Federal Distortion Of Homosexual Footprint (Ignoring Early Gay Death?)

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Abstract

Non-reporting, Exaggeration of Homosexual Prevalence. By ignoring the paucity of older homosexuals, Federal bureaucracies in three countries exaggerated the size of the homosexual footprint. In 2003, *Statistics Canada* reported on a random sample of 121,300 adults, reporting 1.7% were bi/homosexual. Because of a decline in incidence from about 2% of adults aged in their 20s and 30s to a third of one percent among the old, inclusion of respondents aged 60+ yields a revised estimate of 1.4%. In 2005, the *U.S. National Center for Health Statistics* interviewed a random sample of 11,571 younger adults, but misreported findings to indicate more frequent same-sex sexual experience. In 2005, the *British Department of Trade and Industry* said "a wide range of research" indicated "lesbian, gay and bisexual people constitute 5-7% of the total adult population." Yet surveys which included adults of all ages put the prevalence closer to 1-2%. Curious mistakes and omissions for well-funded bureaucracies charged with 'reporting the truth.'

Link to Early Death. Exclusion of older adults increases the reported size of the homosexual footprint, and also tends to obscure the apparent early death of those engaging in homosexuality. Median ages of death in 'gay marriage' for 561 gays and 91 lesbians in Denmark (1990–2002) and 31 gays and 6 lesbians in Norway (1997–2002) were similar to U.S. gay obituaries during the same period: 52 yr. for 710 gays who ostensibly did not die of AIDS, 42 yr. for those 1,476 who supposedly did; and 55 yr. for 143 lesbians. On average, ever-married men outlived the ever-homosexually-partnered by 23 years in Denmark (74 yr. *v.* 51 yr.), and 25 years in Norway (77 yr. *v.* 52 yr.); ever-married women outlived the ever-homosexually-partnered in Denmark by 22 years (78 yr. *v.* 56 yr.), and in Norway by almost 25 years (81 yr. *v.* 56 yr.).

Implications. By not sampling (U.S., Britain) or reporting on (Canada) those aged 60+, the objectivity of central bureaucracies is called into question. That the ~2% of adults who engage in homosexuality have life spans at least 20 years shorter than the general adult population in countries contributing relevant data has implications for social policy: e.g., 'gay rights' (the decrement in the gay lifespan appears similar in societies that legally protect homosexuals or don't, suggesting 'discrimination' does not cause their earlier death); gay marriage (which unlike man-woman marriage appears not to increase longevity); adoption (children of homosexuals are more frequently orphaned); favorable depiction of the homosexual lifestyle in schools (which is inconsistent with condemning the lesser harm of smoking); special protections for those who engage in homosexuality (why not also protect others whose sexual choices — such as polygamy or adultery — cause disruption and extra costs?); and equitable allocation of social resources (why spend excessively on HIV when cancer, heart disease, etc. afflict many more citizens?).

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Under political pressure rather than the weight of empirical findings,[1] the 'soft' disciplines (e.g., psychiatry, social work) did an about-face on homosexuality. Seventy years ago they attempted to 'treat' those who engaged in same-sex sex, directing them toward conventional married, child-bearing productivity. Today these disciplines seek the social acceptance of gays and lesbians, even though homosexuals contribute less (e.g., less frequent child-bearing, less economically productive) and cost more (e.g., AIDS, STDs, substance abuse, smoking) than non-homosexuals.[2]

Federal or central government agencies are supposed to be different. In theory, aloof from politics and social fads, their sole function is to 'gather and tell facts.' It is therefore of concern when they depart from their 'fact-telling' mission to indulge in politics.

Kinsey's 1948 claim[3] that "37% of all men" had had a homosexual orgasm began a series of extravagant claims by gay activists about the prevalence of homosexuality. Three recent reports suggest national bureaucracies may have joined with activists in exaggerating the size of the homosexual footprint:

- Great Britain's *Department of Trade and Industry*[4] declared in 2005 that "lesbian, gay and bisexual people constitute 5-7% of the total adult population." This announcement made Britain the first country to officially estimate its homosexual footprint and was most certainly news. But the uncertainties the department expressed about this estimate — e.g. "[t]here is very little reliable data about the size of the LGB population;" "[w]hilst no specific data is available, a wide range of research suggests" (p. 13) — is cause for concern. Why 5-7% when so many surveys have reported significantly smaller fractions of 'homosexuals?'[6,7,15,18] The research the department cited did not involve a new random sampling of all adults from Britain, but instead utilized studies with sampling frames from different countries that excluded anyone above the age of 44 or the age of 59. A sampling frame that stops at age 59 ignores about a quarter of adults. If homosexuals are less frequently represented among the older,[8] the best estimate might be significantly lower than what was reported.

- In September, 2005, the *U.S. National Center for Health Statistics* [NCHS] reported[5] "[a]bout 6.5 percent of men 25-44 years of age have had oral or anal sex with another man… 11 percent of women 25-44 years of age reported having had a sexual experience with another woman." These statements were inaccurate, since the questions that generated these statistics were about *lifetime* same-sex sexual activity, not merely sex with *adults* (e.g., for men "*ever* done any of the following with another *male*" [6% 'ever', but 2.9% in last 12 months; 1.6% reported such behavior 'only' with men], and for women "*ever* had any sexual experience of any kind with another *female*" (p. 9) [11.2%; 4.4% in last 12 months; 1.3% 'only' with female(s)]).

- In June 2004, *Statistics Canada* announced[9] that for its random sample of 121,300 adults, "1.0% of Canadians aged 18 to 59 consider themselves to be homosexual, and 0.7% considered themselves bisexual." The 1.7% figure was employed both by *Statistics Canada* and the press. Yet, with older respondents (aged 60+) included, the figure drops 16% — from 1.7% to 1.4%.

These instances of what might be called 'sloppiness' are curious — especially in light of the on-going debate as to whether homosexuals experience shortened life spans — a debate that swirls on the internet. Not only longevity — an enormous public health concern — but sizeable sums of money are involved. Thus, according to the British *Department of Trade and Industry*:

> "Under the high take-up scenario, the Government Actuary's Department assumes that, by 2050, 6% of the lesbian, gay and bisexual population aged around 70 who are retired with occupational pensions will be in civil partnerships (the proportions around age 70 being a key driver in determining the cost of benefits to spouses/partners on death). This figure is broadly consistent with the assumption that, overall, around 3.3% of the lesbian, gay and bisexual population aged 16 and over will be in civil partnerships, as compared to around 33% of the heterosexual population aged 16 and over who would be married."[4]

If only a small fraction of homosexuals attain old age, the figures above would be off by a substantial amount. Yet these government surveys and estimates join those referenced as authoritative — surveys and estimates which have continued Kinsey's practice of ignoring those older, often not sampling individuals over the age of 59.[6,7]

A decline with age in homosexuality's prevalence has been documented in databases from around the world and over time — among men and women.[8] If the prevalence of homosexuality diminishes with age, eliminating older adults from sexuality surveys tends to conceal this diminution and to increase the apparent fraction of homosexuals. Furthermore, if the prevalence of homosexuals declines *because of* the early death of those engaging in same-sex sex, and if the practice of homosexuality were to be directly tied to a foreshortening of life, contemporary public health cannon would dictate condemnation and discrimination against such behavior (e.g., consider the parallel of smoking).

While acknowledging that gays evidence many health problems that can result in a reduced life span, a large number of researchers contend that 'homophobia' and 'internal homophobia' cause gays and lesbians to 'feel bad' and lead to more frequent excessive drinking, illicit drug abuse, smoking, depression, suicide, and perhaps acquisition of HIV and other sexually transmitted infections [STI] (see Ref. 2 for a sympathetic review). However, no direct evidence has been presented to prove that 'discrimination' causes the host of unhealthy, life-shortening habits and events that are associated with earlier death among homosexuals.

