than otherwise similar gender egalitarians. In addition, for the theoretical reasons discussed above, I hypothesize that these patterns of gender implication operated similarly among men and women. While men and women may differ in their average position on the *evaluative dimension* of the gender schema, both men and women should have applied the gender schema to their evaluation of health care reform in 1994.

DATA AND MEASURES

I use data from the National Election Studies to test these hypotheses. The NES includes a question about respondents' support for a government insurance plan to address rising health costs.[8] This general measure has several advantages, compared with questions that focus specifically on the Clinton plan. First, because I seek to compare gender implication over time, I need a consistent measure, rather than one tailored specifically to any particular year. Second, this measure represents a somewhat conservative test of gender implication. If the 1993–94 debates engendered opinion on the administration's plan *and nothing else*, that would not say much for the scope of gender implication generally. I am precisely interested in seeing whether a wide-ranging and symbolically rich debate had effects on opinion within the domain of government action and health care more generally. Finally, there is precedent for the use of this standard NES measure in analyses of the effects of health care reform on opinion (Koch 1998).

Gender Ideology

There are two measures in the NES that capture elements of the gender schema. The first is the women's equal role item, which asks whether

8. Cumulative file variable CF0806. With minor variations, this item reads: "There is much concern about the rapid rise in medical and hospital costs. Some people feel there should be a government insurance plan which would cover all medical and hospital expenses for everyone. Others feel that all medical expenses should be paid by individuals, and through private insurance plans like Blue Cross or other company paid plans. Where would you place yourself on this [7-point] scale, or haven't you thought much about this?"

women should mainly stay at home or be equal with men in all sectors of society.[9] This item is ideal, in that it addresses the intersection of gender and social roles and duties, and focuses on what roles men and women *should* have in society. It captures the public/private distinction, it focuses on the cognitive, and it avoids gender identity and the details of current political conflict over gender. The only disadvantages with this measure are that it is a single item, and that it is somewhat skewed toward the progressive response.

The second measure comes from the thermometer score battery, in which respondents were asked to rate their feelings about the women's movement and/or feminists on a zero to 100 scale.[10] Both feminists and the women's movement are closely associated with efforts to make gender arrangements more egalitarian, and so people's positive or negative evaluations of them should relate closely to their own beliefs about proper gender arrangements (Huddy, Neely, and LaFay 2000). My strategy was to build a single composite measure by averaging the equal role item and whichever thermometer score is available in a given year.[11]

Control Variables

Because the debate over health policy included calls to principles of egalitarianism and limited government, I include measures of these two political principles. For egalitarianism, I use the six-item NES scale (Feldman 1988). For limited government, I construct a scale from two items that assess support for government effort in specific programmatic areas: The first asks respondents to indicate the degree to which the government should see to it that all Americans have a job and a good standard of living, and the second asks respondents to evaluate

9. Cumulative file variable CF0834. With minor variations, this item reads: "Recently there has been a lot of talk about women's rights. Some people feel that women should have an equal role with men in running business, industry and government. Others feel that a women's place is in the home. Where would you place yourself on this [7-point] scale or haven't you thought much about this?"

10. A rating for "the women's movement" was included in 1992, 1994, 1996, and 2000; "feminists" in 1988, 1992, and 2000.

11. The items are reasonably highly correlated with each other. Cronbach's alpha for the combined scale is 0.49 (0.51 among women, 0.46 among men). This measure has a mean of 0.64 and a standard deviation of 0.23. The measure correlates quite highly with alternate gender measures from the NES in the few years they are available, and predicts opinion strongly on gendered issues such as abortion. A complete reliability and validity analysis is available from http://falcon.arts.cornell.edu/nw53.

the trade-off between the government supplying more services versus cutting spending.[12]

In addition, the model includes measures of partisan and ideological predispositions (entered as a series of indicator variables), and a set of social location variables, including class (indicators for income and education categories), gender, race, age and age over 65, permanently disabled status, and being unmarried. All variables in the model are scaled to run from zero to one, with one representing the liberal response for nonindicator variables.

I ran a series of regressions, one per year, of support for government health insurance on gender ideology and the control variables.[13] I ran this model for presidential years from 1988 through 2000, and for 1994, providing two years on either side of the crucial 1994 study for comparison.