As an empirical test of the proposition, if about the same drop in prevalence in old age and/or longevity is exhibited in societies where homosexuals are accepted (e.g., Canada, Denmark, Norway) as where they are more apt to be condemned (e.g., United States), a shortened life span would appear broadly inherent to same-sex sexual practice, rather than the 'fault' of society or particular members of greater society. On the other hand, if the homosexual life span is significantly longer in societies where they enjoy greater acceptance, lesser health (and shorter life span) due to discrimination would be a more plausible explanation.

Method

We examined the 2003 Canadian Community Health Survey for the prevalence of homosexuality after the fifth decade of life; *Washington Post* and *Washington Blade* obituaries for life span estimates of men and women and gays and lesbians in the U.S.; and census registries from Denmark and Norway for life spans of men and women who were conventionally married and for men and women who were homosexually partnered. The method and results are presented for each of these components, followed by a discussion.

Canadian Survey

The 2003 release of Cycle 2.1 of the Canadian Community Health Survey was conducted by *Statistics Canada* with over 130,000 respondents. Sexual orientation was explicitly indexed among adult respondents (those aged 18+; N = 121,300). To our knowledge, no systematic analysis of this survey's results regarding sexual orientation has been released. However, on June 15, 2004, *Statistics Canada* put out a press release in which it stated that "Only 1.0% of Canadians aged 18 to 59 consider themselves to be homosexual, and 0.7% considered themselves bisexual."

As the largest probability sample to ever address the prevalence of homosexuality, media outlets across the globe reported on the 1.7% figure released by *Statistics Canada*. But no reporter or researcher commented on the fact that this estimate — albeit considerably lower than Kinsey's famous figure or recent pronouncements in the U.S. and Great Britain, and more in line with other large-scale probability surveys — was limited to those younger than 60 years of age. This despite the fact that the sampling design of the 2003 CCHS asked the sexual orientation question of all Canadians. Although an estimate of prevalence for the entire Canadian adult population was feasible and easily computed, *Statistics Canada* decided to report on only a subset of its sample, excluding approximately a quarter of its weighted sample of older adults.

We purchased a custom cross-tabulation by sex and age group of the sexual orientation question, which *Statistics Canada* prepared. Due to its non-disclosure and confidentiality rules, *Statistics Canada* would only provide the following age groupings: 18-24, 25-34, 35-44, 45-54, 55-64, and 65+. It also did not release sampling or replicate weights, nor did it include any calculation of standard errors. We therefore report on a more complete, but highly summarized, version of the sexual orientation data from the 2003 CCHS.

Results From Canada

The 2003 CCHS is part of an on-going biennial survey that was created to address the health of Canadians and the adequacy of its health care system. Like several large-scale surveys run by the U.S. government, some of the content and questions of the CCHS are periodically changed, in part, to deal "with emerging health and health care issues as they arise." Cycle 2.1 of the 2003 CCHS was the first to ask its adult respondents the following question:

> "Do you consider yourself to be: (read to respondent by interviewer):
> heterosexual? (sexual relations with people of the opposite sex)/ homosexual, that
> is lesbian or gay? (sexual relations with people of your own sex)/ bisexual?
> (sexual relations with people of both sexes)."

23.6% of the sample respondents (N = 28,672) were aged 65 or older.

When older adults (aged 60+) are included in the tallies of sexual orientation, the weighted fraction of the 121,300 respondents answering 'homosexual' or 'bisexual' drops to 1.43% (1.25% of women, 1.61% of men) — 16% smaller than the 1.7% figure originally reported. Other findings are summarized in **Table 1** and **Figure 1**. Viewed longitudinally, a decline in the proportion of individuals declaring homosexuality is evident by the mid-40s, and the fraction claiming to be "homosexual" or "bisexual" in old age was only one-fifth that among young adults (i.e., those aged 18-24). This decline was more precipitous among women than among men. Heterosexuality, by contrast, was essentially constant in prevalence through the 60s (e.g., for those 65+, the rate was 93% that among young adults).

A significant fraction of respondents — both young and old — did not choose one of the available responses for the sexual orientation item (see **Table 1**). *Statistics Canada* did not specify how many refused to answer the question, as opposed to the number who answered "don't know." The latter response could apparently refer to individuals who did not understand the item, those who did not want to give a specific answer but who desired to appear compliant, or perhaps those whose sexuality did not fit the available categories (e.g., asexuals).

The proportion of those refusing or answering "don't know" drifted upward with age. For those aged 65+, the sample proportion was 10.98%, while for those aged 18-24, the sample proportion was 4.27%, about half as much. Also, for each age group and gender, the proportion failing to choose one of the three sexual orientation categories exceeded the fraction claiming a homosexual or bisexual orientation by at least double. For the entire weighted sample, refusals and/or "don't knows" outnumbered non-heterosexuals by greater than 4:1. The extent to which refusals and "don't knows" exceeded those claiming a non-heterosexual orientation for older respondents was higher for women than for men, but particularly so for older respondents.

Statistics Canada reported its 1.7% point estimate of homosexual/bisexual prevalence for those aged 18-59 without an accompanying confidence interval or any discussion of the extent to which refusals and "don't knows" might have impacted the results for those aged under 60. Further, *Statistics Canada* has not published a breakdown as to how many were refusals and how many answered "don't know," nor whether the refusal rate, in particular, was related to age of respondent.

Life Table Estimates of Longevity: U.S., Denmark, & Norway

We now turn to a possible reason for the paucity of older homosexuals — their earlier demise. A significant difficulty in estimating the life expectancy of homosexual practitioners is that no country maintains a registry of citizens who engage in homosexuality. As such, the information necessary to build a current life table or survival function for individuals involved in homosexuality (e.g., number of deaths and survivors classified by age) is not readily available. Nevertheless, direct data on age-at-death pertaining to the homosexual lifespan can now be obtained from selected countries. Homosexual 'marriages' or 'partnerships' have been legal in Denmark since 1989 and in Norway since 1993. Both of these countries have published several years of official registry data on the demographic characteristics of the homosexually partnered.

Statistics Denmark and *Statistics Norway* publish official population cross-tabulations of marital status by age for each sex in their annual statistical yearbooks. Since 1994 in Denmark and 1995 in Norway, these tables have included separate categories for homosexually-partnered

individuals. We obtained these data sets and also purchased non-publicly available data from Denmark and Norway on age-at-death cross-classified by sex and marital status. *Statistics Norway* provided such data for the years 1997 through 2002, including a category of those who died who were ever homosexually-partnered.[1] *Statistics Denmark* provided similar data for the years 1990 through 2002.[2]

For U.S. estimates, we examined a series of consecutive obituaries published from 1993 through 2005 in the *Washington Blade*, a gay newspaper published weekly in Washington, D.C. Each obituary with enough detail was coded for age-at-death, whether the individual was gay or lesbian, whether the deceased was partnered at time of death, and whether the death was due to HIV/AIDS or some other cause. Some of this series has been reported elsewhere.[8] In the current paper, we have re-analyzed all of this data in ways comparable to the sets of Danish and Norwegian deaths.

We gathered four sets of consecutive obituaries from the *Washington Post*, covering the following time periods: June/July 1988, April 1989, Jan 1999, and Jan 2002. Each obituary was coded for sex, age-at-death, and whether the deceased was ever-married or unmarried.

Following Chiang[10] (chap. 9), we estimated life expectancy by constructing *cohort-based* life tables, generally over the common age range of 0 to 99 years, in one-year increments. A cohort life table differs from a current life table in that it does not include a separate 'population at-risk' in its computation. A current life table (such as those published in many countries by official statistical agencies) includes — for a given period of time — numbers of those in the population still alive and those who have died during that time frame. By contrast, a cohort life table follows a single group of individuals until all have died, and computes life expectancy based solely on these individuals and their ages-at-death.

Since a cohort life table requires an age-at-death from every member of the population, it is most often used in ecological or laboratory studies with animals known to have reasonably short life spans. To apply this technique to human populations, we constructed 'cohorts' from each data source by sorting all individuals who died and were uniquely classified at the time of their death (e.g., ever homosexually partnered in Denmark).

The cohort life table is identical in appearance to a current life table in terms of the statistics reported. In particular, we have computed life expectancy as a function of age, standard errors, and approximate upper and lower 95% confidence bounds on this function. Such bounds allow statistical comparison of different life expectancy curves.