RESULTS: GENDERING OF HEALTH CARE OPINION

Table 1 presents the results from this model. The first row gives the effect of gender ideology on health care opinion in each year. In years other than 1994, health care opinion is slightly gender-implicated. The coefficients vary around an average of 0.066 and are on the edge of statistical significance. This is a small effect—compared to gender traditionalists, the most egalitarian respondents are 0.066 more supportive of government health care, which is less than half of the distance between two points on the seven-point scale.

The impact of gender ideology on health care opinion is three times larger in 1994 ($b = 0.198$, $p < 0.01$). Now the most egalitarian respondents support government health care by just over one point on the seven-point scale, compared with the most traditionalist respondents. This supports the hypothesis that the frames deployed in the debate gender-

12. The NES sometimes includes a three-item scale that measures support for limited government (Markus 2001); unfortunately, these items did not appear in the crucial 1994 study. The two items I employ are less abstract than those in the Markus scale, and it could be argued that they represent a policy opinion dependent variable, rather than a predisposition. However, there is precedent for using them as a predisposition (Kinder and Sanders 1996). Moreover, entering this measure of support for government action is conservative. Insofar as the scale picks up social policy preferences above and beyond "principled" feelings about the role of government, its explanatory power in the model will be biased away from zero. The additional variance that it explains will come at the expense, potentially, of the measures of gender predispositions. In any case, substituting the abstract measure, when available, does not change the substantive gender-implication findings.

13. As the dependent variable is measured on a seven-point scale, regression is a reasonable estimation strategy that makes interpretation particularly easy. In any case, and as usual, the substantive results are identical when estimated by ordered probit.

Table 1. Gendering of health care opinion 1988–2000

	Government Health Plan				
Variable	*1988*	*1992*	*1994*	*1996*	*2000*
Gender predispositions	0.060	0.086*	0.198**	0.088*	0.031
	(0.047)	(0.043)	(0.041)	(0.045)	(0.064)
Egalitarianism	0.031	0.193**	0.101*	0.064	0.228**
	(0.054)	(0.042)	(0.048)	(0.046)	(0.058)
Limited government	–0.539**	–0.441**	–0.493**	–0.475**	–0.432**
	(0.047)	(0.039)	(0.041)	(0.045)	(0.047)
Democrat	0.027	0.024	0.025	0.029	0.025
	(0.023)	(0.018)	(0.019)	(0.020)	(0.026)
Republican	–0.069**	–0.062**	–0.104**	–0.083**	–0.063*
	(0.023)	(0.019)	(0.020)	(0.022)	(0.028)
N	1,038	1,450	1,300	1,111	989
R-squared	0.25	0.26	0.36	0.30	0.31
Std. error of regression	0.29	0.27	0.27	0.26	0.32

**$p < 0.01$; *$p < 0.05$.
Source: National Election Studies. Cell entries are OLS regression coefficients, with standard errors in parentheses. Models also include measures of age, age over 65, disabled status, marital status, education, income, ideology, gender, and race. Full results available from http://falcon.arts.cornell.edu/nw53.

implicated health care opinion in 1994. These results are illustrated in Figure 1, which depicts graphically how health care opinion varies with gender ideology, for an otherwise-average respondent.

It is interesting to note that although support for limited government is substantially related to health care opinion, the impact of limited government is *not* noticeably larger in 1994 (average coefficient –0.476, $p < 0.01$ in all years). Despite opponents' emphasis on the specter of government bureaucracy, citizens' feelings about the appropriate size and scope of the federal role played no stronger a role in 1994 than they played throughout the late 1980s and 1990s. This provides additional indirect evidence that the frames deployed in 1993–94 did not resonate particularly with fear of the federal government in the abstract. Rather, this rhetoric—combined with claims that the plan would interfere in the private realm of health care and family—resonated with the gender schema, and thereby increased the association between gender ideology and opinion.

Several other results are interesting. Controlling for the other factors in the model, partisan differences sharpened slightly in 1994, as we might expect given the partisan nature of the debate and of the 1994 congressional campaigns. Republican identifiers were 0.104 more conservative on health care in 1994, compared with independents. In 1988 and 1992, on the other hand, they were only 0.066 more conservative on average.