Life Table Results

Numbers of deaths analyzed, along with estimates of mean life expectancy at birth are tabulated by country, sex, and status in **Table 2**. Statuses include males who have sex with males [MSM], females who have sex with females [WSW], ever-married v. ever-homosexually-partnered, AIDS v. non-AIDS as cause of death, HIV+ v. HIV–, and partnered v. unpartnered homosexuals. Selected life expectancy curves are shown in **Figures 2** through **5**. Each curve is a

[*] We are indebted to Svein Holm of *Statistics Norway* for his kind assistance in this request.

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graph of estimated remaining life expectancy as a function of age. For comparison, official life expectancy curves from the U.S., Denmark, and Norway have been graphed alongside the estimates we computed.

In all three countries, life expectancy at birth (in years) for males-in-general ranged from the lower-to-mid 70s, while that for females-in-general ranged from the upper 70s to over 80. The ever-married in each country and for each sex exhibited slightly greater longevity than males or females in general. By contrast, estimates of life expectancy for MSM in the U.S. ranged from the low 40s (if AIDS was the cause of death) to the low 50s (if AIDS was not the cause). In Denmark and Norway, homosexually-partnered males had a life expectancy in the low 50s. For females, FSF in the U.S. had an estimated life expectancy of approximately 55 years. This compared closely to homosexually-partnered females in Denmark and Norway, both of whom had life expectancy estimates in the mid 50s.

In general, wherever a comparison could be drawn between homosexual and non-homosexual groups, life expectancy at birth was significantly less for homosexuals ($p < .0001$; $p < .01$ for Norwegian females), typically on the order of 20+ years. This was true for men and women in the U.S., Denmark, and Norway, whether partnered or unpartnered at time of death, and also whether or not AIDS was judged the cause of death. In the U.S., MSM who died of AIDS had estimated life expectancies at least 30 years less than either official U.S. figures for males-in-general or estimates from *Washington Post* obituaries for all males or ever-married males.

In terms of fractions surviving to old age (65+ years), there were highly significant differences (t-test, $p < .0001$) between the ever-married and ever-partnered in Denmark and Norway, and between the ever-married and homosexual obituaries from the U.S. In all three countries, proportions of males-in-general and ever-married males who survived to old age ranged from 75-85%, while similar proportions for females-in-general and ever-married females ranged from 80-90%. For partnered MSM in Denmark and Norway, the proportion surviving to old age ranged from 19-21%. In the U.S., the proportion of MSM who died of causes other than HIV/AIDS but survived to old age was also 21%. Partnering overall was insignificantly related to survival past age 64; however, among non-AIDs deaths, partnered individuals tended slightly ($p < 0.2$) to survive to old age more frequently than the unpartnered.

These differences — with a much greater fraction of non-homosexuals surviving to old age — persisted across the sexes, and also whether or not the individuals were partnered or unpartnered at time of death (see **Figure 6**).

Use of Cohort Life Tables

Our use of cohort life tables is somewhat unusual. For one thing, the individuals included in our computations did not all come from the same birth cohort. Furthermore, when calculating separate life tables by marital status, we had no way of determining which individuals had 'switched' their status (e.g., from ever-married to ever-homosexually partnered) at some point in life. Still, the data at hand allow for crude estimates. There is also precedent for this kind of analysis. The famous statistical pioneer, Karl Pearson (1902, cited in Chiang[10]), calculated life expectancies for ancient Egyptians by using ages-at-death recorded on the sarcophagi of 141 mummies.

Of course, without the larger, surviving at-risk population included, there is undoubtedly bias associated with the cohort life table method. In the *Washington Blade* obituary data set, there was no way to construct a population at-risk. In Denmark and Norway, the problem was two-fold: 1) the apparent population at-risk was not stable over time. During the early and mid-1990s, the numbers of partnered individuals increased approximately 40% in Danish gays, nearly doubled in Danish lesbians, and jumped approximately five-fold in Norwegian homosexuals. The state of flux in these countries since the adoption of homosexual partnership registries makes it very difficult to compute reliable *current* life tables by marital status; adding to this, 2) the number of deaths among ever-homosexually partnered individuals was too small in any given year to enable precise or stable survival estimates.

Norwegian homosexual partners were almost 3 years younger in median age than their Danish counterparts. Given that Denmark legalized homosexual "marriage" four years earlier than Norway, it is may be that the age distributions of the homosexually partnered in these countries will approach that of Denmark. Additionally, it is possible that gays and lesbians disproportionately "drop out" of the homosexual lifestyle after younger adulthood and/or re-marry heterosexually rather than die at an early age.

While the cohort life table method, as we have employed it, is undoubtedly biased, it is also fair to speculate that the degree of bias should diminish as the pool of recorded deaths grows larger and the time frame over which the deaths are recorded is lengthened. This should be true whether one has a 'census' of recorded deaths from a given locality, or a random or near-random sample of those deaths. To test this notion, we compared the *cohort* life table for *all* Danish deaths by sex from the period 1990 through 2002 against an average of the officially published *current* life tables from Denmark over the same period of time (www.statbank.dk). We did the same comparison against official life tables using the Norwegian death data over the period 1997 through 2002 (http://statbank.ssb.no/statistikkbanken), and using the *Washington Post* obituary data in the U.S.[11,12,13,14] An overlay of these life expectancy curves is shown in **Figures 2** through **5**.

When looking at males-in-general or females-in-general in Denmark and Norway, the degree of bias — using the officially published life tables as the standard — is at most a year or two. Thus, although we cannot know the degree of bias associated with the much smaller data sets of, say, ever-partnered gays and lesbians, we have some confidence that differences of 20 or more years in average life expectancy are not due to bias inherent in the estimating technique.

Such a conclusion is also bolstered by the U.S. comparison, where the *Washington Post* life expectancy curves (based on cohort life tables) for all males and all females are generally within 1 to 3 years, across the lifespan, of the official U.S. estimates. In this case, the sets of obituaries are much smaller (N = 627 for males and N = 331 for females) and on the order of the MSM and WSW groupings, yet the match to the official U.S. curves is quite good — and this despite the fact that *Washington Post* obituaries generally represent one metropolitan area.

Estimates of life table standard errors assume 1) that the population of ages-at-death is not so skewed as to make central limit theorem approximations untenable, and 2) that the sets of deaths behave statistically like a random sample of all similar deaths. In particular, the standard errors are likely to be somewhat conservative when the sample of deaths is smaller. Also, there is an implicit assumption that officially recorded deaths in Denmark and Norway comprise a random sample of ever homosexually-partnered individuals in those countries, that the obituaries from

the *Washington Blade* behave as a random sample from all such MSM and WSW deaths in at least the Washington, D.C. metropolitan area, and that those from the *Washington Post* are similarly representative of D.C.-area residents. None of these assumptions can be verified one way or the other, limiting our analysis. Nevertheless, the empirical comparisons above do not suggest that any of these assumptions has been outlandishly violated.

The sets of homosexually-partnered individuals from Norway — though including all officially recorded deaths between 1997 and 2002 — are quite small. The standard errors for these groups reflect to some degree the greater uncertainty associated with these data sets, but probably not all of it. Although the Norwegian estimates for life expectancy are generally consistent with those from Denmark, and indeed with obituaries from the *Washington Blade*, we recognize that there may be substantial additional bias associated with these figures.

Discussion

Bureaucratic Distortions

The systematic exclusion of older adults appears to have resulted in inaccurate population estimates concerning the prevalence of homosexuality and to have obfuscated the paucity of older homosexuals. If homosexual activity and/or desire were a constant across the adult life span, excluding those aged 60+ would make little difference. But, as the Canadian findings demonstrate, those who identify themselves as homosexual and/or engage in homosexuality constitute a relatively stable fraction of adults only for those aged into their mid-40s (in the 2003 CCHS, one of every 47-48 adults). Thereafter, their proportion drops regularly, down to one of every 234 adults in old age (see **Table 1**). The same trend is evident in other existing probability samples; no matter how homosexuality is defined, its prevalence generally declines within the fifth decade of life.