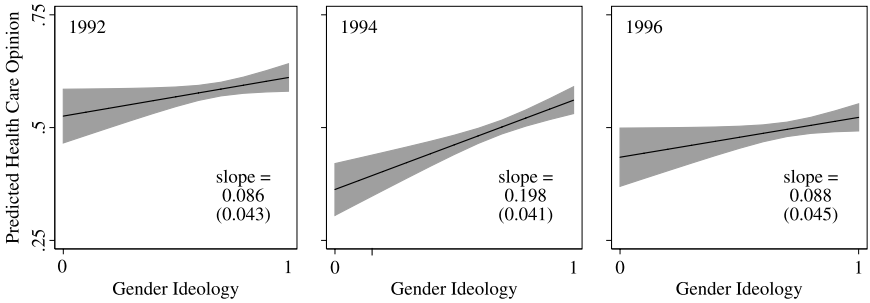

FIGURE 1. Impact of gender ideology on health care opinion, 1992–1996. (*Source:* National Election Studies. Figures show predicted opinion [with 95% confidence interval shaded], based on the models presented in Table 1. Gender ideology varies from zero to one; other variables set at their sample means.)

This partisan difference has faded slowly since 1994, with the estimated coefficient back to −0.063 in 2000 ($p < 0.01$ in all years).

The results for egalitarianism parallel those of Jeffrey Koch (1998): It is strongly associated with opinion in 1992 as a result of the egalitarian frames deployed during the campaign. When the debate shifted away from egalitarian frames in 1994, Americans became less likely to view health care through an egalitarian lens.

One last finding bears mention: Once all the other factors are taken into account, differences between men and women are negligible. The relatively modest gender gap on health care noted here operates through the various other predispositions included in the model.

Feelings Toward Hillary Rodham Clinton

I suggested that Hillary Clinton's role in health care reform should have operated symbiotically with the gendering rhetoric to solidify the gender implication of health care. Another possibility is that the apparent increase in gendering merely reflects the association of Hillary Rodham Clinton, who is herself gendered, with health care policy. To assess this possibility, I ran a model of health care opinion that adds the thermometer score rating of Hillary Rodham Clinton in the years following 1992, when it is available. Table 2 presents the coefficients of interest from this model.[14]

14. The effects of the other control variables are essentially the same in this model; complete results are available from http://falcon.arts.cornell.edu/nw53.

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Table 2. Gendering of health care opinion 1992–2000, model with Hillary Rodham Clinton evaluation

	Government Health Plan			
Variable	*1992*	*1994*	*1996*	*2000*
Gender predispositions	0.054	0.152**	0.067	0.031
	(0.045)	(0.042)	(0.046)	(0.066)
HR Clinton thermometer	0.059	0.130**	0.076*	0.044
	(0.038)	(0.032)	(0.035)	(0.042)
Egalitarianism	0.185**	0.082^	0.066	0.225**
	(0.042)	(0.048)	(0.047)	(0.059)
Limited government	–0.447**	–0.476**	–0.458**	–0.420**
	(0.040)	(0.042)	(0.046)	(0.048)
N	1,383	1,293	1,100	981
R-squared	0.27	0.36	0.30	0.30
Std. error of regression	0.27	0.27	0.26	0.32

**$p < 0.01$; *$p < 0.05$; ^$p < 0.10$ two tailed.
Source: National Election Studies. Cell entries are OLS regression coefficients, with standard errors in parentheses. Models also include measures of partisanship, age, age over 65, disabled status, marital status, education, income, ideology, gender, and race. Full results available from http://falcon.arts.cornell.edu/nw53.

These results confirm that feelings about health care did become associated with feelings about Clinton in 1994. In 1992, one's rating of Hillary Clinton is barely related to health care opinion ($b = 0.059$, $p > 0.10$); by 1994, that rating is substantially related to opinion ($b = 0.130$, $p < 0.01$). The association fades to about half that in 1996 ($b = 0.076$, $p < 0.05$) and falls further in 2000. The inclusion of Hillary Clinton ratings reduces the estimates of gender implication by about a quarter from 1992 through 1996, but if anything, sharpens the central finding that gender implication was stronger in 1994 than in other years. Health care was gender-implicated in 1994 both directly and by its association with a prominent and highly gendered first lady.

Subgroup Analyses

Gender

These results show that women's and men's opinions differ little from each other once we take account of gender predispositions and the other independent variables. As I have argued here, I expect men and women to react similarly to gendered framing. To explore this expectation, I ran the gendering analysis separately among men and women; the relevant

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Table 3. Gendering of health care 1988–2000, by respondent gender

	Government Health Plan				
Variable	*1988*	*1992*	*1994*	*1996*	*2000*
Women					
Gender predispositions	0.097	0.104^	0.196**	0.112^	–0.014
	(0.064)	(0.059)	(0.059)	(0.062)	(0.094)
Egalitarianism	0.035	0.162**	0.047	0.108^	0.210*
	(0.073)	(0.057)	(0.067)	(0.063)	(0.085)
Limited government	–0.529**	–0.480**	–0.463**	–0.484**	–0.423**
	(0.064)	(0.053)	(0.057)	(0.061)	(0.071)
N	549	730	671	606	528
R-squared	0.26	0.26	0.34	0.32	0.28
Std. error of regression	0.29	0.27	0.27	0.26	0.33
Men					
Gender predispositions	0.023	0.066	0.202**	0.045	0.068
	(0.071)	(0.063)	(0.059)	(0.066)	(0.088)
Egalitarianism	0.034	0.233**	0.144*	–0.015	0.258**
	(0.081)	(0.061)	(0.069)	(0.069)	(0.082)
Government action	0.517**	0.386**	0.539**	0.467**	0.426**
	(0.072)	(0.058)	(0.061)	(0.069)	(0.065)
N	489	720	629	505	461
R-squared	0.27	0.27	0.38	0.31	0.37
Std. error of regression	0.29	0.28	0.26	0.25	0.30

**p < 0.01; *p < 0.05; ^p < 0.10 two tailed.
Source: National Election Studies. Results are based on three separate regressions based on the model displayed in Table 1, run separately among the men and women, by year. Models also include measures of partisanship, age, age over 65, disabled status, marital status, education, income, ideology, gender, and race. Full results available from http://falcon.arts.cornell.edu/nw53.

results are presented in Table 3. Women may be *slightly* more prone to perceive health care through the gender schema in the years other than 1994 (the average coefficient is 0.075 among women and 0.051 among men in these years). Most importantly, women and men reacted identically to the gendering rhetoric of 1993–94. In 1994, the effect of gender ideology on health care opinion is 0.196 among women and 0.202 among men, which confirms the expectation that men and women would react to the gendering rhetoric similarly.

Partisanship

We might also expect citizens' partisan attachments to have conditioned their reactions to the very partisan health care debate. To assess this possibility, I ran the basic model separately among identifiers of the two major parties and among independents. Table 4 presents the relevant results.

Table 4. Gendering of health care 1988–2000, by partisanship

	Government Health Plan				
Variable	*1988*	*1992*	*1994*	*1996*	*2000*
Democrats					
Gender predispositions	0.010	0.028	0.252**	0.019	0.066
	(0.081)	(0.076)	(0.084)	(0.090)	(0.128)
Egalitarianism	–0.042	0.132^	0.107	0.028	0.058
	(0.101)	(0.076)	(0.097)	(0.082)	(0.111)
Limited government	–0.562**	–0.460**	–0.384**	–0.349**	–0.344**
	(0.082)	(0.064)	(0.076)	(0.080)	(0.084)
N	340	516	421	420	321
R-squared	0.24	0.17	0.20	0.11	0.17
Std. error of regression	0.28	0.27	0.28	0.29	0.33
Independents					
Gender predispositions	–0.009	0.113^	0.224**	0.116	–0.117
	(0.082)	(0.069)	(0.078)	(0.084)	(0.107)
Egalitarianism	0.136	0.223**	0.013	0.121	0.332**
	(0.088)	(0.067)	(0.084)	(0.082)	(0.094)
Limited government	–0.605**	–0.377**	–0.551**	–0.489**	–0.449**
	(0.076)	(0.063)	(0.072)	(0.080)	(0.078)
N	364	548	444	344	375
R-squared	0.27	0.22	0.30	0.25	0.29
Std. error of regression	0.29	0.27	0.28	0.25	0.32
Republicans					
Gender predispositions	0.160^	0.124	0.109^	0.081	0.152
	(0.083)	(0.085)	(0.059)	(0.064)	(0.107)
Egalitarianism	–0.045	0.178*	0.128^	0.017	0.228*
	(0.091)	(0.082)	(0.072)	(0.078)	(0.109)
Limited government	–0.412**	–0.507**	–0.538**	–0.676**	–0.499**
	(0.090)	(0.085)	(0.069)	(0.076)	(0.092)
N	334	386	435	347	293
R-squared	0.20	0.23	0.33	0.36	0.25
Std. error of regression	0.29	0.28	0.24	0.22	0.30