Furthermore, the survey item employed by *Statistics Canada* asked for a kind of 'identity,' but also included sexual behavior in defining that identity. Respondents could construe it to deal only with current desires, only with actual sexual relations, or some combination of the two. The question does not specify a time frame, so 'heterosexual' might include those who currently have sex with the opposite sex, those who would have sex with the opposite sex if the opportunity presented, or those who once considered themselves 'homosexual.' Thus, a response of homosexual or bisexual seems likely to index a combination of both 'philosophic' and 'behavioral' homosexuals. Given these ambiguities, and the generally lower rates of homosexuality when behavior rather than desire is indexed, it seems unlikely that as many as 1.4% of non-institutionalized Canadian adults recently engaged in same-sex sexual activity.

Despite the ambiguity in wording, given its size, the Canadian sample may permit an empirical bias correction to the prevalence of homosexuality for other studies that excluded older adults. Based on the difference in the 2003 CCHS when the full age-range of adults is included, estimates from samples that excluded older adults might be multiplied by a 0.84 correction factor. We don't know, of course, whether the same level of correction would apply to questions about sexual desire versus those concerned only with sexual behavior. Nonetheless, a downward bias correction would appear appropriate to both.

In 1992, based on a representative sample of 3,432 non-institutionalized U.S. adults aged 18-59, investigators[6] estimated that 1.4% of women and 2.8% of men regarded themselves 'as'

bisexual or homosexual. This kind of question addresses the number of 'philosophic' homosexuals. Presumably most had engaged in sexual activities with a same-sex partner, but it may have also included some who had either not moved beyond sexual desire, wished to make a political statement, or who were not currently sexually active. If the 'Canadian bias correction' is applied, these proportions would have been 1.8% for the population as a whole (2.4% for men and 1.2% for women).

In 1992, a national probability sample of 18,876 non-institutionalized Britons aged 16-59 was asked if respondents "had [homosexual] sex [with an adult]… involving genital area contact" in the last 5 years.[7] 1.5% of men and 0.7% of women said that they had. The survey question in this case addressed 'behavioral' homosexuals — irrespective of what respondents might label themselves. Applying the 0.84 'Canadian bias correction' would result in 0.9% of adults having participated in homosexuality (1.3% of men and 0.6% of women).

In 1996, the National Household Survey of Drug Abuse, with input by the U.S. Centers for Disease Control [CDC], interviewed 12,381 non-institutionalized adults aged 18-59 as to whether they had, in the preceding 12 months, engaged in "anal, oral, or vaginal sex" with a member of their sex.[15] Of respondents aged 18 through 59, 1.2% answered yes (1.1% of women, 1.3% of men). The question in this study also addressed 'behavioral' homosexuals. If the 'Canadian bias correction' is applied here, perhaps 1.0% of all adults engaged in recent homosexual relations (1.1% of men and 0.9% of women). Of further relevance to the question of longevity, the oldest WSW was aged 49, while the oldest MSM was aged 54.

With or without our proposed bias correction, none of these large, population-based studies estimated the prevalence of homosexuality at anywhere near the 5-7% reported by the British *Department of Trade and Industry*, including the survey of over 18,000 Britons. Why were these data neglected by an official government bureaucracy in its public statement on the size of the homosexual footprint?

2002 National Survey of Family Growth

A different kind of distortion is evident in the 2005 report on the 2002 National Survey of Family Growth [NSFG] by the NCHS.[5] On one hand, questions about same-sex sexual activity were apparently asked only of younger adults, thus again excluding a large portion of the population (all those aged 45+). In addition, by not clearly distinguishing between 'male' and 'man' in its published write-up, the NCHS gave the misleading and inaccurate impression that adult-to-adult homosexual behavior is more prevalent than the evidence would dictate.

Many sexual experiences occur 'one or a few times' in childhood and/or adolescence, never to be repeated. A random sample of 337 men from the San Francisco area in 1969-70 who called themselves mainly or exclusively heterosexual was asked by the *Kinsey Institute* about their pre-pubertal and post-pubertal homosexual experiences.[16,17] Out of this group of self-identified heterosexuals, 25% reported some sort of pre-pubertal *homosexual* sexual experience. 81% said they were under the age of 12 when this event occurred.

Importantly, the bulk of these experiences apparently occurred with other boys, since only 10% reported the sex was with an adult (two of which were fathers or stepfathers) and 33% said the event happened only once. The *Kinsey Institute* report does not permit a breakdown as to how many of the oral sex experiences, in particular, were only performed once, or how many

were with an adult. Nonetheless, 2.7% of these heterosexuals said that they had had oral/penile sex with a male before the age of 15.

In the same study, 39% of the 337 heterosexuals reported some sort of homosexual experience *after* puberty. But 40% of these were under the age of 15 when this experience occurred (the median age of those experiencing a homosexual encounter was 15) and only 43% of their partners were adults. Based on the reporting, we do not know precisely what proportion of these post-pubertal homosexual events occurred with another adult while the respondent was under the age of 15. Nevertheless, since at least 2.5% of the sample reported some pre-pubertal oral same-sex experience, and a large fraction were under 15 when they claimed post-pubertal homosexual experience, it would seem unlikely that all the oral and anal sex experiences occurred when the respondents were adults.

A more recent study, the 1991 National Survey of Men,[18] asked about homosexual sex in the last 10 years among men aged 20-39. Of this sample, only 2.3% reported homosexual sex. Broken down by age group, the figures were 2.3% for those aged 20-24; 3.0% for those aged 25-29; 2.2% for those aged 30-34; and 1.3% for those aged 35-39.

Compared to these surveys, the claim by the NHCS that "6.5 percent of men 25-44 years of age have had oral or anal sex with another man" appears highly improbable, even if a majority of such experiences might have occurred between men. The net effect of the imprecise questions and misleading reporting by the NCHS is to inflate the apparent proportion of men with adult homosexual experience. The extent of the inflation is uncertain, but it is possible that if 2.7% of heterosexuals engaged in this behavior before puberty, and many of them never again, it could result in the 6.5% NHCS figure being overestimated by at least a third, and maybe by as much as a half if the 1991 National Survey of Men is accurate.

A similar distortion is evident in the NCHS's claims about adult female homosexuality. In the 1969-70 *Kinsey Institute* survey,[16,17] of 140 mainly to exclusively heterosexual women, 26% reported a pre-pubertal homosexual experience of some sort. Eight percent of this subset said the experience happened only once; while 56% said a homosexual experience happened 2 to 5 times. But apparently none of these pre-pubertal experiences occurred with a woman.

Post-pubertal homosexual contact with a female was reported by 11% of the 140 heterosexual women. Of these, the median age at which the first experience occurred was 16; 20% of the respondents were under the age of 15. From the 'reverse' perspective of potential partners, since only 4% of 289 lesbians in the same survey reported sex with girls "aged 16 or younger" after they themselves had turned 21 (p. 311), it again appears unlikely that many of the homosexual experiences reported by *heterosexuals* in the *Kinsey Institute* study were with a woman, as opposed to occurring between teenagers or girls.

Finally, while the NCHS touted the 2002 NSFG and made explicit comparisons in its report to selected other sexuality surveys, it failed to cite the sex survey of 12,381 adults aged 18-59 conducted via the National Household Survey of Drug Abuse [NHSDA] with CDC input in 1996.[15] Interestingly, in the NHSDA for those aged 25-44, only 1.4% of men and 1.5% of women reported same-sex vaginal, oral, or anal sex in the past 12 months. These estimates are well below the 2002 NSFG estimates on recent same-sex activity for men and for women; in fact, they are substantially less than the lower 95% confidence bounds on such activity reported by the NCHS.