**$p < 0.01$; *$p < 0.05$; ^$p < 0.10$ two tailed.

Source: National Election Studies. Results are based on three separate regressions based on the model displayed in Table 1, run separately among partisan identifiers. Independents who "lean" toward a party are included with pure independents. Models also include measures of partisanship, age, age over 65, disabled status, marital status, education, income, ideology, gender, and race. Full results available from http://falcon.arts.cornell.edu/nw53.

Here, we do find some variation. Democrats and independents followed the pattern observed so far: They gender health care quite substantially in 1994 (b = 0.252 and 0.224, respectively), and much less both before and after (average b = 0.054 and 0.041). In contrast, Republicans seem entirely unaffected by the gendering discourse of 1993–94: in 1994 they gendered health care a bit *less*, if anything, than in other years (b = 0.109 in 1994, compared to 0.157). It is not entirely clear why this

would be the case for Republicans, but it does suggest that the gendered frames employed by opponents were effective in broadening opposition to the Clinton plan by appealing in particular to gender-traditionalist Democrats and independents.

Political Engagement

Finally, we know that citizens vary greatly in the attention they pay to politics and in their exposure to political discourse (e.g., Converse 1990; Zaller 1992). If changes in political discourse truly caused the effects I observed here, then those effects should be strongest among respondents most exposed to the discourse. Insofar as the gendered discourse was subliminal and people were not aware of the gender implication, I expect that gendering should increase with the reception of gendering messages, which should itself increase with political engagement. To assess this expectation, I divided each year's sample into thirds, using a multi-item political knowledge scale (Zaller 1992). Table 5 presents the results of the health care opinion model, run separately among these groups.

As expected, political engagement sharply conditions the results. The least-engaged respondents reacted not at all to the gendering rhetoric. It would seem that the relatively subtle nature of the gender implication passed them by in 1994. Middle- and high-information respondents, on the other hand, reacted sharply to the gendering rhetoric of 1993–94. Before the reform debate, middle-information respondents gendered health care a bit (b averaged 0.058 in 1988 and 1992, n.s. both years). In 1994 the impact of gender ideology is much stronger ($b = 0.285$, $p < 0.01$), and it drops back essentially to zero in 1996 (average $b = 0.017$ in 1996 and 2000).

Highly engaged respondents also gendered health care much more in 1994 ($b = 0.225$, $p < 0.01$) than in 1988 and 1992 (average $b = 0.111$). Among this well-informed group, however, the effect persisted through 1996 ($b = 0.197$, $p < 0.01$) before fading by 2000 ($b = 0.122$, n.s.). Thus, those who pay at least moderate attention to politics picked up on the gendering rhetoric, and the best-informed remembered it for some time.[15] The fact that political engagement conditions gendering so sharply serves as additional confirmation that this gendering was driven by the political

15. Egalitarianism also shows an interesting pattern among the top two-thirds in political information. From 1988 to 1992, these respondents came to frame health care much more in terms of equality; they then abandoned the egalitarian frame for the implicit gendered frame in 1994. These findings for the moderating role of political information are consistent with those of Koch (1998), who also found that those with moderate information were the most influenced by the reform debate.