Homosexual Prevalence in Older Adults

Given the impact of AIDS and other STI on Western society — an impact that even the gay-sympathetic University of Saskatchewan's Community-University Institute for Social Research estimated at $300,000 to $800,000 per case, or $1,200/Canadian citizen to 1998[2] (p. 34) — and the disproportionate role of homosexual conduct in such infections, from a public health standpoint it is useful to have accurate risk estimates of potential transmission. Certainly, such estimates as exist have been utilized by public health officials. When the AIDS epidemic began, the CDC reported that:

> "Estimates of the homosexual male population are derived from Kinsey, *et al.*, (1) who reported that 8% of adult males are exclusively homosexual and that 18% have at least as much homosexual as heterosexual experience for at least 3 years between the ages of 16 and 55 years..."[19]

The apparent drop in homosexual prevalence with age is suggestive of three possible mechanisms: 1) an increased propensity for older individuals to 'hide' their non-heterosexual impulses from researchers; 2) a decrease in the relative proportion of non-heterosexuals among older adults, due either to a) a shorter life span, and/or b) changes in sexual preference away from homosexuality and bisexuality.

Though the first mechanism is conceivable due to the tendency for individuals to accumulate status, position, and/or wealth as they age, thus plausibly making the fear of being 'outed' at an advanced age greater than that for younger adults, to our knowledge no systematic empirical evidence has ever been put forward to support this notion. By contrast, the evidence from Danish and Norwegian death registries and American obituaries of homosexuals suggests that their declining prevalence may be due to an earlier average age of death.[8] The Canadian findings jibe with other databases regarding a paucity of older homosexuals and a decline in the prevalence of homosexuality starting within the fifth decade of life, but as a cross-sectional rather than a longitudinal survey, the CCHS does not address the mechanism of this decline.

As noted earlier, the CCHS found an increase with age in the proportion of individuals who either refused to identify their sexual orientation or who responded "don't know." Perhaps *Statistics Canada* did not report its results for older adults because of the relative increase in the proportion of refusals and "don't knows," thus suggesting a decreased reliability in the estimate for those ages.

However, even if the probability of refusal increased among older adults, do those aged 60+ have any more reason to hide non-heterosexual tendencies than younger adults? Certainly, if refusals and/or "don't knows" were *intentionally concealing* their sexual orientation, and most of them were actually homosexual or bisexual, the overall estimate of non-heterosexual preference could easily be double or treble the value reported by Statistics Canada.

Quite possibly, however, these non-respondents included a segment of 'asexuals' — individuals who are simply not much interested in sex. In the 1983-84 Family Research Institute (FRI) national sexuality study,[20] over 5,000 randomly selected individuals were interviewed in six large urban areas across the U.S. concerning their sexual preferences. That survey was much smaller, mostly urban, and used an item that indexed desire rather than behavior, but which included an option to declare oneself 'asexual.' Though the FRI results differ in magnitude and precision from the 2003 CCHS, the increase with age in those rating their sexual desires as "not

interested" (i.e., asexual) is not dissimilar to the uptick among older adults in the proportion who did not select an available sexual orientation in the CCHS (**Table 3**). Further, the FRI results also suggest a decline in non-heterosexual desires across the adult life span.

Such findings do not prove that older adults involved in homosexuality don't tend to conceal their sexual preferences/identities from researchers. Nevertheless, they are suggestive that older adults may lose and/or lessen their sexual interests and behaviors over time — whether heterosexual or homosexual — and that this phenomenon was picked up indirectly by the CCHS.

Does 'Discrimination' Drive Homosexuals To An Early Grave?

The frequently-made claim that those who engage in same-sex sexual activity have health problems primarily due to discrimination is unsupported by direct empirical evidence. Banks[2] (p. 1) asserted that homosexuals "have a shorter life expectancy and face health risks and social problems at a greater rate than heterosexuals. The reason for these increased problems is the chronic stress placed on GLB from coping with society's negative responses and stigmatization."

There is no uncontested link between the 'stress' of discrimination and taking 'health risks and social problems.' For instance, when large random subsamples of whites and blacks were compared on a number of dimensions of well-being, even though blacks continue to be objects of discrimination, no systematic difference favoring the greater health of whites was found.[15] Still, as Banks documents, the contention that 'discrimination causes injury/harm and/or death' is widely disseminated and apparently accepted.

Canada, Norway, and Denmark are far more accepting of homosexual practitioners than the United States (where homosexuals are still barred from the military and 'gay rights' laws do not exist in most states). If we consider life expectancy as an index of overall health (in agreement with Banks), we can make a rough test of the proposition that 'discrimination drives gays to an early grave.' For Canada, of course, we do not have age-at-death data tabulated by sexual proclivity or by gender of legal partner. Still, there is an apparent drop in homosexual preference by the fifth decade of life.

In Denmark and Norway, average life expectancies for almost 700 partnered gays and lesbians were similar to obituaries for U.S. gays and lesbians during the same period: 52 yr. for 710 gays who ostensibly did not die of AIDS, 42 yr. for those 1,476 who supposedly did; 55 yr. for 143 lesbians. The comparable European estimates were 51 yr. (Denmark) and 52 yr. (Norway) for gays, and 56 yr. (Denmark, Norway) for lesbians. Average life expectancies for the married were also similar across the three countries. From U.S. obituaries: 75 yr. for 550 ever-married men and 77 yr. for 272 ever-married women. In Denmark, ever-married men lived on average 74 yr. and in Norway 77 yr. Ever-married women lived 78 yr. on average in Denmark and 81 yr. in Norway.

Regardless of country, the ever-married outlived gays and lesbians by more than 20 years on average. By this test, the similarity of the findings across the three countries — despite differing social policy and law regarding homosexuality — falls in a direction *against* the hypothesis that 'discrimination causes early death.' Instead, lesser longevity might be inherent in practices associated with the homosexual lifestyle.

Implications

The contention that 'society' is to blame for the misfortunes that befall those who engage in homosexuality is part of the modern doctrine of victimhood.[1] According to this philosophy, individuals are not responsible for their troubles, 'society' is. The same claim is often made by drug users, members of communes, bigamists, and other species of nonconformist.

Traditionally, good citizens: 1) produce more than they consume (reflected in contemporary radio commentator Paul Harvey's "put more wood on the woodpile before they leave"), 2) obey the law; and 3) marry and have children. As a group, those who engage in homosexuality fail — substantially — to produce more than they consume, given the costs in medical care and law enforcement they impose on society. As well, besides the more frequent unemployment mentioned by Banks,[2] they are more apt to miss work.[15] While Banks does not mention the more frequent criminality of homosexuals being caused by 'homophobia' per se, almost all comparative studies report that homosexuals are more apt to engage in criminality (see review in ref. 9). As to getting married and having children, homosexual practitioners have no more than a quarter of the children required to reproduce themselves.[21] Only those committed to a philosophy of victimhood could 'blame society' for the ills of those who practice homosexuality while neglecting the reality that any society has to cultivate good citizens to long continue.

The implications of a foreshortened homosexual life span include:

1) 'Gay rights' appears to have no effect on the size of the decrement in gay longevity. As such, our findings provide no empirical support for the argument that while 'gay rights reduces the constitutional rights of assembly, free speech, and parental control of non-homosexuals, it is worthwhile because it increases the longevity of homosexuals.' If society wants to excuse from good citizenship those who engage in same-sex relations, because it meets the approval of gay activists, it will have to do so without claiming any health benefit. Further, if 'gay rights' encourages others to take up same-sex relations, society will risk failing to maintain minimum fertility levels for replacement.

2) 'Gay marriage,' unlike conventional man-woman marriage, appears to have no effect on the longevity of those who engage in homosexuality. As such, it is of no benefit to allow those who are voluntarily non-productive (that is, who don't bear and raise children) to share the benefits of marriage with the productive. That such an attitude is already bearing destructive fruit is evident in that men and woman less frequently aspire to marriage in favor of cohabitation, and an increasing share of children are born outside of marriage.

3) 'Gay adoption' is ill-advised since, on average, a homosexual couple aged 35 yr. would be about as close to demise as a man-woman couple aged 55 yr.

4) 'Favorable depiction of same-sex behavior and the homosexual lifestyle' in schools would appear contraindicated. Smoking is condemned because it is associated with a reduction in longevity of 1 to 7 years. It is inconsistent to condemn smoking yet celebrate homosexuality when the decrement in life span for those practicing homosexuality approximates 20 or more years.

5) It is inconsistent to provide 'special protections for those who engage in homosexuality' but not for polygamists or adulterers, especially when no available empirical evidence

suggests anything like a 20+ year decrement in life span linked to these (or similar) sexual nonconformities; and

6) Disproportionate expenditures on HIV seem unfair, given that the association between HIV infection and same-sex sex is similar to the association between lung cancer and smoking. No one has to smoke or engage in homosexual sex. So while the decrement in longevity associated with these choices is unfortunate, the decrement in lifespan that millions suffer from cardiovascular disease, cancer, and diabetes — to name a few of the diseases in which no obvious choice was made to engage in high-risk activities — would seem to merit proportionately more research dollars. Despite enormous expenditures on HIV, those who engage in homosexuality appear to find numerous alternate ways to reduce their longevity (e.g., excessive drinking, use of illegal drugs, careless driving).

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Table 1. Sexual Preferences In Canada: 2003 (in weighted %)

Age	N	Hetero	Homo/Bi	Unknown	Hetero/Homo
18-24	11,335	92.85	1.96	5.2	47/1
25-34	19,204	92.96	1.96	5.1	47/1
35-44	21,269	92.79	1.92	5.3	48/1
45-54	21,282	93.04	1.32	5.6	70/1
55-64	19,538	92.56	0.85	6.6	109/1
65+	28,672	86.25	0.37	13.4	233/1
All	121,300	91.81	1.43	6.76	64/1

Note: Hetero = heterosexual; Homo/Bi = homosexual or bisexual; Unknown = refused or coded as "don't know"; Hetero/Homo = Ratio of heterosexual to non-heterosexual

Table 2. Life Expectancy Estimates (in yrs) by Country, Sex, and Status

Country	Sex	Status	N (dths)	Life Exp. at Birth	S.E. (yrs)	LCL (yrs)	UCL (yrs)	% Surviving 65+ yrs
Denmark	M	All	387,569	71.8	0.026	71.75	71.85	.746
		Ever-Married	333,336	74.4	0.021	74.32	74.40	.794
		Ever-Partnered	561	51.2	0.647	49.92	52.46	.216
	F	All	394,301	77.5	0.024	77.46	77.56	.841
		Ever-Married	353,483	78.3	0.021	78.29	78.38	.854
		Ever-Partnered	91	55.8	1.538	52.79	58.82	.242
Norway	M	All	132,082	73.8	0.045	73.67	73.85	.795
		Ever-Married	110,031	76.5	0.036	76.46	76.60	.844
		Ever-Partnered	31	51.7	2.156	47.50	55.96	.194
	F	All	134,825	80.0	0.039	79.95	80.10	.886
		Ever-Married	117,833	80.9	0.034	80.81	80.94	.900
		Ever-Partnered	6	56.4	5.657	45.29	67.47	.333
U.S.	M	All *Post* obits	627	73.6	0.578	72.50	74.77	.772
		Ever-Married	550	75.4	0.531	74.34	76.42	.816
		All MSM	2,186	45.2	0.257	44.66	45.67	.073
		All AIDS	1,476	41.7	0.201	41.33	42.12	.005
		All non-AIDS	710	52.3	0.588	51.17	53.47	.214
		All Partnered	1,243	44.8	0.338	44.11	45.44	.071
		All Unpartnered	943	45.7	0.396	44.90	46.45	.076
		AIDS-partnered	890	41.4	0.254	40.86	41.85	.006
		AIDS-unpartnered	586	42.3	0.327	41.64	42.93	.005
		Non-AIDS-partnered	353	53.4	0.844	51.75	55.06	.235
		Non-AIDS-partnered	357	51.3	0.816	49.65	52.85	.193
	F	All *Post* obits	331	76.2	0.849	74.52	77.85	.813
		Ever-Married	274	77.0	0.803	75.39	78.54	.850
		All FSF	143	54.8	1.385	52.07	57.50	.259

Notes:

LCL = 95% lower confidence limit; UCL = 95% upper confidence limit

Denmark and Norway —

    All = official death tallies over 1990–2002 (Denmark) or 1997–2002 (Norway)

    Ever-married = official death tallies of married, widowed, separated, and divorced individuals

    Ever-partnered = official death tallies of registered same-sex partners, separated partners, widowed partners, and dissolved partners

U.S. —

    All *Post* obits = obituaries systematically sampled from *Washington Post* during 1988, 1989, 1999, and 2002

    Ever-married = obituaries of married, divorced, separated, or widowed individuals from *Washington Post*

    MSM = gay obituaries from *Washington Blade* 1993–2005

    FSF = lesbian obituaries from *Washington Blade* 1993–2005

    AIDS = gay obituaries reported to have died of HIV/AIDS

    Non-AIDS = gay obituaries reported to have died from causes other than HIV/AIDS

    Partnered = gay obituaries reportedly partnered at time of death

    Unpartnered = gay obituaries reportedly unpartnered at time of death

Table 3. Sexual Desires in U.S. Urban Areas: 1983-84 (in %)

Age	N	Homo/Bi (Male)	Asexual (M)	Homo/Bi (Female)	Asexual (F)
18-29	1,809	8.0	1.3	2.9	1.4
30-39	1,276	9.0	1.1	2.0	1.7
40-49	652	7.5	0.8	1.7	4.4
50-59	513	3.0	1.3	0.7	12.8
60-69	412	1.8	7.1	0.4	30.6
70-79	154	2.6	15.0	1.4	40.5
80+	29	—	30.0	—	57.9
All	4,845	6.9	2.5	2.0	6.8

Figure 1.
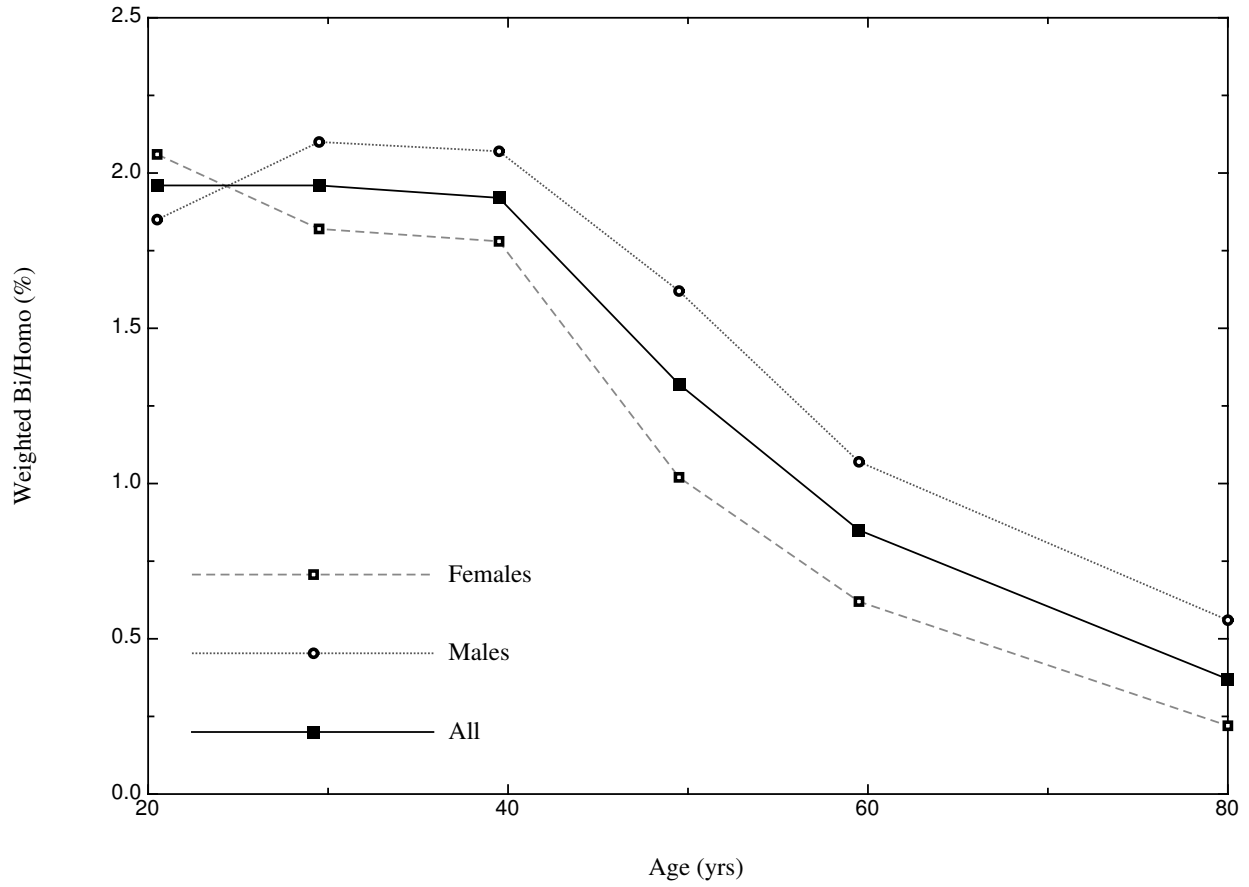
Figure 2.