Table 5. Gendering of health care 1988–2000, by political engagement

	Government Health Care				
Variable	*1988*	*1992*	*1994*	*1996*	*2000*
Top third political engagement					
Gender predispositions	0.100	0.122^	0.225**	0.197**	0.122
	(0.068)	(0.066)	(0.057)	(0.064)	(0.120)
Egalitarianism	0.038	0.229**	0.061	–0.082	0.234*
	(0.070)	(0.061)	(0.065)	(0.060)	(0.103)
Limited government	–0.501**	–0.401**	–0.545**	–0.693**	–0.532**
	(0.069)	(0.065)	(0.060)	(0.067)	(0.083)
N	504	595	608	497	300
R-squared	0.31	0.36	0.45	0.43	0.45
Std. error of regression	0.26	0.25	0.24	0.22	0.29
Middle third political engagement					
Gender predispositions	0.115	0.000	0.285**	0.020	0.013
	(0.089)	(0.075)	(0.074)	(0.078)	(0.112)
Egalitarianism	–0.051	0.158*	0.036	0.156^	0.323**
	(0.102)	(0.067)	(0.083)	(0.087)	(0.107)
Limited government	–0.565**	–0.412**	–0.481**	–0.341**	–0.351**
	(0.090)	(0.065)	(0.074)	(0.080)	(0.087)
N	316	527	397	375	332
R-squared	0.25	0.25	0.37	0.25	0.29
Std. error of regression	0.30	0.27	0.27	0.27	0.32
Bottom third political engagement					
Gender predispositions	–0.038	0.115	0.041	–0.042	–0.048
	(0.113)	(0.091)	(0.101)	(0.110)	(0.107)
Egalitarianism	0.116	0.085	0.208^	0.241^	0.157
	(0.149)	(0.113)	(0.125)	(0.136)	(0.101)
Limited government	–0.580**	–0.451**	–0.340**	–0.404**	–0.424**
	(0.105)	(0.083)	(0.096)	(0.104)	(0.084)
N	218	328	295	239	357
R-squared	0.24	0.21	0.18	0.27	0.26
Std. error of regression	0.32	0.31	0.31	0.30	0.34

**$p < 0.01$; *$p < 0.05$; ^$p < 0.10$ two tailed.

Source: National Election Studies. Results are based on three separate regressions based on the model displayed in Table 1, run separately among the top, middle, and bottom thirds of information, by year. The thirds were created separately for each year, since the information scale does not have a common metric across studies. Models also include measures of partisanship, age, age over 65, disabled status, marital status, education, income, ideology, gender, and race. Full results available from http://falcon.arts.cornell.edu/nw53.

discourse, insofar as only those who were reasonably engaged in politics were affected by it.

CONCLUSIONS

Clearly, there are many deep roots of the failure of health care reform in 1994. The American political system makes major policy innovation dif-

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ficult to achieve under the best conditions, and health reform has failed repeatedly during the twentieth century. Many factors having nothing to do with public opinion contributed to the failure in this instance (e.g., Hacker 1997). However, the administration's choice of a public opinion strategy does raise the question of what impact, if any, the gender implication of opinion had on the overall fate of the reform effort and whether there might have been ways the administration could have countered the gender implication.

Because gender implication implies polarization on gender ideology, it is theoretically possible that gender implication *increased* support for reform by increasing the support of gender egalitarians over what it otherwise would have been. However, gendering frames came primarily from reform opponents, so it is reasonable to assume that the net effect of gender implication was to depress opinion by reducing the support of gender traditionalists below what it would have otherwise been. This is consistent with Figure 1, which indicates that (holding constant the other factors in the model) from 1992 to 1994, support among the most gender-traditional fell by 0.170 on the zero–one scale (from 0.524 to 0.353); this corresponds to a change of about one point on the original seven-point scale. In contrast, support among the most gender-egalitarian fell by 0.058 (from 0.609 to 0.551). Support for the plan fell across the board, but the drop was about three times as large among gender traditionalists. An instructive exercise is to imagine that support among gender traditionalists had not declined any more precipitously than among egalitarians—that support declined by 0.058 across the board. In this scenario, the left-hand end of the line in the middle pane of Figure 1 would be rotated upward until the 1994 line had the same slope as the 1992 line, albeit at a lower level. In this case, the overall average opinion in 1994 would have been 0.524 on the zero–one scale—about equal to its level in 1988.[16] This is not overwhelmingly higher, but still represents a potentially significant difference politically. It is implausible that this difference by itself would have turned the tide of opposition to the administration plan, but it does suggest that gender implication added an additional nail to the coffin.[17]

16. Of course, this is entirely hypothetical and heuristic. If we imagine instead that gender egalitarians dropped as much as traditionalists between 1992 and 1994 (which would imply equalizing the slopes in Figure 1 by rotating the right-hand end of the 1994 line *downward*), average opinion in 1994 would have been 0.412. Without experimental evidence, we cannot be sure which scenario, or what intermediate one, in fact would have obtained without gender-implicating framing.