Male Life Expectancy — U.S.
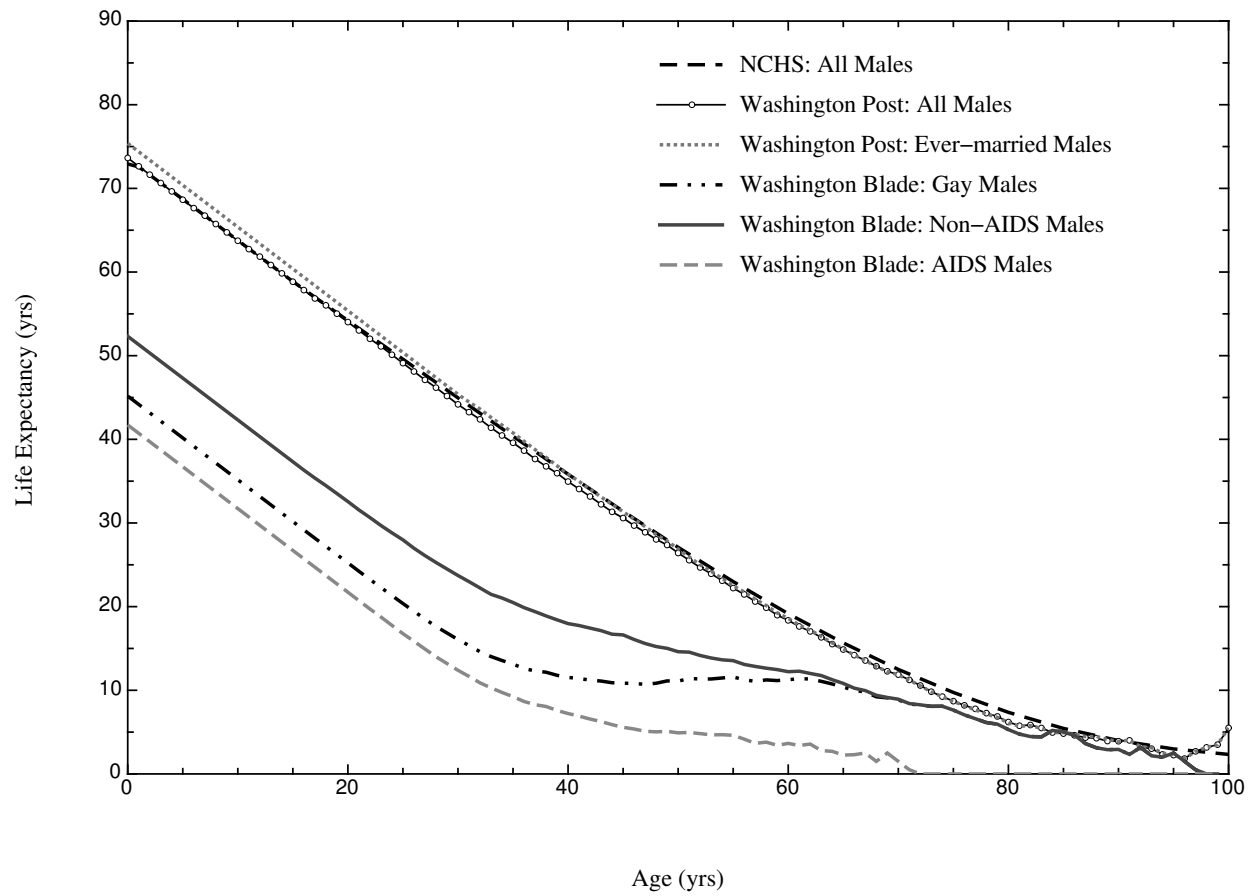
Figure 3.

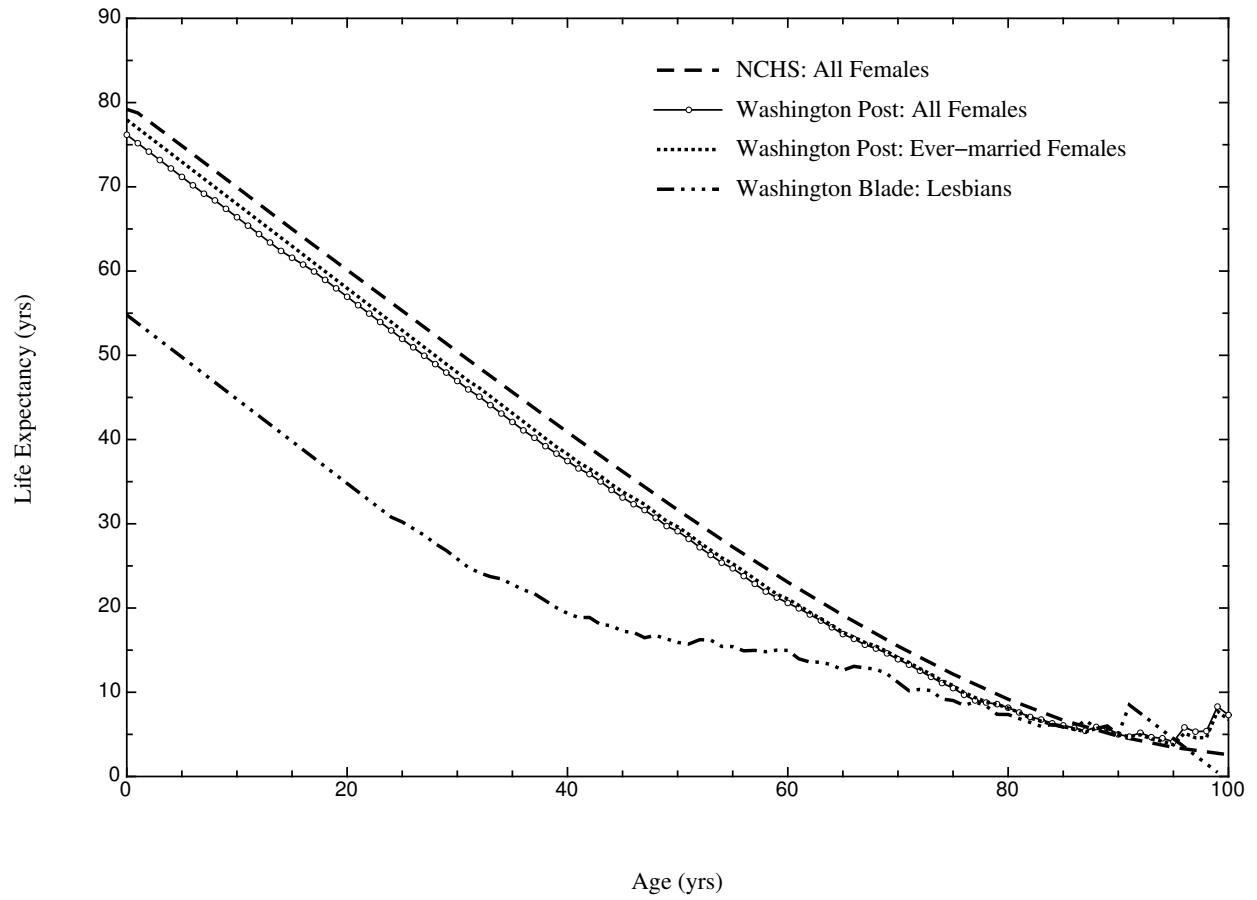**Female Life Expectancy — U.S.**

Figure 4.