17. Lawrence Jacobs and Robert Shapiro discuss the ultimately limited influence of public opinion on congressional action, although they do acknowledge the ways that fading public support contributed to the loss of an important group of moderate Republican legislators (2000, 125–48).

If we grant for a moment that the gendering frames depressed net opinion and thereby hurt reform, how might the administration have countered or avoided the gender implication? Unless the plan itself had been radically different, the administration could probably not have avoided antigovernment frames from opponents. However, if the Clinton team had managed to keep that aspect of the debate focused on who should be responsible for *paying*, rather than who would be responsible for making health care decisions, then the specifically gendered impact of opposition frames might have been muted. Mark Schlesinger finds that Americans are much more supportive of government financing of health care compared with government influence on the content of health care provision (Schlesinger 2004); perhaps if the administration had not opened the door by focusing on personal benefits, then opponents would have been prevented from deploying the potent combination of limited government and private-sphere interference frames. Or perhaps not. In any case, it seems likely that a traditional debate over the relative efficiency of government versus private-sector provision and over the need for a systemic approach to universal coverage would have been better for reform advocates.

More broadly, the results presented in Table 4 indicate that the impact of gendering was strongest among Democrats and independents, which suggests that the gendering frames were particularly effective at decreasing support among these groups. Thus, the gendered frames may have been particularly effective for opponents of reform insofar as they separated gender-traditionalist Democrats (and independents) from the rest of the Democratic coalition. In this sense, gender implication may have served an analogous role to the implicitly racialized rhetoric deployed by Republicans to attract support from racially conservative Reagan Democrats in the 1980s (Edsall and Edsall 1992; Kinder and Sanders 1996).

Gender issues have come on and off the political agenda over the years, but in contrast with matters of race, gender issues have not served as a fundamental basis of partisan alignment.[18] This likely means that elite debate does not invoke gender frames as frequently as racial frames, and that the public is therefore less well trained to view political issues through the "lens of gender."[19] Nevertheless, the current analysis shows

18. Although Christina Wolbrecht (2000) demonstrates that parties' elites polarized on gender issues beginning in 1980, she does not explore the relationship between that polarization and mass opinion, nor the relationship among the public between gender attitudes and partisanship.

19. This is consistent with Burns and Kinder's (2003) findings that people's explanations for gender inequality predicted opinion much less pervasively than did their racial explanations, and also with my finding (Winter 2001) that racialization is much easier than gendering to induce experimentally.

that gender *can* serve as an organizing principle for a political issue under the right circumstances. We can imagine this happening for other issues, when political elites choose frames that trade on gender schemas among the mass public and convey those frames loudly enough. Because gender is not central to the mainstream partisan alignment, we would not expect this to happen often. However, precisely for this reason, gendering can be a useful strategy for fracturing an existing coalition (e.g., Riker 1986). Just as the gendered frames moved gender-traditional Democrats and independents against health care reform, we might expect there to be other issues where Republicans can use gendered frames in this way. In fact, Republicans' ability to attract gender-traditionalist Democrats and independents with implicitly gendered political rhetoric is a pattern we may be seeing continued today with the explicit emphasis on so-called cultural issues, many of which involve matters of gender ideology at their heart.

More broadly, this article demonstrates that gender can matter for public opinion in ways that go beyond our current approaches. Virginia Sapiro lays out a typology of three ways that public policies may be gendered: because they are "manifestly about gender," because men and women have "different experiences, needs, or problems" relating to the policy, or because policies inadvertently affect men and women differently. She points out, though, that there is no necessary correspondence between the gendered *content* of policies and the public's *perception* of those policies in gendered terms, and suggests that more research is needed for "investigating the conditions under which culturally derived stereotypes and frames are activated" (2003, 619–20). This article is an example of this kind of research for a policy that the public does not consciously associate with gender.

The theoretical approach presented here, as well as the results for this case, suggest that one important route to the gendered *perception* of issues—what I call gender implication—is a correspondence in structure between elite frames and mass schemas. It further implies that gendered issue *perceptions* can be largely or entirely symbolic and metaphorical: The gender implication of health care opinion in 1993–94 turned not on the fact that women and men have different health problems. Rather, gender implication occurred because the frames that were deployed structured reform as interfering metaphorically with intimate power relations within the private sphere of health care provision.

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