Male Life Expectancy — Denmark
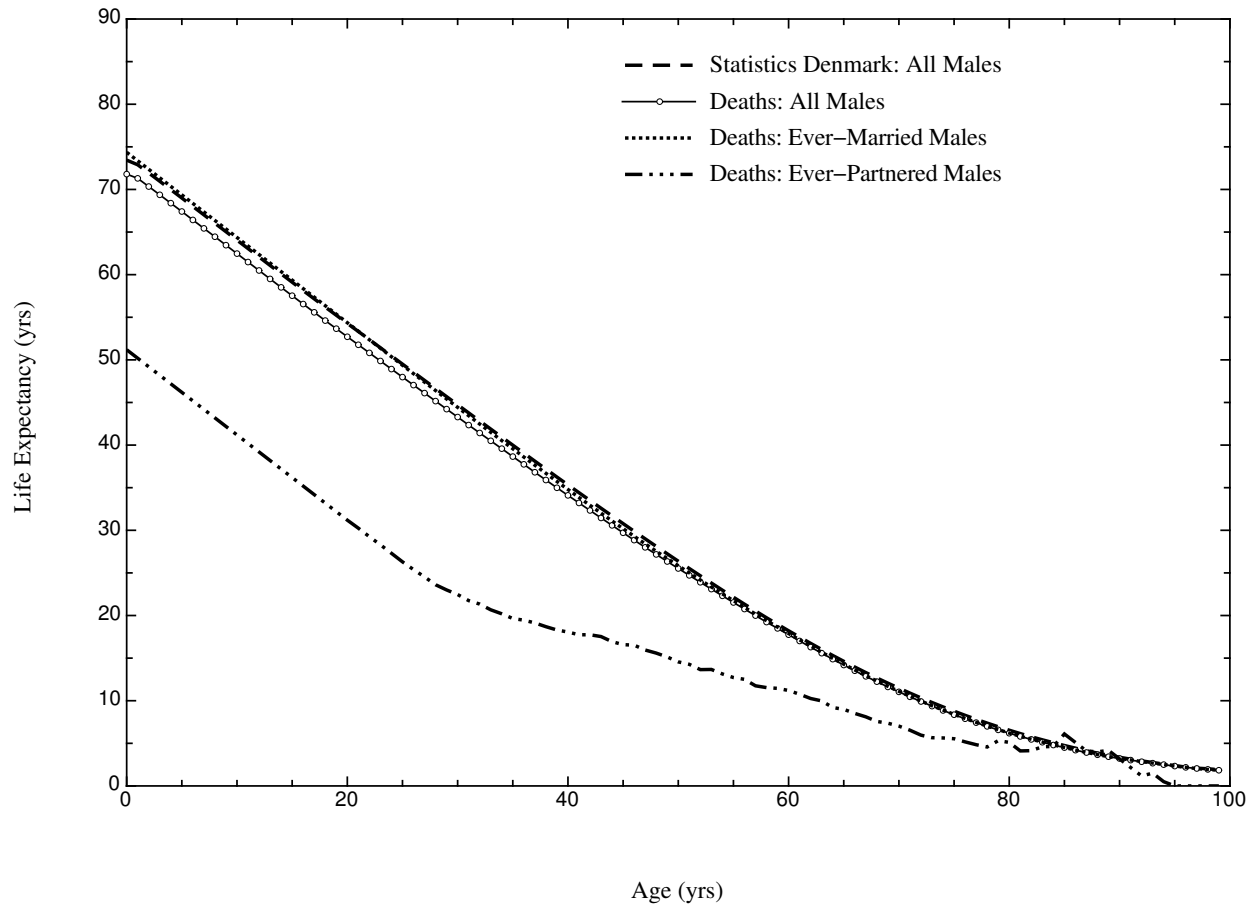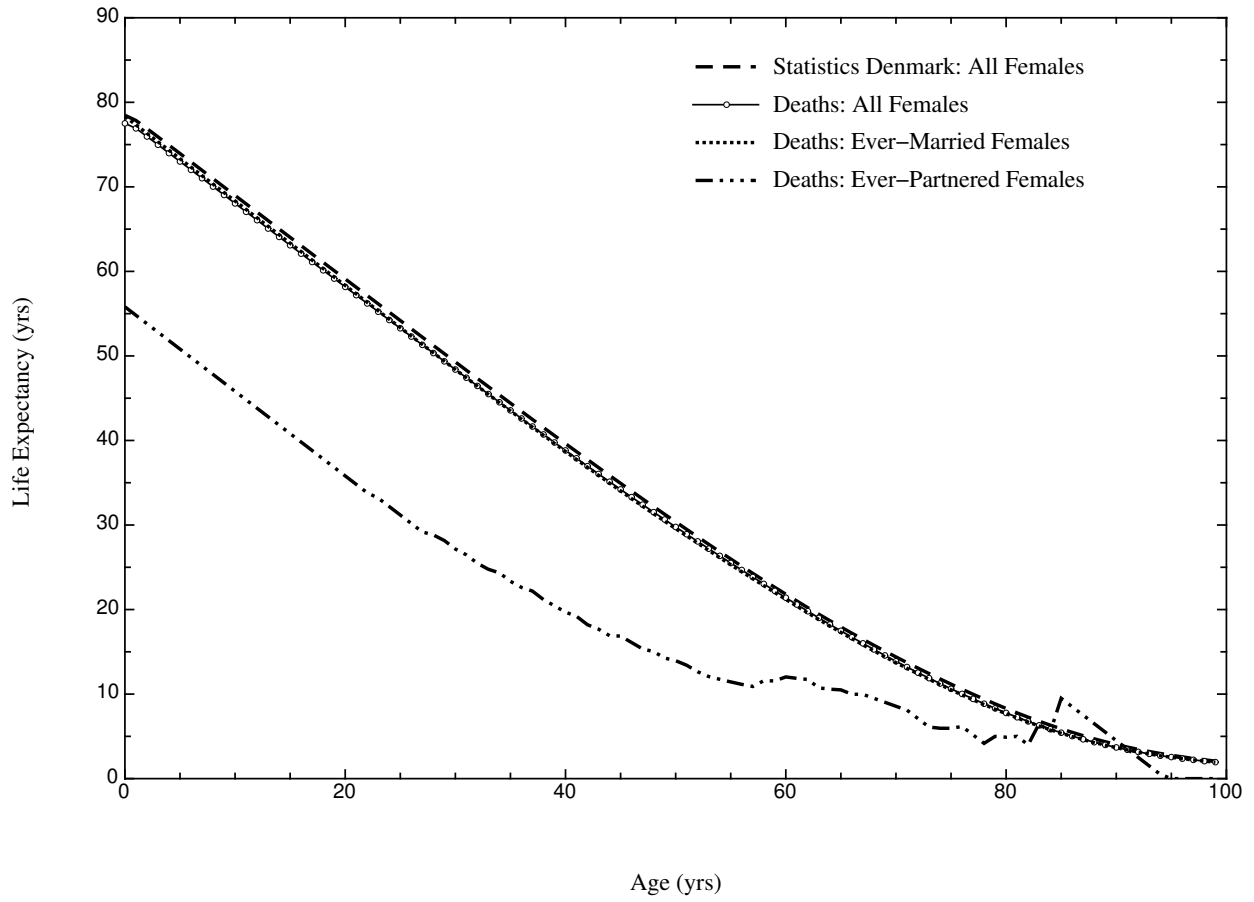
Figure 5.

Female Life Expectancy — Denmark

Figure 6.

Surviving to Old Age: Cross-National Comparison